HealthWorkforce AUSTRALIA

Mental Health Peer Workforce Literature Scan

An Australian Government Initiative

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Purpose

The aim of this paper is to draw out issues relating to the mental health peer workforce from the recent academic and grey literature. It is intended to be a scan rather than a complete literature review, and to ensure that the Mental Health Peer Workforce (MHPW) project is informed by the evidence currently available. This paper draws on national and international literature reviews and studies undertaken by others (including reviews undertaken by Repper & Carter (2011); the Cochrane Collaboration (Pitt et al 2013); and the New South Wales (NSW) Consumer Advisory Group (CAG) (2010).

Issues for consideration include definitions; identification of the benefits of utilising peer workers in mental health services; and issues relating to the employment of peer workers. The majority of the literature referenced is from the United States of America (USA) and United Kingdom (UK), where the peer workforce is further developed than in Australia. The literature generally has a greater focus on consumer peer workforce than carer peer workforce.

Background

Recovery

In December 2008, Australian Health Ministers adopted a new National Mental Health Policy to guide reform across the mental health service system. The vision of this policy is a mental health system that enables recovery; prevents and detects mental illness early; and ensures access to effective and appropriate treatment and community support to enable full participation in the community by people with mental illness.

A recovery philosophy is woven throughout mental health policies in countries such as Canada, New Zealand (NZ), the UK, the USA and Australia. Recovery is defined in a range of different ways, but is often understood to be a philosophy and approach to services focusing on hope, self-determination, active citizenship and a holistic range of services (Davidson, Chinman, Sells and Row, 2012). Recovery is not synonymous with cure, and for many people who experience mental illness, problems will recur, or will be persistent. The National Standards for Mental Health Services (2010) include an overarching set of principles for recovery-oriented practice.

These are:

- Uniqueness of the individual (which includes empowering the individual to be the centre of care).
- Real choices (which includes achieving a balance between duty of care and support for an individual to take positive risks).
- Attitudes and rights (which includes listening to, learning from and acting on communications from the individual and their carers).
- Dignity and respect.
- Partnership and communication (which includes acknowledging each individual is an expert on their own life, and that recovery involves working in partnership with individuals and their carers).
- Measuring progress towards recovery (which includes measuring outcomes on a range of indicators in addition to health and wellness, such as housing, employment and social relationships).

The employment of peer workers is often seen as a key component of transforming mental health services to a recovery orientation (Sledge, Lawless, Sells, Wieland, O'Connell & Davidson, 2011). Since the 1990s, the recovery movement has gained momentum, and this has been accompanied by significant growth in the employment of peer support workers (PSWs) in the USA, Australia and NZ, predominantly in the community sector. The paid employment of PSWs within public mental health services has been slower to develop (Repper & Carter, 2011).

Terminology

Peer work had its origin in self-help and mutual support movements that were volunteer in nature (Davidson et al, 2006). People came together to help one another, often meeting in groups for support, or to advocate for better services. Recently, peer work has evolved into more formalised approaches, and people are employed as peer workers in varying roles. This document focuses on literature relating to peer workers in paid employment.

Definitions of peer workers and related terms vary. For the purposes of this paper, peer workers (PWs) are defined as people who are employed in roles that require them to identify as being, or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness and recovery is an essential criterion of job descriptions, although job titles and related tasks vary (Mental Health Coordinating Council, 2011). Peer support, which is one element of peer work, is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations (Davidson et al, 2006).

Consumers and carers may have very different perspectives on their interaction with the mental health service system; experience of recovery; and requirements for information and support. Both groups, however, can contribute to and benefit from peer work. The National Mental Health Consumer and Carer Forum notes that it is not appropriate to expect carer workers to be able to provide expert advice or assistance for consumers, or for consumer workers to be able to provide expert advice or assistance for carers (2010). Consumer peer workers can and do support consumers, and carer peer workers can similarly assist carers and families.

Roles and functions

Peer workers undertake a range of roles in different mental health service settings. They may, for example, provide individual support, deliver education programs for mental health workers, provide support for housing and employment, advocate for systemic improvements, or run groups or activities. A wide range of titles are assigned to peer workers, and efforts have been made to better define peer worker roles and functions. The varying titles currently in use include, but are not limited to:

- Consumer academic
- Consumer advisor
- Consumer advocate
- Consumer assessor
- Consumer companion
- Consumer consultant
- Consumer coordinator
- Consumer liaison officer
- Consumer policy officer
- Consumer provider
- Consumer representative
- Consumer support worker
- Consumer survivor
- Consumer team leader
- Consumer worker
- Consumer or carer educator
- Carer academic
- Carer advocate
- Companion carer
- Carer consultant
- Carer representative
- Community support worker
- Community Rehabilitation support worker
- Mental health outreach worker
- Mental health rehabilitation support worker
- Mental health support worker
- Peer advocate
- Peer educator
- Peer mentor
- Peer respite worker
- Peer specialist
- Peer support worker
- Recovery advisor

The array of titles is potentially confusing, and in some cases the same role may have different titles in different services and jurisdictions. Consideration of role and function can be helpful in understanding peer workforce. The NSWCAG has defined seven key functions relating to the mental health consumer workforce (NSW Consumer Advisory Group, 2013):

- Individual advocacy.
- Peer support.
- Systemic advocacy and representation.
- Health promotion.
- Education and training.
- Quality and research.
- Coordination and management.

This approach to functions has been developed specifically for the consumer workforce in public mental health services in NSW. However, it may usefully be applied more broadly in considering the peer workforce.

Although a role may be classified as, for example, a peer support role or a systemic advocacy role, in practice there may be crossover of functions in any one position. A peer support worker may contribute to systemic advocacy work through representation on a committee, and a systemic advocate may utilise engagement skills and draw on their lived experience, to establish a relationship with a peer.

Advocacy and representation

Peer workers can support individual consumers and carers to understand and navigate mental health services, and other services they may need. This might include the provision of information; liaison with services, and attending appointments with the individual service user or carer.

Systemic advocacy can involve participation by consumers and carers at all levels of the mental health system, including at individual services, district, state and national levels. The role provides a lived experience perspective and may involve membership of committees; involvement in policy development or service redesign; or participation in workshops, forums or conferences.

Peer support

Some peer workers will provide peer support to other consumers or carers. There is no one, universally accepted definition of peer support. Mead (2003) suggests peer support can be viewed as 'a system of giving and receiving help, founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships'

As one service user put it: 'Yeah, it's nice to know… it's like having someone that you can confide in, you feel like you're kind of in the same boat…She was depressed, homeless, with a drug problem. And that's where I was. And I'm newer to it. She's got a car, she's got her apartment, and I'm building those things, and it's just… you know, somebody who really knows' Person with a severe mental illness describing experiences with a peer provider (Davidson, Bellamy, Guy & Miller, 2012)

Health promotion

Peer workers may be involved in health promotion in relation to mental health, recovery, physical health, and other areas. Both consumers and carers often have poor health in a range of areas. Some consumer peer workers are specifically employed in roles aimed at improving the physical health of people with severe mental illness, and some carer peers are employed in programs aimed at improving the health of carers. Program aims may include improvements in physical health, self esteem and social connectedness.

Education and training

Education of other mental health workers, and students undertaking health studies, can be an area of focus for peer workers. The National Practice Standards for the Mental Health Workforce (2002) stress the importance of involving both consumers and carers in the education of the workforce. Peer workers may also be involved in facilitating education groups for peers in a range of areas from art therapy to relaxation.

Quality and research

The role of some peer workers includes participating in quality projects or research. This may include facilitating the evaluation of mental health services by consumers and carers, and promotion of the involvement of consumers and carers in quality improvement initiatives and research.

Coordination and management

Some peer workers have a management role, supervising and managing peer and other workers. Tasks may include managing budget and other resources.

Evaluation and benefits

Mental health peer work is a relatively new approach to service delivery. Evaluation has lagged behind implementation of peer workforce roles, however, it is important to consider the available evidence regarding the utility of peer workforce. Many studies are qualitative, however, some randomised control trial findings are available. The quantitative and qualitative evidence suggests that the peer workforce can be as effective as the professional mental health workforce in some roles, and may offer particular benefits to consumers, peer workers, families, carers and service providers.

Research has focused more on some areas of peer work and service delivery than others. More studies have been undertaken on consumer peer workers than on carer peer workers. Research has often focused on peer support as a specific element of consumer peer work. Where research specifically concerns peer support, an effort has been made in this literature scan to ensure that this is clear, however, it should be noted that definitions in relation to aspects of peer work are often ambiguous. Research has also focused on peer work in the context of adult services; there are fewer studies on which to draw with regard to children, young people and older people. For particular age groups, the definition of peer may also involve a person of a similar age or developmental stage, as well as lived experience of mental illness (Daley et al 2013). As the research base grows, knowledge of the utility of peer work for people across the lifespan, and their families and carers, will be enhanced.

Benefits for consumers

Admission rates and community tenure

The phenomenon of cyclic hospital re-admission of people with mental health conditions is well identified in the literature and in practice. The provision of support that is appropriate and engaging on discharge can offer significant benefits to the consumer, and assist them in making a successful transition back into the community. Peer support can also be provided to individuals who may be at risk of readmission, assisting them to stay well.

Evidence suggests that peer support may be effective in reducing hospital admission rates. Repper and Carter found that people engaging in peer support tend to show reduced admission rates and longer community tenure. Chinman, Weingarten, Stayner and Davidson (2001) compared a peer support outpatient program with traditional care and found a 50% reduction in readmissions compared to the general outpatient population. A South Australian study of a mental health peer support service providing hospital avoidance and early discharge support to consumers over a three-month period found savings of 300 bed days, equating to some $93,150 saved (Lawn, Smith & Hunter, 2008).

The South Australian project model provided some structured processes around discharge, similar to a model evaluated by Forchuk, Martin, Chan and Jensen (2005). The latter study found that using peer support as part of the discharge process significantly reduced readmission rates and increased discharge rates. The model was tested in a randomized clinical trial involving either peer support for one year, or ongoing support from hospital staff until a therapeutic relationship was established with a community care provider. The peer supported group were discharged far earlier (116 days), with a reported saving of $12M. An evaluation of the Phone Connection and Hospital to Home Program in NSW lacked sufficient data to be definitive, but suggested that that the program made a difference in reducing the extent and number of readmissions (Weavall & Goodrick, 2009).

Empowerment

Many mental illnesses affect a person's functioning in social, family, educational and vocational roles. For most people, mental illness has its onset in childhood or adolescence, and this can have long term implications. People with a mental illness are among the most socially and economically marginalized members of the community. Opportunities for employment may be poor, and people with mental illness are over-represented in the homeless and prison populations.

Several studies of peer support report raised empowerment scores by consumers (Repper and Carter, 2011). One study found that both providers and recipients of peer support reported an increased sense of independence and empowerment, which may have related to increased stability in work, education and training (Ochocka, Nelson, Janxen & Trainer, 2006). Peer workers can support individuals in taking responsibility for their own recovery, by encouraging people to define their own needs, think about the choices that are open to them, and support and experiment in terms of different recovery strategies (Campbell & Leaver, 2003).

Social inclusion

People with severe mental illness often experience exclusion from key areas of social inclusion, such as housing and meaningful occupation. Maintaining connections and support can be critical to people with mental illness, who may experience loss of employment, family breakdown and other difficulties.

Mead, Hilton and Curtis (2001) argue that engagement in a peer support relationship allows participants to create relationships and practice a new identity (rather than that of a mental patient) in a safe and supportive environment. Studies have found that consumers involved in peer support initiatives have higher levels of community integration (Repper & Carter, 2011). Forchuk, Martin, Chan & Jensen (2005) found that consumers who received peer support demonstrated improved social support, enhanced social skills and improved social functioning.

"I've done a complete turnaround in my life. Even just going to a restaurant or a shopping centre, I don't feel that anxiety and stress any more. Yeah, I'm a citizen, whereas before, I didn't feel as if I was' (person involved in peer support program, Mental Illness Fellowship Victoria, undated).

Reduced stigma

Community awareness and understanding of mental illness appear to be making progress, particularly with high prevalence disorders such as anxiety and depression. However, people with mental illness are still at risk of being discriminated against in areas such as employment and housing, and there are still stigmatising attitudes evident in the media and community.

Being labelled as mentally ill can lead to expectations of devaluation and discrimination. People may perceive that they belong to a devalued social group and may devalue themselves. Experiences and expectations of being discriminated against or devalued may enhance feelings of shame or a belief they are set apart from others, and may cause people to re-evaluate and reconceptualise themselves (Verhaeghe, Bracke & Bruynooghe, 2008). Self stigma can cause people to avoid situations where they may feel publicly disrespected: 'Why should I even try to get a job? Someone like me – someone who is incompetent because of mental illness – could not successfully accomplish work demands' (Corrigan, Larson & Rusch 2009 p. 76).

Personal empowerment can be regarded as a parallel positive process to the negative processes associated with self-stigma. Repper and Carter note that peer workers embody the possibility of acceptance and success, so they can challenge the barriers created by self-stigmatisation (2012). Engaging in peer support can alter attitudes to mental illness, and break down stigma, as well as fostering hope (Mowbray, Moxley & Collins, 1998).

'I've been unwell for many years, and for the first time I don't feel ashamed of my illness. I don't feel that I'm less of a person' (person involved in peer support program, Mental Illness Fellowship Victoria, undated).

Hope

Recovery has hope as a keystone. For many people, their hopes and dreams are quashed with the onset of mental ill health, and the essence of participating fully in life can be taken away. Mental health practitioners have an important role in 'holding the hope' for that person, until they are strong enough within themselves to move forward (Stratford, Brophy & Castle, 2012).

Peer workers often receive comments from people using services, perhaps a statement such as 'You don't look like someone with a mental illness' (Heffernan 2010). The physical presence of a recovered peer can give people a reality to which they can aspire and work. A recent study of four mental health services noted that both peer workers and non-peer staff regarded the capacity of peer workers to offer hope and provide a role model of recovery as important. 'I've been there, done that and bought the t-shirt so I want to put my experience through to them and how to lead them into that right direction instead of going downhill like I did (North Peer Worker, quoted in Gillard et al. p. 9).

Benefits for peer workers

The literature reports that in addition to benefits for people using services, there are a number of benefits of peer support and peer work for the peer workers themselves.

Mental health and wellbeing

Giving peer support, like receiving it, results in increased self-esteem and increased levels of hope (Razlaff, McDiarmid, Marty & Rapp, 2006). For many people, work provides structure and meaning, and Hutchison et al (2006) suggest that for peer workers, employment can provide an identity shift from patient/consumer/client to that of valued worker and contributing citizen. Moran, Russinova, et al (2012) report that peer providers discovered personal strengths that they were not aware of previously, and that their sense of themselves as capable human beings was augmented through their work. As a London manager of peer workers commented, 'it's very powerful how it lifts people out of that sick role, to say, 'let us give them a job, here's some responsibility, I believe in you, you can do this' (Gillard et al 2013).

The nature of the role means that peer workers can increase their knowledge of mental illness and, through their work with service users, develop a clearer understanding of themselves.

'One thing that has really helped me about being a peer provider is reminding myself of the things I need to do to keep myself well, like, things that I encourage other people to use but I don't necessarily use them myself. So it's kind of a reminder bouncing back of them that, you know, you need to be doing this for yourself' (Moran et al 2012).

Acceptance

The role provides peer workers with an opportunity to integrate mental illness into their life and their identity in a positive way. Experience with mental illness and recovery are valued as a key element in designing and delivering mental health care. Moran et al reported that instead of trying to hide or ignore a mental illness, peer providers were able to embrace the notion of having a psychiatric condition and at the same time, pursue a fuller life beyond the illness (2012).

'My life experience is an asset, not a liability. It is required! It really informs my work every day and it has personally helped me transform a lot of pain into meaning and fuels my passion to make the mental health system a kinder, gentler place' (Maline, quoted in Bluebird).

Skills and employment

Training and work as a peer worker can increase an individual's skill base, which makes them more employable and opens up other employment and educational opportunities (Razlaff et al, 2006). Some peer workers may have been out of formal employment for many years. Working as a peer provider can give an opportunity to develop skills and competencies, in areas from approaching someone in distress, to group facilitation and curriculum development. For some individuals, peer work is a stepping stone to further education and employment in other areas.

Benefits for carers

Caring for a family member or significant other with a mental illness can have a tremendous impact on families and carers. It can affect relationships, work and finances, people's sense of personal freedom, recreational life and the mental and physical health of carers as a whole (Baronet 1999). Families and carers experience higher rates of depression and anxiety, social isolation, and decreased quality of life compared with the rest of the community (Pirkis et al 2010).

Families and carers often feel excluded when the person for whom they care is receiving mental health services. They may feel also, that professionals have a critical attitude towards them, are disrespectful, or that they are not welcome at the service. The limited available literature indicates that carer peer workers can improve outcomes for those with whom they work in a range of areas.

Admission of a family member or significant other to a mental health service can be a difficult and stressful event. Carer peer workers 'have a lived experience, which many parents/carers and staff might benefit from. They can offer hope to families who are overwhelmed by their child's admission to hospital. They can share with the staff the vulnerabilities they experienced when they were using the mental health system. In a very practical way, they can help ease the burden for families. By sharing the load, they can empower families and staff to communicate more sensitively and to work more collaboratively' (Gerraghty et al, 2011).

Empowerment and knowledge

Carers provide care for people with mental illness to a much greater extent than the mental health system, but their contribution is often unacknowledged and invisible. Peer support can provide people with the chance to air their feelings in a safe environment. Carers may experience guilt, anger, worry, blame, fear for the future, or a range of other feelings – and yet may also feel it is inappropriate or disloyal to voice those feelings. The peer worker role 'enables parents [of children with a mental illness] to give voice to these kinds of concerns without fear of judgement and without alienating the clinical staff upon whom they and their child depend. Shared lived experience, relative freedom from the time constraints of a busy ward, and greater power equivalence means that the consumer consultant is well credentialed to provide support to families' (Geraghty et al, 2011).

Peer support programs for carers can improve carers' knowledge about the illness, increase confidence and reduce caregiver burden (Dixon, Lucksted, Stewart, Burland, Brown & Postgrado, 2004). Studies of family education programs have found that families that participate in these interventions gain knowledge and feel greater satisfaction with mental health treatment; experience a reduction in burden, distress and anxiety; and improved self-efficacy and coping behaviours (Solomon 1996).

The Hunter Institute of Mental Health looked at the literature on family members and carers of people with depression (2013). A number of studies involved interventions that focused on providing information about depression, its treatment and service availability. Subsequent research by the Institute on the Partners in Depression program showed a profound improvement in participant ratings with regard to knowledge about depression and awareness of its effects on the individual, relationships, and carers. ARAFEMI recommends that in order to be effective, carer peer support programs need to have built into their structure and philosophy a dual purpose of learning and support.

Improved relationships

In families where someone has a mental illness, crises and tensions in relationships are common. The person with the illness may be highly dependent on carers, and issues such as the person's symptoms and treatment may become the central point around which family life revolves (l'Anson, 2004).

Peer support can assist carers with better management of difficult feelings; improved self care and better family relationships. Some interventions, for example, are designed to increase carers' stress management and coping skills. Chien, Chan and Thompson (2006) reported on their study of a mututal support group that operated over a six month period. At an 18 month follow up, carers reported greater improvement in the person's and the family's functioning and less caregiver burden. A Victorian peer-led education program led to significant reductions in participants' tension, worrying and distress. Participants also reported that the program had helped them improve their communication skills with their relative or friend with a mental illness (Stephens, Farhall, Farnan & Ratcliff 2011).

A participant in a carer support program noted 'before the course I used to call 'me' time self-indulgent, and now I call it self-care' (Hunter, 2013).

Social support

In a recent Australian study, more than half of the carers involved reported that the care and support role had a negative impact on their ability to engage in social activities, the quality of their relationships with the person experiencing depression and other family and friends (Hunter Institute of Mental Health 2013). Families frequently report feeling isolated from usual sources of social and emotional support.

Peer work with carers often involves family education programs, delivered in groups facilitated by trained carers. The wellbeing of carers is often a primary focus. The groups offer families and carers with a friend or relative with a mental illness an opportunity to meet and discuss issues with others who have a similar experience. A study of the Well Ways program in Victoria found that gaining a sense of universality (a sense that one is not alone, that 'we're all in the same boat') was perceived by participants as the most helpful group therapeutic factor (Stephens et al 2011).

Benefits for mental health services and the service system

Engagement of consumers

Studies report that peers can be very effective at establishing connections with 'hard to reach' clients. Sells, Davison, Jewell, Falzer and Rowe (2006) reported that peer support workers were highly skilled, and effective at engaging and communicating acceptance. They were able to increase treatment participation amongst the more disengaged in case management for consumers with comorbid mental health and alcohol and drug issues. Davidson, Bellamy, Guy and Miller note that peer staff can be especially effective in engaging people into care and acting as a bridge between clients and other staff. In this and other ways, peer support can be an important and useful complement to existing mental health services (2012).

"I just stand back and watch him work his magic. Not just with the patients who come in here so frightened and hopeless, but with staff too. He can help them see things in a completely different way…' (Nurse, quoted in Shepherd 2013).

Organisational culture

A key benefit for services of utilising peer workforce can be a positive change in organisational culture and improved recovery focus. A Scottish study found that having peer support workers in teams enhanced commitment to recovery. Staff reported being more aware of their use of language and being more reflective on recovery-oriented practices in their services (Bradstreet & Pratt 2010). In a study by O'Hagan, about half of the respondents said the presence of peer workers had helped to create culture change, through role modeling, informal dialogue, education and creating the conditions where some professionals felt safe to 'come out' as consumers/survivors (2011).

Peer workers can educate mental health professionals about the experience of living with mental health problems. Walker and Bryant found that non peer staff developed increased empathy and understanding toward people in recovery as a result of working with peer support workers. They also gained from peer workers a belief in recovery (Walker & Bryant, 2013).

Cost effectiveness

Peer workers may offer benefits in relation to cost-effectiveness. Hutchison et al, 2006, argues 'by increasing their trained peer personnel, an agency can increase the number of people served and their own cost-effectiveness due to the flexibility in scheduling and organizational commitment that is often inherent in the employment of peers. Davidson et al note that when well-trained and supervised, peer staff can lessen the load carried by other practitioners, enriching consumers' lives while allowing other staff to concentrate on their respective roles (2012).

A recent review using Cochrane Collaboration methodology (Pitt et al 2013) considered eleven randomized controlled trials in all. Part of the study compared five trials of consumer-providers to professionals in similar roles within mental health services. Four of these trials concerned case management and one, facilitating group therapy. Overall, they found that the outcomes for clients were no better or worse than those achieved by professionals employed in similar roles. Put differently, in delivering the same functions and activities, peer support workers produced outcomes comparable with their non-peer colleagues.

In reviewing the five trials, the Collaboration found no significant differences between mental health teams involving consumer-providers or professional staff in similar roles, in relation to client quality of life; depression; general mental health symptoms; client satisfaction with treatment; client or professional relationship; use of mental health services; hospital admissions and length of stay; and attrition. They did find a small reduction in the use of crisis and emergency service use in clients receiving services from consumer-providers. Further, past or present consumers who provided mental health services did so differently to professionals; they spent more time face-to-face with clients, and less time in the office, on the telephone, with friends and family, or at provider agency.

The Collaboration report notes caution about peer workers as they may not carry a full case load and may work fewer hours than non-peer staff. Absenteeism was noted to be a concern in some of the reviewed studies, and there may be challenges in retaining peer workers (2013).

Basset, Faulkner, Repper and Stamou (2010) note that mental health problems cost England over £77 billion per annum through care, economic losses and premature death. It was suggested in this report that an increase in the peer workforce would lead to a reduced use of treatment services and medication, which would lead to considerable savings across the mental health field. The report further estimated that some £26.1 billion is lost in the United Kingdom as many people diagnosed with a mental health problem are unable to work. The use of peer support can facilitate involvement in education and progression to employment, ultimately decreasing the unemployment costs for this particular population group.

In Australia, AIHW (2012) estimates that almost $7 billion was spent on mental health-related services in 2010/11. Services included residential and community services, hospital based services (both in-patient and outpatient), consultation with specialists and general practitioners. However, this estimate does not reflect the full economic burden of mental illness and costs to government. Because of the disability associated with mental illness, many people depend on governments for assistance that extends beyond mental health treatment. They may require community services including housing, community and domiciliary care, income support, and employment and training opportunities. AIHW has previously found that outlays by government on mainstream support for people with mental illness substantially exceed the costs of specialist mental health care. A recent report by private insurer Medibank (2013) estimates the overall direct cost of supporting people with a mental illness in Australia is at least 28.6 billion dollars per year.

In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and impairing the productivity of those who are employed. The Medibank report excludes indirect costs such as these. In contrast, the Herald-Lateral Economics Index of Australia's Wellbeing – which uses a range of indicators to measure changes in national welfare – calculates a dollar figure for how mental illness affects the Australian population beyond its narrow economic effect. According to the index, the cost of mental illness to Australia's collective wellbeing has reached $190 billion a year – equivalent to about 12 per cent of the economy's annual output (The Guardian, 2013).

Overall, the evidence with regard to cost-effectiveness and peer workers is limited, largely as not enough rigorous studies have been undertaken. A recent report by the Centre for Mental Health in the UK (Trachtenberg et al 2013) specifically examined whether peer support workers can reduce psychiatric inpatient bed use and thus prove cost-effective. The study found that peer support workers bring about significant reductions in bed-use among the patients they support, leading to financial savings which are well in excess of additional pay costs [for the peer workers]. The study concluded that the use of peer support workers is justified on value for money grounds (Trachtenberg et al 2013 p. 9).

Peer workers may be cost-effective in a range of different ways. They may complement the non-peer workforce, allowing both peers and non-peers to focus on using their respective expertise. Supporting health practitioners to use their full scope of practice can improve satisfaction, retention and productivity. By contributing to reductions in hospital admissions and improved employment for people with mental illness, peer workers can benefit the individual, their family and carers, and also reduce the costs associated with mental health treatment, income support, and other forms of government assistance.

Responding to crisis and reducing coercive practices

National safety priorities in mental health in Australia include reducing use of, and where possible eliminating, seclusion and restraint. This is consistent with the United Nations' Principles for the protection of people with mental illness and the improvement of mental health care.

In the USA, some services are using peer workers to receive people in psychiatric crisis. Recovery Innovations in Arizona carried out a study based on two crisis services that serve about 12,000 people annually (at the larger centre) and 2,500 annually at the smaller centre (Ashcraft and Anthony 2008). Some 32% of admissions were involuntarily admitted clients who were brought by police and others who believed them to be a danger to themselves or others.

The service undertook an initiative to completely eliminate the practice of seclusion and restraint, using strategies including strong leadership direction, policy and procedural change, staff training, consumer debriefing and regular feedback on progress. The larger centre took ten months until a month registered zero seclusions and 31 months till a month recorded zero restraints. The smaller crisis centre achieved these same goals in two months and fifteen months respectively. Adding peers to the staff team was an important element in the initiative, changing staff attitudes towards recovery, and reducing acceptance of seclusion and restraint.

Workforce challenges and barriers

The employment of peer workers can offer significant benefits to people using services, carers, families and mental health services. Davidson et al have warned, however, that implementing peer support services in mental health settings is messy and complicated work. Gates and Akabas (2007) classify the issues that may arise into five categories: poorly defined jobs; negative attitudes from non-peer workers; role conflict and confusion; lack of clarity around confidentiality; and limited opportunities for networking and support. These categories reflect the literature from Australia and internationally.

Poorly defined jobs

The roles and responsibilities of peer workers are often vague and unclear. Peer workforce roles often lack job descriptions and associated structures such as supervision, training and effective communication about the roles to other employees. Remuneration may also be problematic with peer workers having unequal pay and benefits to other workers. Peer worker roles have expanded over time to include a range of tasks and duties, as outlined previously. Services have sometimes struggled to clarify the role of consumer workers, and to develop a better understanding of what is reasonable to expect from the workforce (Moll, Holmes, Geronima & Sherman, 2009).

Supervision and support is important for all employees, to ensure that a work role is delivered successfully, and to address issues that may arise on the job. As for any worker, the requirements of the job need to be mastered, and workers need to manage their time and productivity. Additionally, for consumer workers, there is a possibility of becoming unwell and requiring treatment for mental illness, and for carer workers, there may be a need to respond to care requirements for which they are responsible.

Peer workers should have the same access as other workers to benefits such as employee assistance or leave. Additionally it may be helpful to put in place an agreement between a consumer worker and the mental health service as to what will occur if the worker requires treatment for their mental illness. This may include having the consumer worker seek treatment outside of the service where they are employed, to maintain boundaries between the work role and the patient role (Nestor & Galletly, 2008). Similarly, a plan can be put in place for carer peer workers who may be required to take time off to assist the person for whom they care.

Hansen (2003) notes that consumer workers can be left with a juggling act as they try to define their role within the service and establish clear definitions for themselves around their roles and responsibilities. It is important that mental health services address role confusion through creating clearer position descriptions, and establishing a work environment that provides supports such as supervision and training. It is also important that other staff are clear about the purpose and scope of peer roles, to support people from different disciplines and expertise working well together.

Negative attitudes from non-peer workers

In considering barriers to the employment of peer workers, the attitude of mental health professionals is consistently reported as an impediment (Gordon, 2005). Hodges and Hardiman (2006) suggest that medically-oriented professionals are often pessimistic about the usefulness of experiential knowledge and are therefore reluctant to encourage consumer participation at both the individual treatment and broader system levels. Stigma may also play a part, with some clinicians doubting the capacity of people with mental illness, or a background as a carer, to contribute to service delivery.

Inequality and marginalisation of people who have received a mental illness diagnosis continues to have an impact on consumers as well as the people who work in and run the mental health system. In a Canadian review of peer support (O'Hagan et al, 2010), some people believed government officials, planners and funders may have lower expectations of peer support initiatives than of professionally led services. Similarly, some mental health staff do not value the role of consumer worker, and believe there is a degree of tokenism involved in peer participation in service planning and delivery.

The attitudes of service staff with regard to mental illness is a complex area. However, it is important to challenge attitudes regarding mental illness; peer providers; and the ways in which business can be done if the use of peer workers is to be successfully expanded.

Role conflict and confusion

Peers are required to combine their experience as service users with provision of mental health care and support. They may be uncertain of the boundaries between being a consumer and an employee, or of being a friend to fellow consumers or carers and being their service provider. Peer workers can find it challenging to be a paid member of the mental health service and to be an advocate for the consumer or carer. The latter role may involve dealing with complaints, which may cause difficulty with or concern from other staff.

Establishing clear boundaries between consumers and consumer workers can be a difficulty, with some workers describing their role as a constant balancing act between being a peer and being a paid staff member (Moll et al, 2009). Examples might include consumer workers lending money to a client or meeting the client out of hours.

Training and education are important in dealing with issues with regard to dual relationships and role conflict.

Lack of clarity regarding confidentiality

Another potential barrier to peer worker employment is lack of clarity regarding disclosure of personal information by peers to others, and disclosure of confidential information to staff by peers about the consumers or carers that they work with. Issues that may arise include the right of peers to control disclosure of their peer status; a perception by non-peer staff that client records should not be shared with peers, and a perception by peer staff that client information to which they were privy should not be shared with non-peer staff.

Some agencies maintain a policy that peers should not have access to client records, possibly because of concerns that confidentiality might be breached. A consequence of this approach can be that there is miscommunication between peer and non-peer staff regarding planning for the service user (Gates & Akabas, 2007).

Limited opportunities for networking and support

Peer workforce roles are relatively new, and some workers have reported feeling isolated in their role. Some peer workers are the only peer worker in a mental health service, and others may be part of a small team. Watson (2007 quoted in Beattie et al) argues that support structures should be established to ensure that workers have contact and networking opportunities with one another.

Gates and Akabas (2007) also note that people with severe mental illness have restricted social support networks. The same is true of carers. Social and professional support can have benefits for both groups. Peer workers, by the nature of their roles, draw on their lived experience at work. They may feel more comfortable discussing work issues that relate to lived experience with a fellow peer worker, rather than a non-peer.

Possible solutions

Gates and Akabas (2007) propose a number of strategies relating to human resource policy and practices; workgroup relationships and operations that can improve employment of peer workers.

Factor affecting peer integration	Workplace strategies that promote integration
Attitudes towards recovery	Clear recovery position in mission statement. Leadership commitment to recovery well communicated. Leadership support of recovery. Peer position viewed as essential rather than an add-on.
Role conflict and confusion	Well-defined recruitment strategies. Consistent application of workplace policies to peer and non-peer staff. Written job descriptions for all staff including peers. Supervision to ensure that actual job expectations are the same as written job expectations. Training to staff and clients to provide understanding of roles. New employees receive formal orientation.
Lack of confidentiality	Neutral job titles that do not disclose peer status. Implement a formal disclosure process for peers. Keep previous treatment records of internally recruited peers in confidential files. Do not allow peers to receive services in the units where they are employed. Training on policies and practices related to confidentiality. Establish a formal process for sharing work-related information between peer and non-peer staff.
Job structure	Accepts experience in lieu of formal credentials as HR policy. Peer positions are permanent. Peer positions have clear path for promotion. Apply the same performance standards to peers and non-peers. Compensate peers and non-peers equally in comparable positions. Provide benefits counseling to help inform the peer's decision on hours to work.
Social support	Opportunities for interaction in agency life (team meetings). Include peer input in treatment planning and case notes. Offer peers training to learn language of the workplace. Supervision. Meet ADA requirements for accommodation.

Training and education

In Australia, there is no agreed entry level to employment in mental health services for peer workers. Development of a nationally accredited Certificate IV qualification in Mental Health Peer Work (Certificate IV) was completed in 2012 through the Community Services and Health Industry Skills Council. At the time this literature scan was prepared, development of course materials was in progress.

Community Mental Health Australia has agreed to accept the revised Certificate IV Mental Health Peer Work as minimum entry requirement for employment in their services. Much of the training for Australian peer workers currently occurs in house or is outsourced to Registered Training Organisations (RTOs) or other providers.

Australia is unusual in having a number of initiatives that involve consumers and carers working together on a common agenda. Elsewhere, consumers and carers have remained separate although they might come together to take up particular issues or campaigns (Anglicare Tasmania 2009). This combined approach is also reflected in the structure of the Certificate IV.

The six core units of the Certificate IV in Mental Health Peer Work cover:

- Applying peer work practices in the mental health sector.
- Contributing to continuous improvement of mental health services.
- Applying lived experience in mental health peer work.
- Working effectively in trauma informed care.
- Promoting and facilitating self advocacy.
- Contributing to work health and safety processes.

In addition to the six units above, a further nine elective units must be completed. At least one of these electives must be either working effectively with culturally diverse clients/co-workers or working effectively with Aboriginal and/or Torres Strait Islander people. The new qualification has been designed for both consumer and carer peer workers. Students are required to undertake either two consumer peer worker units or two carer peer worker units, depending on their chosen stream.

International utilisation of peer workforce

United States of America

Consumer peer workforce is well established in America, in both non government organisations and public mental health services. In many American states peer support workers can provide services under Medicaid. The Center for Medicare and Medicaid Services, USA recognises peer support providers as a distinct provider type for the delivery of support services, and considers it an evidence-based mental health model of care.

Since 2007, peer support providers have been required to complete training and certification as defined by the state in which they are employed. This training forms the basis of peer support workers' ability to provide Medicaid billable services. The training must provide peer support workers with a basic set of competencies necessary to perform the peer support function. In addition to this training, the peer support worker's employer should consider training that is specific to their role. The training requirements must be met for peer support services to be reimbursable under the Medicaid program (The Center for Social Work Research, University of Texas at Austin, 2012).

Of the available training, the Georgia program is particularly well established, and started in 2001 (Bluebird undated). By 2005 there were 285 graduates filling key roles in the public mental health system in Georgia. Georgia was the first American state to implement Medicaid reimbursable services for peer support, and the Georgia Peer Specialist Certification is now used in many other states. It is, however, one of many paths to certification as a peer specialist. In America, some 26 states provide access to Medicaid funds for provision of peer support services by peer specialists. Individual states may employ up to 500 consumers, with ten states employing at least 50 certified peer specialists (Grant et al 2012).

A National Association of Peer Specialists was formed in 2004, and a process to develop national practice guidelines is currently in train.

In America, peer support 'has gained an important and effective role in state systems of mental health care. While there are ongoing challenges, it is clear that participating states have been successful in integrating peer support in their workforces and overall systems of care.' (Grant et al 2012, p. 7).

United Kingdom

Peer support has been identified as a key facilitator across a range of UK health and social care policy agendas, including recovery, self-care, and personalized health and social care. An implementation program to support the UK mental health strategy has been established in England with a specific remit to develop and demonstrate new peer worker roles. As part of this program a peer worker research project, 'New ways of working in mental health services: assessing and informing the emergence of peer worker roles in mental health service delivery' recently concluded in March 2013.

The employment of peer workers and peer support are recognized and promoted in a range of policy documents in England, Scotland, and Wales. Peer support, for example, is recommended as one of the roles of mental health organisations in implementing the mental health strategy (Department of Health 2012).

The employment of peer workers is growing rapidly. Repper notes that before 2010, it would have been difficult to find a single peer worker employed in mental health services in England, but in 2013, Nottinghamshire NHS Trust employs 25 peer support workers, Cambridgeshire and Peterborought NHS Foundation Trust employs 32; Central and North West London NHS Foundation Trust employs 12 (Repper 2013).

Recovery Colleges are another initiative emerging in Britain, and are also known as recovery education centres (Perkins, Repper, Rinaldi and Brown 2012). They draw on approaches from America, in areas including Boston and Arizona. The approach involves peer workers and mental health practitioners, and takes an educational approach to recovery rather than a traditional approach. 'We decided to use education as the model for approaching recovery, rather than develop more traditional alternatives. We did this because we want our center to be about reinforcing and developing people's strengths rather than adding to the attention on what is wrong with them. The guiding vision we had for the Recovery Education Center is reflected in the mission statement: people will discover who they are, learn skills and tools to promote recovery, find out what they can be, and realise the unique contribution they have to offer. (Ashcraft, 2000).

In Scotland, mental health organisations are working with the peak body for training and qualifications, Scottish Qualifications Authority (SQA) to develop an accredited award and learning materials to further support the training of future peer support workers. In addition to training, Scotland are also developed a values framework to help increase understanding of the peer worker role and ensure that it maintains the peer support ethos and guidelines to support the implementation of peer work emerging in the country.

New Zealand

The participation of peer workers with experience of mental illness, distress or addiction is regarded as important to improving and developing responsive and effective mental health and addiction services in New Zealand (NZ). A number of policy documents emphasise the importance of the peer workforce and a culture of resilience and recovery (Minister of Health 2005, Mental Health Commission 2007).

Mental health and addiction peer workforce development has been identified as a priority in national mental health and addiction policies and plans. Service users are 'an underutilized resource which could be strengthened to address current workforce shortages and contribute to building a more effective mental health and addiction workforce' (Te Pou 2010, p. 9).

New Zealand undertook a workforce study of this group of workers in 2010 (Te Pou). 153 people took part in the study, and the total contracted full time equivalents (FTE) for this workforce was 223. 37% of respondents were 50 years or over and 70% were women. About one quarter were Maori, and the level of education was higher than for the general population.

Conclusions from the workforce study included:

- There is a need to clearly specify and map career pathways and competencies for peer workers.
- Clear specification and description of service user workforce roles would provide greater national consistency.
- Regular peer workforce surveys would help monitor progress in building the capacity and capability of this workforce.
- Planned recruitment strategies targeting specific age and ethnic service user groups at national, regional and local levels would help ensure that the future peer workforce is representative of service users.
- Increased provision of mentoring or supervision would enhance peer workforce capability.

More broadly in New Zealand, peer run recovery houses are being used to support people with acute mental health problems. One example is the Key We Way (KWW), which is a peer delivered recovery house. The recovery house is an alternative to inpatient care in an acute psychiatric unit. KWW provides 24 hour support, supervision and treatment which is not provided any other Acute Day Service or Crisis Respite in NZ.

PeerZone is a training program developed by New Zealand peers, that involves a number of workshops. It is being used by a number of services in New Zealand and Australia, and is intended for implementation at a service level. PeerZone staff do not deliver the workshops, instead they prepare and support local peers to facilitate them.

The New Zealand Standards Qualification Authority (NZQA) has endorsed a Certificate in Peer Support (Mental Health) as a Level 4 Qualification in 2008. At this stage, a private provider, Mind and Body Learning and Development Ltd is accredited to teach it. Mind and Body Consultants also provide peer support services under contracts to some district health boards.

Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development, has recently funded a Peer Competencies development project with Northern Region Alliance and Midland District Health Boards/HealthShare. The project will complete three tasks before the end of 2013:

- Develop peer work competencies for New Zealand.
- Inform the development of the proposed peer support qualification through Careerforce.
- Prepare guidance on peer roles for planners and funders and service providers.

Summary

The literature suggests that peer workers can provide an important and useful complement to the traditional teams delivering mental health services. Particular benefits of using this workforce can include improving the recovery orientation of services; better engagement with people using services; reduction in hospital admissions; and reduced load on other practitioners. For some people using services and their families and carers, peer workers offer an improved experience of treatment, care or support.

America, Britain and New Zealand are among the countries making more use of peer workers than Australia. Further developing this workforce is not without its challenges, however, it appears that considerable benefits would follow from a well-supported broad implementation of peer workers in the mental health sector.

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