



Mental Health Peer Workforce Study



An Australian Government Initiative

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Contents

Introduction	5
Purpose	5
Scope	5
Methodology	5
Policy context and levers	6
Case for change	8
Benefits of the peer workforce	11
Challenges and barriers	13
Workforce innovation and reform	14
Domain 1 - Health workforce reform for more effective, efficient and accessible service delivery	16
Domain 2 - Health workforce capacity and skills development	23
Domain 3 - Leadership for the sustainability of the health system	30
Domain 4 - Health workforce planning	34
Domain 5 - Health workforce policy, funding and regulation	36
Glossary	40
References	44
Appendix A – Case study sites	48
Appendix B – Mental health peer workforce project online survey analysis	54



“Shortly after being discharged from hospital I was introduced to a PHaMs peer support worker. This peer worker was probably the single most important factor in my recovery. Working with him over many months I was able to slowly get some perspective on my life as well as design what might be my future. It was inspiring to hear his story of recovery and I felt that I could trust him more than any other mental health worker because of his own experience of mental illness.”

Service user who worked with a peer worker in Personal Helpers and Mentors program, Australian Capital Territory

Introduction

Purpose

The purpose of this document is to report on the findings of the mental health peer workforce (MHPW) study, and to provide a set of recommendations that will strengthen and develop the mental health peer workforce as an important component of quality, recovery-focused mental health services.

Scope

The focus of this study is the mental health peer workforce in public, non government and private mental health services. For the purposes of this report, 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 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).

The requirement of lived experience of mental illness or mental health issues for identified peer roles leads to key differences between a peer role and the role of other mental health workers. 'It is possible to be a mental health worker without lived experience however it is not possible to be a consumer worker or carer worker without the lived experience' (Watson 2007, quoted in Beattie, Meagher and Farrugia 2013 p19). There are also people working in mental health who choose not to disclose lived experience. By definition, they are not peer workers, and are outside the scope of this study.

The National Mental Health Consumer and Carer Forum (NMHCCF) notes that it is not appropriate to expect carer peer 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 families and carers.

Methodology

The project began in November 2012, and involved gathering information regarding the mental health peer workforce from a range of sources. A Mental Health Workforce Reform Program Advisory Group (MH PAG) was established, and a number of services currently using mental health peer workers were identified through the MH PAG, and asked to complete a questionnaire in February and March 2013. Thirty-one services from the public, private and non government sectors were contacted, and 19 services returned a completed questionnaire.

Following receipt of the initial questionnaire, 17 case study interviews were undertaken with mental health services nationally. Eleven services were visited, and a further six services were interviewed by telephone. It was not possible to arrange a suitable time with the remaining two services that responded to the initial survey. The visits and interviews involved 58 consumer peer workers, six carer peer workers, and 39 service managers. The full list of services involved in site visits and interviews is provided at Appendix A.

A literature scan was also completed, drawing on national and international academic and grey literature, and is available as a separate document.

Finally, an online survey for peer workers was developed. The survey was open for the month of June 2013, and gathered data from 305 peer workers nationally. A full analysis of the data is provided at Appendix B.

These combined project activities provided a national picture of the current mental health peer workforce and the opportunities and challenges it faces. The study also identifies opportunities for Australia to take a more structured and strategic approach to peer workforce development.

Policy context and levers

National Mental Health Strategy

First established in 1992, the strategy comprises the National Mental Health Policy and the National Mental Health Plan (now in its fourth iteration), underpinned by the Mental Health Statement of Rights and Responsibilities.

The policy provides strategic vision for a mental health system that:

- Enables recovery.
- Prevents and detects mental illness early.
- Ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The National Mental Health Policy was revised in 2008, and the *Fourth National Mental Health Plan 2009-14* (Fourth Plan) is currently in progress. The Fourth Plan promotes an integrated, whole-of-government response to the improvement of mental health outcomes, with five priority areas:

- Social inclusion and recovery.
- Prevention and early intervention.
- Service access, coordination and continuity of care.
- Quality improvement and innovation.
- Accountability – measuring and reporting progress.

The National Mental Health Strategy supports and encourages the delivery of recovery-oriented services. The employment of peer workers can be seen as a key component of transforming mental health services towards a recovery orientation. The Fourth Plan, the Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-2011*, the *National Mental Health Workforce Strategy (2011)*, and *The Roadmap for National Mental Health Reform 2012-2022* reflect recognition of the alignment between peer workforce development and the successful transition towards a recovery orientation, and to improved outcomes for people accessing mental health services.

The Fourth Plan includes the following actions:

- Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.
- Increase consumer and carer employment in clinical and community support settings.

Recovery can be defined in a range of different ways, and is often understood to be a philosophy and approach to services focusing on hope, self-determination, active citizenship and a holistic range of services. The *Principles for Recovery Oriented Service Provision* and the *Supporting Recovery Standard of the Australian National Standards for Mental Health Services* (2010) require that mental health services incorporate recovery principles into service delivery, culture and practice, providing people with access and referral to a range of programs that will support sustainable recovery.

In August 2013, the *National Framework for Recovery-oriented Mental Health Services* was released, providing further guidance to service providers in relation to recovery. The framework is intended to help mental health professionals align their practice with recovery principles, in order to improve outcomes for people using mental health services. It is also intended to encourage a fundamental review of skill mix within the mental health workforce, and an expanded role for peer workers.

Health Workforce Australia

Health Workforce Australia was established in 2010 as a national health workforce agency through the National Partnership Agreement on Hospital and Health Workforce Reform 2008. HWA drives a strategic, long-term program which addresses the future challenges of providing a skilled, flexible and innovative health workforce. The reforms are needed to address workforce shortages and to ensure Australia's health workforce can meet increasing demands for services resulting from an ageing population, increasing levels of chronic disease and community expectations.

The following key policy foundations form the context for HWA's work:

[National Partnership Agreement on Hospital and Health Workforce Reform \(2009/10 – 2012/13\)](#)

The National Partnership Agreement (NPA) outlines the workforce reform initiatives agreed by governments to improve health workforce capacity, efficiency and productivity. These include funding, planning and coordinating clinical training across all health disciplines; supporting health workforce research and planning; improving international recruitment efforts; and progressing new workforce models and reforms.

[Health Workforce 2025](#)

Health Workforce 2025 (HW 2025) outlines Australia's first major, long-term national projections for the health workforce out to 2025. The reports suggest we cannot afford to continue business-as-usual approaches and that reform is essential to ensure a sustainable, affordable health workforce for the future.

[National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015](#)

The National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 provides an overarching, national policy platform to guide health workforce reform. HWA aligns all its programs and initiatives with the five domains for action identified within this framework. The five domains are the essential areas for activity for the development of a sustainable health workforce for the future. This framework provides a national approach to guide all stakeholders in their actions to support the changes necessary to drive essential workforce reform.

[National Mental Health Commission](#)

This mental health peer workforce study has been undertaken in partnership with the National Mental Health Commission (NMHC), under a Memorandum of Understanding between HWA and NMHC. The NMHC was established within the Prime Minister's portfolio as an executive agency. The Commission's core function is to monitor, assess and report on how the mental health system is performing and its impact on consumer and carer outcomes.

The National Mental Health Commission in its *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, recommended a range of actions relevant to the peer workforce, including: collaboration to increase the levels of participation of people with mental health difficulties in employment in Australia, to match best international levels; the expansion of service approaches that provide early intervention and support an alternative path to a hospital admission; and multi-skilled teams that collaborate to provide integrated and effective support, care and treatment for people living with a mental health difficulty, and their families and support people.

In addition to this project, the Commission is supporting Community Mental Health Australia (CMHA) to produce national development and training materials to assist the uptake of the new Certificate IV in Mental Health Peer Work qualification. A small number of pilots have been undertaken of the new qualification, and the national materials will support and promote uptake of the course.

The Commission has also developed a number of principles and requirements that it believes must underpin the development of the peer workforce in Australia:

- A peer worker has acknowledged lived experience of mental illness and recovery.
- Peer workers should be respected and regarded as an essential part of not an add on to the support team, with equal status to their team colleagues and not a “time or cost saver”.
- Peer workers should be remunerated appropriately at a level commensurate with their skills and training – a good and willing volunteer is just that, not a peer worker.
- Peer workers are adequately supported and sustained into and in the role with quality, ongoing training and supervision.
- The peer workforce should be supported by national competencies and standards.
- The peer workforce should have a career trajectory.

Consumers and carers have been active in advocating for the peer workforce. In 2011, the NMHCCF released a position statement that outlined recommendations for supporting and developing the mental health consumer and carer identified workforce as a strategic approach to recovery. The Forum called on Australian governments to urgently address the needs of consumer and carer identified workers by developing a National Mental Health Consumer and Carer Identified Workforce Development Strategy.

Policy drivers in relation to mental health peer workforce include the Fourth Plan, NMHC Report Cards, and the WIR Framework.

Case for change

Mental illness is among the ten leading causes of disease burden in Australia and demand for mental health services is increasing. Mental illness and mental health problems can be devastating in their impact, and come at a considerable economic and social cost. People with severe mental illness often have poor overall health, and may experience exclusion from housing, employment, and other areas of social participation.

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 healthcare. 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.

The economic costs of mental illness are significant, as are the personal, family and social costs. Methods of treatment, care and support have changed over time, and adopting recovery approaches can pose challenges for services that may have long used more traditional approaches to mental healthcare. A service with a more clinical model of treatment may focus on reduction of symptoms, generally through medication, and the restoration of social functioning. There is widespread recognition among major disciplines in the mental health workforce that the recovery paradigm is a fundamental platform for practice, however, shifting organisations to change the way they provide mental health services can be difficult.

Recovery approaches provide one impetus for change. Nationally and internationally, it is acknowledged that peer workers and peer support are important ways of promoting the principles of recovery (Bassett, Faulkner, Repper and Stamou, 2010). The Sainsbury Centre for Mental Health outlines ten key organisational challenges for implementing a recovery-focused approach. Challenge 8, transforming the workforce, states that working in partnership with service users will lead to a change in the make up and composition of the workforce:

As services become more truly focused on service user's needs and accept the value of 'lived experience', so there are obvious implications for the composition of the workforce. Professionals will remain important, but they will have to recognize that their contribution needs to be made in a different way, acknowledging service users' self-defined priorities. By contrast, we expect to see a greatly expanded role for 'peer professionals' in the mental health service workforce of the future'.


The other impetus for change is the stark workforce challenges facing mental health services. The mental health workforce includes a range of different disciplines, and operates across a complex set of interrelated services. For public mental health services, nursing is the single largest discipline involved in care. Workforce projections conducted by HWA demonstrated that in the absence of any change, demand for mental health nurses will substantially exceed supply by 2025 (by approximately 9,000). Research also indicated the psychiatry workforce is perceived to currently be in shortage – which workforce projections indicated would worsen if recent trends in supply and demand continue (HWA 2012). In 2011, approximately 41 per cent of all psychiatrists were aged 55 or over (AIHW 2013).

Non government mental health services too are facing workforce shortages. The disciplines comprising the non government mental health workforce are different, with nursing and particularly psychiatry much less prominent. However, challenges include annual staff turnover exceeding 25 per cent, specific staff supply shortages, and challenges in recruiting staff with adequate experience and longevity to match the complexity of client issues (Reifel and Pirkis 2012).

Distribution of mental health professionals is skewed to the cities, and Australians living in rural and remote areas may have very limited access to mental health treatment, care and support. People who work in mental health services are among the major strengths of the system, but there are significant shortages in supply, and difficulties with distribution. Peer work does not replace clinical or other services, but instead can complement and support existing mental health and community care services. Exploration of new and emerging roles is one way to support service delivery.

Peer workers have been identified as being able to contribute to better health outcomes, and are employed in significant numbers in countries similar to Australia. There is evidence to suggest that peer workers offer a number of benefits, and can reduce the rate of hospital admissions for the service users with whom they work (Trachtenberg et al 2013, Lawn et al 2008). In America, the Centre for Medicare and Medicaid Services 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. Currently, 26 states offer Medicaid Benefits for services delivered by mental health peer workers, and the number is growing (Minnesota Department of Human Services 2013).

This study has gathered information regarding mental health peer workers from a range of sources, with a view to informing future policy directions within the broader mental health workforce. Further development and growth of the peer workforce can improve the recovery orientation of services, produce positive outcomes for individuals and families, and has the potential to reduce some of the pressures on the mental health workforce.



"Getting together with other carers makes me feel less isolated – I don't know where else to get such information."

Participant at carer support group run by a peer worker, Victoria

Benefits of the peer workforce

Mental health peer work is a relatively new approach to service delivery. Internationally, evaluation has lagged behind implementation of peer workforce roles, however, it is important to consider the available evidence regarding the utility of the peer workforce. Many studies are qualitative, however, some randomized control findings are available. The limited quantitative and qualitative evidence available 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, carers, peer workers and service providers. The evidence is explored more fully in the accompanying literature scan.

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 report 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.

People with mental illness are amongst the most socially and economically marginalised members of the community. In addition to their illness, they may experience loss of employment, family breakdown and other difficulties. Stigmatising attitudes are still evident in the community and the media, and discrimination can create further problems. Peer workers appear uniquely placed to assist people using mental health services, and their families and carers.

The roles and functions of peer workers are discussed in more detail later in this report. Some peer work roles, such as advocacy and health promotion, are also undertaken by other workforce groups. One unique function is the provision of peer support to other consumers or carers. There is no one, universally accepted definition of peer support. Mead (2003) describes peer support as 'a system of giving and receiving help, founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful'. The capacity to connect with a peer with lived experience during difficult times, and to model recovery, can be powerful:

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 and Miller, 2012).

Benefits from the use of peer workers can be identified and organised by the recipient of the benefit – people using services, peer workers, carers and mental health services (Repper and Carter 2011).

Service users/consumers

For service users and for peer workers themselves, many of the benefits are in areas such as empowerment, hope and employment, reflecting the broad effect that mental illness can have on people's lives.

Several studies of peer support report raised empowerment scores from people using services. Peer workers can encourage individuals to define their own needs, consider the available choices, and experiment with different recovery strategies (Campbell and Leaver 2003). A peer worker also offers hope, and provides a role model of recovery. The physical presence of a recovered peer can give people a reality to which they can aspire and work.

Peer support can also increase levels of community integration, and offer people a chance to practice social skills and 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 p.4).

The available evidence also suggests that peer support may be effective in reducing hospital admission rates. Peer support has been used successfully in a range of programs to support people on discharge, assisting them to make a successful transition to the community. Peer support can also be provided to people who may be at risk of readmission, assisting them to stay well (Trachtenberg et al 2013, Lawn et al 2008). This is an important benefit at a personal, family and a system level.

Peer workers

In addition to benefits for people using services, benefits of peer support and peer work are also demonstrated for peer workers themselves. For many people, work provides structure and meaning, and peer work in addition provides people with an opportunity to draw on a difficult experience and assist others (Moran et al 2012; Razlaff et al 2006).

‘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).

Benefits for consumers	Benefits for peer workers
Lower admission rates and longer community tenure	Mental health and wellbeing
Empowerment and hope	Acceptance
Social inclusion	Skills and employment
Reduced stigma	

Families and carers

The effects on families and carers of providing support to a family member or significant other with mental illness can be profound. 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 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.

Carer peer workers can provide support to families and carers, who may feel excluded when the person for whom they care is receiving mental health services. Again, the capacity to connect with someone who may have had a similar experience, and may offer understanding of the impact of the illness on significant others, is critical. Peer support can provide people with the chance to air their feelings – guilt, anger, worry and so on – in a safe environment, without fear of being regarded as disloyal or unsupportive. Often carer peer workers are involved in family education, which can increase the knowledge of families and carers about the illness or regarding coping strategies.

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). Similar benefits also apply to carer peer workers working in adult services.

Mental health services and systems

Mental health services and systems benefit from the employment of peer workers. Peer workers can be very effective at establishing connections with 'hard to reach' clients, and act as a bridge between clients and other staff (Davidson, Bellamy, Guy and Miller 2012). In a report by Trachtenberg et al. (2013), it was found that peer support workers can reduce psychiatric inpatient bed use. Evidence suggests that peer workers can also contribute to reduced use of seclusion and restraint (Ashcraft and Anthony 2008).

A further key benefit for services of utilising peer workers can be a positive change in organisational culture and an improved recovery focus. Staff may become more aware of their use of language, and more reflective regarding recovery-oriented practice (Bradstreet and Pratt 2010, Walker and Bryant 2013). As one nurse involved in an English study commented: *'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...'* (Shepherd 2013).

Benefits for carers	Benefits for mental health services
Empowerment and knowledge	Engagement of consumers
Improved relationships	Organisational culture
Social support	Cost effectiveness
	Responding to crisis and reducing coercive practices

Challenges and barriers

Both international and local experience suggests that there are a number of challenges and barriers to the introduction of peer workers. The literature, and practical experience from case study sites, suggests that there are also a number of strategies that can be put in place to address these issues. Introducing peer workers will not change a service overnight, and can be a complex process. Gates and Akabas (2007) classify the issues that may arise into five categories, outlined below. As with introducing any new job role, planning to address potential problems can ease the introduction of peer workers.

Poorly defined jobs

The roles and responsibilities of peer workers are often unclear. Peer workers are sometimes employed with positive intentions, but perhaps insufficient preparation. Job descriptions and associated structures such as supervision may be lacking. Role clarity is important not only for peer workers, but also in order that other staff are clear about the purpose and scope of peer roles.

Negative attitudes from non-peer workers

Negative attitudes from mental health practitioners to peer workers are consistently reported as a barrier to the employment of peer workers (Gordon 2005). Some mental health staff do not value the role of consumer or carer peer worker, and may have concerns about the capacity of peer workers to contribute to service delivery.

Role conflict and confusion

Peer workers are required to combine their experience as service users with provision of mental healthcare and support. There can be uncertainty regarding the boundaries of being a consumer and an employee, or being a friend to fellow consumers or carers and being their service provider.

Lack of clarity around confidentiality

Confidentiality may be a particular concern with regard to peer workers. 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, can be problematic.

Limited opportunities for networking and support

Finally, as the peer workforce is relatively new, there may be limited opportunities for peer workers to network and gain professional support.

The challenges and barriers outlined above were found throughout the case study sites, and strategies to address them are suggested in the domains later in the report.

Workforce innovation and reform

Efforts are being made to grow the supply and improve the distribution of existing disciplines within the mental health workforce. It is important that these efforts continue, and that attention is also given to other areas such as recruitment and retention. However, of themselves, these efforts will not be sufficient to meet demand for mental health services.


The findings and recommendations from this study are organised by reference to the WIR Framework, which was developed for the whole of Australia's health workforce. Mental healthcare is now primarily delivered in community settings, and access to mental health services in the non government sector and primary care has substantially increased in recent years. Mental health service delivery does not always fit neatly into whole-of-health frameworks, however, mental health remains a crucial aspect of good general health.

Developing and supporting new roles, such as peer workers, is needed to support the delivery of recovery-oriented mental health services in Australia.

The WIR framework forms the policy platform for all HWA program and strategy initiatives. This mental health peer workforce report includes a set of recommendations organised by the five domains for action within the WIR framework.

The five domains are:

1. Health workforce reform for more effective, efficient and accessible service delivery.
2. Health workforce capacity and skills development.
3. Leadership for the sustainability of the health system.
4. Health workforce planning.
5. Health workforce policy, funding and regulation.

A close-up photograph of two men in an outdoor setting. The man on the left, wearing a green t-shirt, is looking towards the man on the right. The man on the right, wearing a red t-shirt, is shown in profile, looking down. The background is a soft-focus green, suggesting foliage. A blue rectangular box is overlaid in the top right corner, containing a quote and attribution.

"Our organisation's most valuable asset is the lived experience of our peer workers." Manager, NGO, Victoria

Domain 1 - Health workforce reform for more effective, efficient and accessible service delivery

Objective: Reform mental health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address mental health needs.

Key points

- Workforce reform, including supporting the introduction of new workforce roles, can improve system capacity and the delivery of recovery-oriented services across a range of settings.
- Lack of role clarity and workforce supports reduces the effectiveness of peer workers. Currently, there is wide variation in peer work roles, practice, training and supervision.
- Benefits from use of peer workers flow to people using services; carers and families; services and systems; other workers; and peer workers themselves.
- National guidelines are needed to support the adoption of peer workers in Australia.

Workforce development and reform can improve both capacity to deliver recovery-oriented services and ability to meet increasing demands on mental health service providers. Workforce reforms to improve efficiency and effectiveness and support access to new models of care include:

- Models of care that are person-centred and developed from community, service user and carer need perspectives.
- Supporting practitioners to work to their full scope of practice, expanding scopes of practice, and the introduction of new categories of staff, in particular assistant roles where appropriate.
- Reconfiguring health systems to provide more community and home-based care.

More systematic and more extensive use of peer worker roles can contribute to more accessible, recovery-focussed and efficient service delivery. Currently, peer worker numbers are small, and they are largely employed in non government organisations. Peer workers undertake a range of roles in a variety of non government and public sector settings, for example, providing individual support; delivering education programs for mental health workers; providing support for housing and employment; advocating for systemic improvements; or running groups or activities. The use of peer workers in private mental health services appears to be in its very early stages. A wide range of titles are assigned to peer workers, and efforts are being made to better define peer worker roles and functions. Introducing some standardisation of this workforce through National Guidelines will assist in broader use of peer workers nationally.

Benefits of peer workers to mental health and wellbeing outcomes of service users and/or their families and support people – views of managers at case study sites:

"Our organisation's most valuable asset is the lived experience of our peer workers."

(Manager, NGO Victoria)

"There are many benefits, especially engagement. 'Working with, not doing to'. Stigma is automatically gone when a peer worker is involved – this is powerful. Often they can get a message across that staff can't, for example, a carer consultant talking about the benefit of Well Ways program to a family member – much more powerful than the manager talking."

(Manager, NGO Victoria)

"Someone who understands what the person is going through. It is different for someone who has been there, a lot more real. Employment of consumers also demonstrates that the organisation is trying to understand the position of consumers."

(Manager, Queensland)

"Peer workers can bridge the gap. They are good at crossing barriers. They can bring the best out of people."

(Manager, NGO, New South Wales)

"Hope and relationship – this is what the peer symbolises to clients and staff."

(Manager, NGO Victoria)

"Their presence changes attitudes. A few years ago, people would have asked why would you have a consumer on an interview panel. Now they ask about availability."

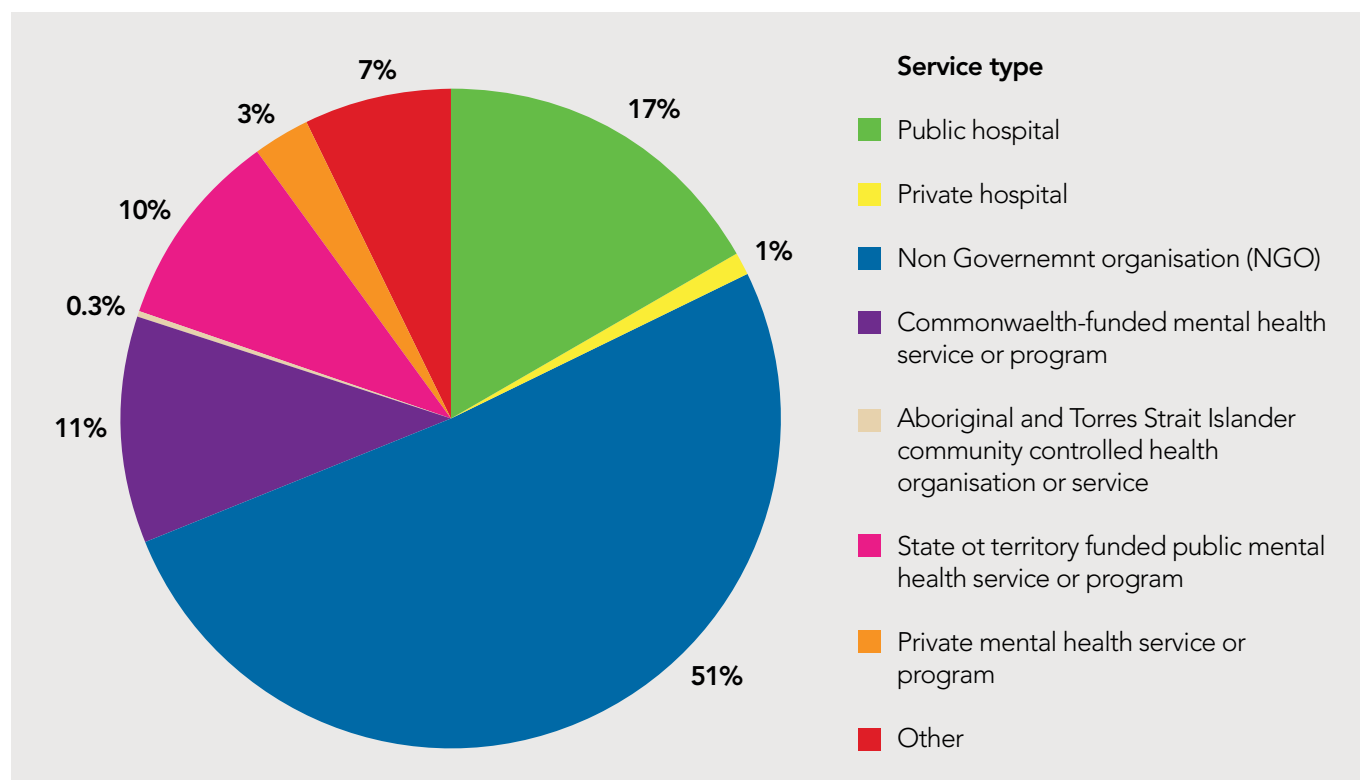
(Manager, public mental health service, Queensland)

Settings

Programs and services using peer workers are found throughout Australia. From the case study sites it was found that peer workers were employed in metropolitan, regional, rural and remote settings. Information from the initial questionnaire indicated that most of the organisations offer metropolitan based services (38 per cent), with a number of sites offering regional and state wide services (24 per cent and 29 per cent respectively). Some organisations have a particular focus on population groups. TEAMhealth, in the Northern Territory, for example, works with Aboriginal and Torres Strait Islander peoples and ADEC in Victoria, specialises in working in neighbourhoods where there are high numbers of people from Cultural and Linguistically Diverse (CALD) backgrounds.

The settings were further explored in the online survey and the results are presented overleaf.

Figure 1: Mental health peer workforce online survey – Service type



Note: 7 respondents did not provide their service type

Role and functions

This study indicates that a wide range of titles are currently used for peer workers. 'Peer support worker' was the most common title identified by survey respondents, with 48 per cent of respondents identifying with this role title. The next most common response was 'Consumer consultant' (11 per cent). The 'Other' category was selected by 13 per cent, and related text responses included a wide range of titles.

As noted previously, mental health peer workers in Australia undertake a range of roles and functions. *'Tasks performed by peer workers include... assisting people in articulating their goals for recovery, helping them monitor their progress, assisting them in managing their wellbeing, modelling and articulating effective recovery strategies based on the worker's own experiences, supporting the person to obtain appropriate and/or effective services and helping them to understand different pathways to recovery.'* (Bennett, Meagher 2010)

The New South Wales Consumer Advisory Group (CAG) has defined seven key functions relating to the mental health consumer workforce (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 New South Wales. However, it may usefully be applied more broadly in considering the peer workforce. It should also be noted that 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 peer support engagement skills, and draw on their lived experience, to establish a relationship with a person using services or a carer.

The online survey asked respondents about the frequency with which they undertook a range of tasks. The results indicated that responding peer workers most commonly undertook advocacy work – 89 per cent of respondents said they did this either sometimes or every day. Respondents also said they commonly provided training and education (85 per cent), networking with other peers (82 per cent) and referral to other services (80 per cent). The least performed area of work identified by respondents from the online survey was respite support (21 per cent) and comorbidity programs (39 per cent).

Interviews with managers indicated that peer workers were highly valued, and many services were seeking to expand the number of peers employed. *‘Peer workers are viewed as a specialised role and a distinct discipline within our organisation – they are viewed as part of our organisational furniture’* (NGO, Victoria). A large public mental health service is seeking over time to place a peer worker on every team, as a means of offering a different and more recovery-focussed service. *‘It would really add a lot to the team, to be able to introduce someone with a lived experience’* (Public Mental Health Service, Victoria).

Peer worker roles at case study sites

Peer workers from the case study sites performed a range of roles and functions in non government and public mental health services. A common feature was strong commitment to their roles, and compassion for people and families affected by mental illness.

One peer worker noted *‘my role is to use my own personal experience, as painful as that was and can be, to help others with their personal recovery.’* A youth peer worker explained her role in a similar way *‘my role involves helping other young people to have hope and to believe that they can recover and get on with their lives’* (Public Mental Health Service, Victoria).

Ashcraft and Anthony (2012) summarise the benefits that well-trained peers can offer:

- Dedication and commitment to work.
- Ability to create an immediate connection with the people they serve.
- Ability to use their stories and lived experiences to inspire hope.
- Ability to build bridges that engage other providers on the treatment team.
- Ability to guide people in accessing community resources and service.
- Ability to model healthy relationships that others can replicate in the community by being trustworthy and supportive in an intentional relationship.
- Ability to demonstrate to family members and other supporters that people like their loved one can recover.

* Categories were everyday and sometimes, for the purposes of this table these two categories were combined

** Face to face assessments refers to peer workers helping to determine consumer needs, providing support and goal setting

At Richmond PRA in New South Wales, a large number of peer workers are employed in services including Personal Helpers and Mentors program (PHaMS), Housing and Accommodation Support Initiative (HASI), and Day to Day living (D2DL). Richmond PRA owns and runs a number of businesses and social enterprises. An example is Prestige Packing, a training and employment service with factories in Marrickville, Harris Park and West Ryde. Peer workers provide support to people who are working and training in these factories and work through the Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS) with the client. This validated tool is designed to look at barriers to people's goals, and provides a focus for discussions about people's recovery aspirations. Peer workers provide a role model for both recovery and employment.

Peer workers are also providing support for people who may be experiencing mental health crises, and are walking alongside people who do not wish to, or are unable to, engage with mental health services upon discharge from emergency departments or from hospital. Consumer run services of this nature are provided by FSG Australia's Peer Engaged Assisted Recovery Lifestyles (PEARL) program; the Brook Red Centre; and CAN Mental Health's Hospital to Home and Phone Connections services.

Whilst not completely peer run, a number of organisations offer services that are staffed by significant numbers of peer workers, and which provide step up, step down services and other alternatives to hospitalisation (Mind, Woden Community Services) and peer support during hospitalisation and upon discharge and transition into community living (Mind, Woden Community Services, NorthWestern Mental Health, Peel and Rockingham Kwinana Mental Health Service).

Managers at case study sites visited indicated that peer workers, along with their colleagues assist people to work on their personal recovery and optimise their capacity to live independently in the community.

Managers also spoke of their interest in expanding both the number of peer workers, and the way in which they are used. Examples included potentially utilising peers to work with people upon their first involuntary admission, as well as with those who are frequently involuntarily admitted, or under involuntary treatment orders in the community. Additionally, a number of organisations expressed interest in crisis and emergency responses and using peer workers in new alternatives to hospital.

Workplace supports

Peer workers should have the same access as other workers to benefits such as employee assistance and leave. Jobs in mental health are stressful for everyone, and self-care is an important area of focus for all mental health staff (Davidson et al 2012). Organisations using peer workers should operate in accordance with disability and discrimination legislation, including implications for employment and the provision of reasonable adjustments.

The Commonwealth *Disability Discrimination Act 1992* views 'reasonable adjustments' as specific actions or strategies developed by an employer to address the effects of an employee's disability (for example, mental illness or psychosocial disability). Many of the case study sites provided examples from the field of reasonable adjustments. To promote the employment of people with mental illness or psychosocial disability, the Australian Human Rights Commission has provided organisations and their managers with guidance for implementing reasonable adjustments for people with lived experience of mental illness (AHRC 2010).

It may be helpful, as some case study sites do, to put in place an agreement between a consumer worker and the mental health service as to what will occur if the peer worker requires treatment for their mental illness. This might include having the consumer worker, if possible, seek treatment outside of the service where they are employed, to maintain boundaries between the work role and the service user role. 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. The development or adoption of templates for wellness or other planning could be a useful approach.

Case study sites have often needed to attend to developing reasonable adjustment policies and actions. FSG in Queensland found that they needed to alter their existing organisational policies and guidelines to implement their PEARL program. Richmond PRA has developed a number of strategies to recruit and retain people with lived experience. They provide staff with the opportunity to plan for preferred work adjustments when needed.

Often peer workers have part-time roles. This suits some workers, but is difficult for others, who may prefer additional hours and a higher income. Some peer workers operate across two roles and in this way obtain full time hours. Appropriate employment arrangements in areas including hours and permanency support a stable workforce base.

Role clarity

Consistent with the literature, peer workers interviewed frequently reported that their roles and responsibilities were vague and unclear. Roles often lacked job descriptions, or the documentation was so broad as to provide little direction. Eighty-eight per cent of survey respondents indicated that they had a job description. However, it may be, that as Berry et al found (2011) there can be major discrepancies between peer work professional identity, the job description presented at interview, and the reality of the role.

A rural New South Wales peer worker who provided comment on an earlier draft of this report noted 'even though I do have a job description it is broad to allow flexibility, but so broad as to provide only minimal direction. Am still figuring out in consultation with clinicians and others in the service the scope of what I can do, but no one seems very well placed to tell me what I SHOULD do.'

Some peer worker roles have expanded over time to include a range of tasks and duties. 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 et al 2009). Hansen (2003) notes that peer 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. Peer workers can also be left trying to negotiate tensions and conflicts inherent in their roles, including for example, confidentiality, maintaining both client and fellow-staff trust, and whether or not they can access and write in client's service records.

A number of service managers described how their approaches to employing peer workers had developed and improved over time. Often they had started from a position description that was unclear, leading to difficulties for both the worker and for other staff at the service. In many services, this had improved, with, for example, an emphasis emerging in job descriptions on not only lived experience, but also recovery and communication skills. However, for services that are considering the future employment of peers, this is an area needing attention.

It is important that mental health services address role confusion and role tensions by providing clear position descriptions and clarity regarding job roles.

National guidelines

Peer workers are effectively a new work role in Australian mental health services. There has been considerable activity in the non government sector, and by state and territory governments, to further support and develop the peer workforce. The PHaMS program, established by the Commonwealth in 2007, provided much of the initial impetus for using these workers.

In a general sense, Australia has often been slow to establish new workforce roles, despite evidence of their effectiveness. For example, roles such as nurse practitioners and physician assistants are long established in other countries, and it has been demonstrated that they contribute to the same or improved outcomes for service users. In Australia, however, numbers of nurse practitioners and physician assistants remain small.

Peer workers offer benefits in improving the recovery orientation of services, and supporting other practitioners to work to their full scope of practice. Davidson notes 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). Considerable work has been done nationally and internationally on supporting elements for national guidelines, and hence there is a sound base of material to draw on.

More systematic and more extensive use of peer workers in Australia will be facilitated by the establishment of National Mental Health Peer Workforce Development Guidelines.

Domain 1 recommendation

1.1 Establish National Mental Health Peer Workforce Development Guidelines for use in a range of settings inclusive of:

- Agreed definitions.
- Key roles and functions.
- Guiding principles and a code of ethics.
- National capabilities for peer workers and supervisors (including diversity).
- Principles for employment and reasonable adjustment.
- Training and support.
- Practical resources.
- Supervision, coaching, and mentoring.
- Dissemination/implementation approach.

Domain 2 - Health workforce capacity and skills development

Objective: Develop an adaptable mental health workforce equipped with the requisite capabilities and support that provides team-based, interdisciplinary and collaborative models of care

Key points

- Working effectively in mental health requires adequate and appropriate training.
- The Certificate IV in Mental Health Peer Work offers an opportunity to move towards nationally consistent training for peer workers.
- Mentoring and supervision are important elements of support for peer workers.
- Interdisciplinary collaboration is an important element of mental healthcare, and can be supported by establishing clear understanding of workforce roles.
- Career pathways for peer workers, particularly multiple entry and exit points, and stackable education and training outcomes are lacking.
- Sharing resources can improve capacity, reduce duplication of effort, and support the development of networks and services.

Working in mental health offers particular challenges and benefits. It offers the opportunity to contribute to the recovery of people using services, assisting them in addressing the challenges they meet and providing support to families and carers. However, it can involve working with people who may be very distressed or may have severe behavioural disturbance. The work can be stressful, and can test the capabilities, resources and needs of workers. Appropriate and contemporary education and training regarding mental health and mental illness is an important part of preparing practitioners for practice, including peer workers.

The capacity to work in teams and collaborate effectively across professions and services is important to the delivery of effective mental healthcare. Educating other disciplines about peer workers, and educating peer workers about other disciplines, is also important to establishing clear understandings and shared approaches to service delivery.

The recent establishment of the Certificate IV in Mental Health Peer Work offers the opportunity to embed a national qualification for mental health peer workers.

Training

The literature, case study interviews and online survey all concur that lived experience of mental illness is the key requirement for peer work. One manager, in stressing the importance of lived experience, described it as 'that different perspective [which] is another instrument in the toolkit. It provides the possibility of things' (Public Mental Health Service, Victoria). However, there was also consensus from managers, peer workers and the literature that training in a number of areas is important. Peer workers often wanted more training in peer work. Areas that were specifically identified by peer workers included interacting with consumers; boundaries; communication skills; effective and safe sharing of lived experience.

Davidson notes that providing training for specific skills and tasks required by peer roles may include: using their recovery story to the benefit of the people they work with, effective listening skills, creating positive relationships, goal identification and setting, what to do in an emergency situation, agency documentation requirements and how to fulfill them, ethics and confidentiality, boundaries, self-care, and ways of resolving conflicts in the work place (2012).

Accredited training

The Certificate IV in Mental Health Peer Work was developed in 2012 and is in the early stages of rollout. Availability of and access to the vocational qualification is still limited. A small number of organisations are supporting people to undertake this training both before and following the commencement of their employment.

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.

To complement peer workforce development directions, two nationally recognised skill sets have been developed for peer leadership and peer management. The peer leadership skill set provides an early career pathway for peer workers who have completed the Certificate IV, the peer management skill set is intended for line managers of peer workers (both peer and non-peer).

The NMHC in the *National Report Card on Mental Health and Suicide Prevention* (2012), recommends collaboration to increase the levels of participation of people with mental health difficulties in employment in Australia, to match best international levels. The Commission is supporting Community Mental Health Australia (CMHA) to develop national learning and assessment materials to assist the uptake of the new Certificate IV in Mental Health Peer Work qualification and related peer leadership skill set.

Other training

In the absence of nationally accredited peer work training courses, some Australian organisations have developed their own training, or utilised peer worker/peer support training from overseas. Mind and NEAMI developed their own peer worker and peer support training. Mind's training is used internally as well as by a range of external organisations throughout Australia. NEAMI's training is largely used for internal purposes and provides newly employed peer workers with initial training in the fundamentals of peer support. Brook RED Centre in Queensland also provides training to workers from other jurisdictions.

Other organisations have developed training programs to meet local need or specific needs such as youth participation. A number of consumer-run and community organisations are providing peer work training in specialised areas. Hearing Voices group facilitation is one example. Voices Vic, the hearing voices network of Victoria, offers a range of training options to support voice hearers.

Some of the well developed training courses available could be mapped to the new Certificate IV. The West Australian Mental Health Commission and Arafmi Western Australia are supporting Polytechnic West to develop a Recognition of Prior Learning (RPL) tool that might be used in this regard. Articulation of existing courses to the Certificate IV should assist in the development of a training pathway for peer workers.

Peer work project (PWP), South Australia

The Mental Illness Fellowship and Baptist Care SA collaborate to deliver training for peer workers. The 'Introduction to Peer Work' course has been run since 2006, and is complemented by work with organisations so that they are ready to employ peer workers. In 2012, the Certificate IV in Mental Health Peer Work was piloted in partnership with TafeSA for consumer peer workers. In mid 2013, it was run again, with both carer peer workers and consumer peer workers participating.

The PWP team offers mentoring to peer workers and to people seeking peer work positions. The employment rate for graduates from the introductory and Certificate IV courses is just over 75 per cent.

PWP also offers online resources for peer workers and employers. This includes a toolkit for employers considering the employment of peer workers. Additionally, a peer network is run through the PWP website, and advice regarding regular training workshops is provided.

Mentoring and supervision

Supervision and support are 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 position, the requirements of the job need to be mastered, and workers need to manage their time and productivity. Supervision should be put in place that concentrates on job skills, performance, and support, and not the person's health status, and which establishes expectations of peer workers that are equivalent to the organisation's expectations of other employees.

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. People with severe mental illness often have restricted social support networks, as do many 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. Watson (2007) argues that support structures should be established to ensure that workers have contact and networking opportunities with one another. A number of case study sites had put arrangements of this type in place. At ARAFEMI for example, peer workers come together regularly and are able to discuss issues of concern with one another, and at the Carer Consultants Network of Victoria, bi-monthly group carer peer supervision is provided with the assistance of a carer academic. These arrangements are separate from and in addition to line supervision arrangements.

National guidelines for the effective mentoring, coaching and supervision of the mental health peer workforce, would assist in ensuring the workforce is appropriately supported.

Promoting understanding, respect for and recognition of peer work

The attitude of service leaders and other staff had a significant impact on the acceptance of peer workers at the case study sites. A number of managers and peer workers described initial difficulties in non-peer worker attitudes towards the introduction of peer roles. The literature on barriers to the employment of peer workers consistently identifies the attitude of mental health professionals as an impediment (Gordon 2005). 'The biggest barrier is the lack of understanding in mental health organisations about the role of peer workers. More education is required... [to assist] greater understanding of the value of lived experience... '

Hodges and Hardiman 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 (2006). Stigma may also play a part, with some practitioners doubting the capacity of people with mental illness to contribute to service delivery. Similarly, some mental health staff do not value the role of consumer peer worker, and believe there is a degree of tokenism involved in peer participation in service planning and delivery. A peer worker explained the impact of these views and attitudes.

'I had to battle my reactions to the lack of acceptance and recognition of my role among other staff as well as among clients – it reinforced my own self stigma when I heard people say 'they are only a peer worker' or 'my son needs to see a professional not you.'

Another peer worker explained the role of management and opinion leaders in changing stigmatising or negative views.

'Champions of a peer workforce within management and throughout the organisation makes a huge difference; it gives legitimacy and paves the way.'

Training and education for non-peer staff regarding the role and benefits of peer workers can help support the introduction of this workforce. Such training might include expectations, ethics, boundaries, language, and a respectful attitude toward all co-workers. Involving non-peer staff, organisational leaders and service users or families early and throughout the process of moving in to peer workforce is another strategy suggested by Davidson et al (2012). Disseminating success stories to encourage hope and persistence by all staff can also be useful.

It is acknowledged that attitudes of service staff with regard to mental illness is a complex area. However, peer workers and managers advocated for action and support nationally to challenge mental health workforce attitudes regarding mental illness; peer workers; and the ways in which business can be done. This is essential if the use of peer workers is to be successfully expanded.

Aboriginal and Torres Strait Islander Peer Workers

Arafmi Western Australia operates an Aboriginal Outreach Program from Broome, which employs local Aboriginal people in the 'Countrymen looking after Countrymen' program. This west Kimberley program supports carers in communities, including the provision of support to families and carers affected by suicide. Support may include helping the family with their identified goals; working with the community (for example, participating on a clean up day); providing a program such as Partners in Depression; or facilitating respite by way of traditional dance and music.

Mental Illness Fellowship (MIF) delivers the Well Ways Program for families and carers nationally. The Well Ways suite of programs is designed to increase the capacity of families, carers and friends to care effectively for themselves, other family members and their friends living with mental illness. MIF WA has adapted the program to meet the needs of Aboriginal women, and two Aboriginal women participants have now become Well Ways facilitators in Bunbury. One of the women has subsequently been employed as a Noongar Access Worker at the local hospital.

Career pathway options

A mental health peer work career pathway would offer a clear sequence of training credentials and education linked to employer-validated capabilities; multiple entry and exit points; and stackable education and training outcomes (Larsen 2011). It would increase individuals' educational and skills attainment and improve their employment outcomes, while meeting the needs of mental health service employers.

The online survey asked whether respondents felt there was an opportunity to progress their career within their organisation, or another field. Sixty-two per cent of respondents indicated that peer workers did not feel there was an opportunity to progress. This can create issues with retention. A peer specialist from South Australia commented that *'barriers are around a lack of career progression. I love peer work but have not advanced my career since starting peer work six years ago.'*

The development of the Certificate IV in MHPW is a significant step forward with regard to training and education that is strongly linked to the workplace. However, more systematic entry points would be beneficial, and the development of a career structure would provide experienced workers with scope for progression. For some people peer work may be a first step in employment, and they may move on to different work or study opportunities. For others, it will be a long term pathway, and many of the workers at case study sites demonstrated a very strong commitment to their roles. There was support at many case study sites for recognition of peer work as a discipline similar to other mental health workforce groups. Mental health has valued interdisciplinary approaches over time, and peer workers are seen to be an emerging workforce group. At some services peer workers had opportunities for progression, and in some jurisdictions, there is an award structure that offers different levels of responsibility and remuneration. In one Victorian service, for example, a PHaMS team leader had moved into the role from a peer worker position, a development that was regarded very positively by both peer workers and managers at the service. Some larger non government agencies were aiming to fill a large proportion of their positions with people who have lived experience. More commonly, however, the structure for the peer workforce was flat, and many workers had a sense that there was 'nowhere to go.'

Progress is variable, however, some jurisdictions have made considerable headway in supporting the peer workforce. An example of this is the Queensland Health *Mental health carer and consumer workforce pathway*. The Pathway clarifies the range and variety of roles for consumers and carers with the Queensland Mental health workforce, and includes remunerated, full-time, part-time and casual career opportunities. The Pathway documents and affirms the importance of the role of the Consumer and Carer Workforce Network (CCWN) coordinated by a team consumer and carer senior managers. The Network provides regular opportunities for mental health consumer and carer peer workers to share information, discuss planning and improvement strategies and to provide advice. An annual workshop is also held; enabling mental health consumers and carers across Queensland to come together. A three yearly Consumer and Carer Participation Survey seeks to both document and to learn from the experience of the consumer and carer workforce.

In most of the case study organisations, peer work was recognised as a specific role and skillset. Some organisations had determined to increase and strengthen the peer workforce, and support peer workers to move between designated and non-designated peer work positions, as well as into leadership and management positions. Mind and Richmond PRA are both large organisations operating in multiple jurisdictions. Both services had an active commitment to expanding their peer workforce, for example, by reviewing vacant positions with a view to redesigning or reconfiguring them to enable a greater peer workforce involvement.

The capacity for peer workers to operate within a career structure that offers progression is an important part of further establishing this workforce.

Resources to support the implementation of a peer workforce

Sharing resources is one way of supporting peer workers and promoting communication. Enhancing access to resources including research; current activities and other information can make it easier for services to use a peer workforce. Technology also offers a range of options for peer workers to network with each other and share information and ideas.

The Centre of Excellence in Peer Support (www.peersupportvic.org) is an example of a centralised specialist clearinghouse and online resource centre for mental health peer support. It was established in June 2011 with philanthropic support, in response to the growing interest in and recognition of peer support work. It aims to support a sustainable peer support sector by providing linkage, service mapping and information sharing. The Centre's resources are intended for use by consumers, families, carers, peer support workers, community mental health organisations, NGOs and individuals who provide or want to provide peer support. The website includes a news and events listing and capacity for online fora.

This type of initiative could be extended to include other aspects of peer work, and more workforce-based resources, such as job description templates for a range of peer worker roles and wellness plans.

Domain 2 recommendations

- 2.1 Promote the national rollout of the Certificate IV in Mental Health Peer Work including the implementation of the national learning and assessment resources (once developed by Community Mental Health Australia with the support of the National Mental Health Commission).
- 2.2 Support the development and implementation of Recognition of Prior Learning tools that recognise existing peer worker skills.
- 2.3 Build awareness of and further establish traineeships and scholarships to support entry into the mental health peer workforce.
- 2.4 Develop national guidelines for the effective mentoring, coaching and supervision of the mental health peer workforce.
- 2.5 Describe career options into and beyond mental health peer work, recognising that some workers will choose to remain with peer work, and others will choose different career options.
- 2.6 Develop training resources for mental health and health practitioners and service providers outlining the role of the Mental Health Peer Worker in supporting recovery, and potential benefits at an individual, family, service and system level.
- 2.7 Support the development of opportunities for members of the peer workforce to network with each other, including:
 - Developing a national mental health peer workforce online forum and network.
 - Providing opportunities for showcasing examples of best practice and innovative approaches, such as a national peer worker conference.
 - Providing opportunities for sharing and disseminating resources, information and research.

"Peer workers can bridge the gap. They are good at crossing barriers. They can bring the best out of people."

Manager, NGO, New South Wales



Domain 3 - Leadership for the sustainability of the health system

Objective: Develop leadership capacity at all organisational levels to support and lead mental health workforce innovation and reform

Key points

- The peer workforce can contribute to positive changes in organisational culture, and an improved recovery focus.
- Leadership is needed to overcome barriers to the peer workforce and support organisational change.
- Recognition of and support for peer leaders promotes people-centred services and system improvements in mental health.
- Involvement of peer workers in the education and training of other health professionals can counter stigma and discrimination and build awareness of the value of peer workers; consumer and carer perspectives; and recovery.

Leadership is critical when an organisation faces the need to mobilise a workforce in a new way towards a vision, a set of values, or to changing work practices. Moreover, leadership can influence an organisation's outcomes and the health and wellbeing of people using the service, families, carers and staff in both positive and negative ways.

Shifting Australia's mental health services to have a greater recovery focus is a significant task, and leadership is a crucial factor for success. Facilitating and supporting new ways of working, including greater use of peer workers, is an important task for leaders in mental health. Associated with this is the need to provide others with the knowledge and skills necessary for change; to provide an environment where change happens; and to acknowledge and address the risks of change.

The NMHCCF has argued that the lack of progress around recovery is linked to the barriers to effective consumer and carer participation in mental health services. These barriers include a lack of understanding about recovery, mental health stigma, a workplace culture that cannot respond to change and is not yet able to work in equal partnership with consumers and carers (2010). The Forum argues that without leadership, the barriers to establishing a peer workforce will not be overcome, and further, that a recovery orientation will remain elusive to many services.

Distributed leadership involves everyone with the capacity and desire to lead for improvement. There is growing recognition of leaders among people with lived experience of mental health issues and among families and carers. Their advice and expertise can contribute to better policies, services and programs with a greater recovery orientation. However, leadership development opportunities for peer workers are limited. Building and supporting the leadership capacity of the peer workforce can accelerate progress towards the delivery of recovery focussed services.

Organisational culture and values

A key benefit for services of utilising peer workers 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 and 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 (2010).

The benefits of peer workers for other staff were described by one manager as providing another point of view. Rather than seeing the consumer just in the 'sick' role, they see people who are well enough to participate.

It brings the recovery model in a living way to the ward. Rather than just 25 patients, 25 beds, you see people getting better. It also makes staff consider the language that they use. Staff can forget the way in which they speak to people, even though communication is a core part of the way we do our job. People forget and for some staff it isn't as good as it should be. Having consumers [as peer workers] present reminds staff to hear what they are saying (Manager, public mental health service).

Experience suggests that as with introducing other organisational or systemic changes, introducing a peer workforce can be difficult. Leadership can contribute to addressing challenges, which may relate to culture, attitudes, budget and other factors. As noted earlier, involving non-peer staff, service users and families early and throughout the process of employing peer workers can promote engagement and buy-in. Articulating the purpose of the change and organisational commitment to recovery, and executive sponsorship, are also important. Champions can support workers within the immediate team, and also support development of peer worker roles in the wider service (Berry et al 2011).

What is best about being a peer worker? The views of peer workers from the case study sites

"The encouragement people get from lived experience can make a massive difference. People's faces sometimes light up when you tell them that you have also been a patient—they become very engaged, it makes things possible."

(Consumer peer worker, New South Wales)

"I'm not the expert, I like the equality of the way the work is done. Peer workers are living examples of recovery and hope. [We have] an education that training can't provide. Peers can promote a positive outlook – that it isn't hopeless, and assist people to make positive choices."

(Carer peer worker, Victoria)

"I had an average experience in the mental health system. The input to improvements, and evolution of the system is important. Making it better for others – and the pay is good too."

(Consumer peer worker, New South Wales)

"I wouldn't do anything else. I love what I do, working with them, seeing people change."

(Consumer peer worker New South Wales)

Consumer and carer leadership

The National Mental Health Consumer and Carer Forum (NMHCCF), provides a combined national voice for consumers and carers participating in the development of mental health policy and sector development in Australia. Through its membership, the NMHCCF gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform. As noted, in 2011, the Forum released a position statement entitled, *Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery*. The forum continues to advocate for a mental health peer workforce strategy.

Once the new national mental health consumer peak body becomes operational, it is anticipated that the new organisation will collaborate with the forum and with nationally-based carer organisations to contribute advice and leadership about peer workforce development.

Recognising and supporting peer leaders

Consistent with national mental health policy frameworks, organisations across many mental health settings and sectors have appointed consumer and carer advisors. Employees with lived experience of mental health issues either personally or among their families and friends have also been appointed to leadership and management positions. Some of these leadership positions are peer-designated and others are not.

Many consumer and carer leaders sit on advisory groups and committees at the service or organisational level, locally, regionally and at the state or territory and national level. Advice is provided across sectors and service settings and to representative, professional and educational bodies.

In some states, mental health consumer and carer academic positions have been established. For example, a Carer Academic (mental health) position was established at the Bouverie Centre, La Trobe University in 2005. The position has a leading role in better understanding, articulating and supporting families and carers, mental health services and the community to establish working partnerships in caring for people with a mental illness. Some of the core objectives of the position include: facilitating better understanding of the experience and significance of carers and the various impacts on families living with mental illness; and supporting the development of collaborative models and practice that promote participation and service change through carer consultants within mental health services. Activities include research and publication, education and training, and maintaining active linkages and networks with representative groups and organisations at state and national levels. A similar Consumer Academic (mental health) position was established at the Centre for Psychiatric Nursing, Melbourne University.

Mental Health consumer and carer leaders participate in the International Initiative for Mental Health Leadership (IIMHL), a collaboration of eight countries: Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, United States of America and Sweden. The IIMHL organises processes for international networking, innovation sharing and problem solving across countries and agencies. The overall aim is to provide better outcomes for people who use mental health and addiction services and their families. Benefits from participation in the IIMHL have included: promotion of workshops/training/education, support of learning collaboratives; information dissemination; internships; scholarships; adjunct and other professorial appointment/exchanges and secondments. Supporting the recognition of peer work as a profession in its own right and the development of the mental health peer workforce internationally are also priorities of the IIMHL.

Supporting and growing peer workforce leaders will contribute to spreading innovative recovery-oriented practice. Such leaders contribute towards people-centred services and system improvements in mental health. As a peer worker from the Australian Capital Territory commented, *'we need more high profile leaders to engage the existing mental health workforce and advocate for inclusion.'*

Domain 3 recommendations

- 3.1 Expand use of the peer workforce within the mental health service system, supported by appropriate structures including training for both peer and non-peer staff, including:
 - An implementation project to broaden the use of mental health peer workers in non-traditional settings with evaluation built into project design.
- 3.2 Build awareness, respect for and understanding within the broader mental health workforce of the role of the peer workforce in achieving a recovery orientation and improved service outcomes for individuals and their families or carers by:
 - Embedding and promoting respect for and an understanding of the peer workforce in vocational and tertiary education, and professional development, for mental health, health and community service practitioners.
 - Identifying and supporting the development of peer worker leaders.
- 3.3 Leaders and managers to actively consider the use of peer workers in mental health services.

Domain 4 - Health workforce planning

Objective: Enhance workforce planning capacity, taking account of current and emerging mental health workforce configuration, mental health needs, technology and capabilities

Key points

- Peer workers are a small but growing workforce, about whom little information is available.
- There is no accepted national definition of 'peer worker' and a national approach to data collection cannot be established until a definition is in place.
- Data indicates there were 68.5 FTE consumer workers and 43.4 FTE carer workers in 2010/11 in specialised mental healthcare facilities.
- PHaMs service teams included 217 peer support workers in the community as at 30 June 2013.
- The evidence base for peer work is still in development and further research is needed.

In any workforce planning, the first key step is to understand the existing workforce. This encompasses both the supply and demand sides – understanding the size and characteristics of the existing workforce as well as service demand for the workforce. HWA is undertaking a workforce study of the entire mental health workforce that encompasses a range of workforce groups. The study includes mental health peer workers, however, very little information is available about this workforce.

Peer workers are known to be a small but growing part of the Australian mental health and community services workforce. AIHW reported that in 2010-11, there were 68.5 FTE consumer workers and 43.4 full time equivalent (FTE) carer workers employed in specialised mental healthcare facilities. Between 2006-7 and 2010-11 there has been an average annual increase in this workforce of 4.7 per cent. Specialised mental health service organisations are equivalent to the area health services or district mental health services in most states and territories. Organisation types include public mental health hospital services, community mental healthcare services, residential services and day clinics. Most peer workers, however, are employed in the non government sector.

The National Health Workforce Planning and Research Collaboration undertook a study of the mental health NGO workforce published in 2011. The study included a landscape survey that was targeted at NGOs providing services to mental health consumers and carers. The survey found that 31 per cent of organisations employed one or more consumer workers and 19 per cent employed one or more carer workers. 238 respondents answered the question regarding staff categories (p.67).

The Personal Helpers and Mentors (PHaMs) initiative established by the Department of Families, Housing, Community Services and Indigenous Affairs in 2007 employed 217 peer workers nationally as at 30 June 2013. FAHCSIA is funding 28 new Mental Health Respite: Carer Support service teams in 2013. In response to feedback from carers of people with a mental illness, the new teams will include carer peer workers.

Data about the peer workforce is scant, and it is not possible to say with any precision how many peer workers are currently employed in Australian mental health services. However, there is evidence that the workforce is growing and services in the public, private and non government sector appear willing to engage peer workers in mental health programs.

The online survey conducted as part of this study received 305 individual responses. Forty four per cent of respondents identified themselves as having lived experience of mental health issues and 46 per cent of the respondents identified themselves as having lived experience of mental health issues and supporting a family member or friend with a mental health issue. Nine per cent of the respondents identified themselves as supporting a family member or friend with a mental health issue. Whilst the survey was conducted and provided these results, it is unknown how representative the data is and conclusions can not be made for the peer workforce as a whole. This supports the recommendation to develop a national approach to data collection. See Appendix B for further data from the online survey.

A first step in relation to data is establishing an agreed definition of 'peer worker'. A national approach to data collection cannot be established until a definition is in place.

Research example – United Kingdom

A research team led by the University of London commenced a project in 2011 with the aim of testing the existing evidence on introducing peer worker roles in a range of mental health service settings, in order to identify what works best in different contexts.

An initial paper was based on research at four English mental health NHS Trusts in three study sites (Gillard et al 2013). At each site an innovative intervention providing support for self-care for mental health service users had been developed, all of which included peer worker roles as a core component. An example is peer support groups established in London for people experiencing personality disorders.

The paper presents a qualitative analysis of organizational benefits and challenges associated with introducing consumer peer workers.

Building the evidence

There is a need to build the evidence base for the peer workforce internationally and nationally. It has been suggested that the introduction of peer workers represents a unique set of challenges to existing mental health workforce practices, necessitating further research that pays close attention to the specifics of service context, and acknowledges a learning curve in the development of roles, the needs of the worker and the workplace environment (Gillard et al 2013). Where possible there is value at looking at differences in outcomes when peer workers are included as partners on mental health service delivery teams.

Evidence is lacking in relation to peer interventions for people outside the 'working age' group. Peer work in relation to people aged over 65 years, and young people, has not been greatly researched. There is also less research evidence available in relation to carer peer work than consumer work (within the small existing research base). It cannot be assumed that models successful in one age group can be applied to all, or that peer work operates in the same way for consumer and carer peer workers and those with whom they work.

Empirically grounded learning that can be applied in practice would assist mental health services and teams in successfully developing and using the peer workforce.

Domain 4 recommendations

- 4.1 Develop a national mental health peer worker definition, dataset, data collection and public reporting approach across employment sectors to measure progress and support evaluation.
- 4.2 Encourage and support Australian research to build the evidence base for collaborative models of practice in mental health and increase understanding of the contribution of the peer workforce.

Domain 5 - Health workforce policy, funding and regulation

Objective: Develop policy, regulation, funding and employment arrangements that support mental health workforce reform

Key points

- Variation in wage levels for peer workers, within and across jurisdictions and services is common.
- Lack of job security is a problem for some peer workers.
- A range of work is underway in states and territories to increase consumer and carer participation and employment in mental health services.

The mental health workforce is affected in the same way as other parts of the health workforce by a range of policy, funding, industrial relations, regulatory and accreditation processes and agreements. Australia's federal system of government, and the complex mix of public, private and non government mental health service delivery, can give rise to inequities. The substantial variation in peer worker wage levels, depending on service, sector of employment and jurisdiction is an example. Other mental health workers in comparable roles often receive higher remuneration, and this may be influenced by differences in training pathways and industrial awards.

Policy levers available to governments to shape the mental health workforce include education, occupational regulation, and healthcare funding and organisation. Using relevant policy levers can play a part in promoting uptake of the peer workforce.

Increasing job security and promoting parity

Peer workers and managers frequently advocated for action to address the job insecurity faced by many peer workers. Factors underpinning this insecurity appeared to include the provisions of funding programs; how organisations respond to the limitations of budget allocations; and the duration of funding for peer work positions.

"For the last year of a funding cycle, staff start to worry about how long they will have a job for – sometimes they don't find out whether their job will continue until the 11, 12th or 13th hour' – we battle both the reality and perceptions of a fragile funding base. Funding uncertainty is really difficult. People don't know if they have a job. Funding is often for two or three years and it is not some time into the last six months that people know whether our program will be funded again." (Manager, NGO, New South Wales)

"Funding programs do not provide enough funds for peer workers to be employed at an appropriate award level – organisations try to cobble together funds to initiate or grow peer workforce".

One organisation reported that it is running its peer worker positions at a loss.

Peer workers and managers called for support to ensure that peer workers are remunerated appropriately and that they are afforded the same employment condition and entitlements as other employees—within organisations, across and within service sectors; within and between areas/regions and states.

Work underway

Many mental health directorates and organisations are establishing a peer worker/consumer and carer workforce strategy or framework. This project's research, site visits and consultations has emphasised the need for mental health peer workforce strategies that span public, private and community mental health and community sectors, and which identify the settings in which this workforce is required or has the potential to work.

All Australian states and territories have policy and planning documents for increasing consumer and carer participation and employment in mental health services. This section briefly summarises recent developments and directions of relevance to building and supporting the mental health peer workforce.

Victoria

In Victoria, the Mental Health and Drugs Division at the Department of Health has provided recurrent funding for all public adult mental health services for the employment of consumer and carer consultants to represent the interests of consumers and carers, and to advocate for their needs and to have input into quality improvement processes. Many consumer and carer consultants also provide peer support.

A number of health services utilise co-funding or in-kind arrangements to employ specific carer peer support workers. Additionally, several psychosocial disability rehabilitation and support services and private mental health services also fund the employment of carer and consumer consultants and peer workers.

New South Wales

New South Wales, like Victoria, has a history of employing consumer and carer consultants dating back to the 1990s. Family and carer peer support has been provided by NGOs since 2005 through the New South Wales Health funded Family and Carer Mental Health Program. New South Wales Consumer Advisory Group (NSWCAG), Mental Health Inc has played a key role in supporting the development of consumer workforce. NSWCAG and the New South Wales Mental Health Consumer Workforce Committee (MH CWC) have long been concerned about the inconsistency in professional salary awards and conditions, lack of appropriate job descriptions and other issues including hours of employment, training, professional development and appropriate supervision. The MH CWC received funding from the NSW Mental Health Drug and Alcohol Office to develop a framework for the New South Wales Public Mental Health Consumer Workforce. The framework will be released in the near future, and is designed to guide consumer workforce development within public mental health services in New South Wales by providing a consistent, State-wide approach and by promoting the profession of the consumer workforce. It includes a Code of Professional Standards for the New South Wales Public Mental Health Consumer Workforce.

South Australia

The South Australian Mental Health Services' *Pathways to care: participation by people with mental illness, their families and supporters* provides a framework for the increased participation of consumers and carers and declares a commitment to growing the peer workforce. The peer workforce is described and a clear career pathway within the Mental Health Services organisational structure is articulated.

Western Australia

In Western Australia (WA), the WA Mental Health Commission is guiding the expanded involvement of consumer and carer peer workers to include consultants, advocates, educators, advisors and support workers in mental health services. The Commission's vision is for the roles of peer workers to be recognised and embedded in the delivery of mental health services throughout WA. The Commission has identified a number of tasks required to achieve this including the following

- Defining Peer Work: functions; place within the organisation; position descriptions/JDFs; training; remuneration.
- Peer worker support and development: line management; professional supervision and mentoring including external mentoring; professional development and training.
- System support for peer workers: Establishing champions; educating other staff and managers; policies, procedures and systems.
- Developing the peer worker profession: Code of professional standards; evaluation measures; career structure.

The WA Commission is working collaboratively with various stakeholders including consumer, family and carer organisations, NGO and public mental health and drug and alcohol services as well as training organisations, to develop a strategic approach to embedding the peer workforce into services.

Differing knowledge bases: Peer workers and professionals (Orygen 2012)	
Experiential knowledge	Professional knowledge
1. Knowledge learned from the personal experience of living with mental illness.	1. Knowledge learned from discursive reasoning, observation, reflection, didactic teaching.
2. It is 'lay knowledge' gained informally. Unless you have had the experience, you cannot know it in the sense of 'what it feels like'.	2. It is knowledge applied and transmitted by an established specialized occupational profession.
3. Common elements in people's experiences can be discovered through the sharing of these experiences.	3. Common elements for professionals are based on training, and research which is analytical, theoretical and scientific.
4. Information is a two-way flow.	4. Information can and often flows one-way; for example, clinicians may initially need to be didactic in culturally sensitive situations, or where there is significant risk, or impaired judgement.
5. Helping activities are mostly non-scheduled.	5. Helping activities are scheduled (appointments), and made more difficult by large caseloads.
6. Experiential knowledge embraces the total phenomenon-emotional reactions, effect on lifestyle, effect on others in the person's social environment.	6. Professional knowledge focuses primarily on the client-crisis, symptoms, hospitalization, treatment, the client's 'system', employment and friendships.

Queensland

Throughout the last decade, Queensland Health has made considerable progress in employing and supporting consumer and carer peer workers, generally in the role of either a Consumer/Carer Consultant or Recovery Support Worker. In 2011, Queensland Health sought to further embed a consumer and carer perspective within public mental health services through the *Mental Health Consumer and Carer Workforce Pathway*. The Pathway provides a guide to the development of career opportunities and appropriate mechanisms for supporting consumer and carer peer workers within the Queensland Health mental health services.

In 2011, the Queensland Government also launched the Consumer Operated Services funding program. This program funds consumer operated services and provides funding for support through peer workers to prevent escalation into crisis, particularly for people who are isolated in the community. This support may be provided through non-residential or residential services. To date three non-government organisations have been funded to provide consumer operated services: Brook Red, Brisbane, Richmond PRA, New South Wales and FSG Australia, Queensland.

Australian Capital Territory

A formal career structure for peer recovery workers is an integral component of *A Real Career – A Workforce Development Strategy for the Community Mental Health Sector of the Australian Capital Territory*. This document was the culmination of four years of ground-work which included extensive consultations with all stakeholders.

Access to training in the Certificate IV in Mental Health Peer Work and other relevant training is being facilitated as is the establishment of web-based resources and a peer worker network.

Tasmania

State-wide and mental health services within the Department of Health and Human Services has engaged a Senior Consumer and Carer Liaison Consultant, to ensure the progression of consumer and carer/family participation in Tasmania. The objective of the position is to enable the input and involvement of a consumer and carer/family perspective, systematically and strategically, into the planning and delivery of mental health services across Tasmania. This includes advice concerning the roles of peers within mental health service delivery.

Northern Territory

The Department of Health in the Northern Territory aims to have consumers with lived experience provide input in service planning and delivery both at policy and service delivery levels. Having a small and dispersed population, the Northern Territory faces many challenges resourcing, training and supporting peer workers to perform these roles. Non-Government organisations who employ people with lived experience receive funding from the Department of Health and, together with the Northern Territory Consumer and Carer Advisory Group, provide strategic advice and representatives for committees and staff interview panels. Currently one peer worker is providing advice to mental health services on a part time basis. Links with established training and mentoring programs in larger jurisdictions will be explored to enable expansion of the peer workforce from this small beginning within available resources.

Domain 5 recommendations

- 5.1 Facilitate access to existing interdisciplinary practice platforms and develop models of practice to enhance collaboration and understanding between the mental health peer workforce and other health, mental health and related professions.
- 5.2 The National Mental Health Commission, in partnership with state mental health commissions, facilitate a national peer work policy forum, planned in consultation with peer worker representatives.

Glossary

Carer	A person who has a caring role for a person with a mental health problem or mental illness. They could be family, a friend or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the person and carer.
Community	How the community is defined depends on the purpose, structure and type of service. The community may be determined by a target population, such as people and/or clinicians who access the service or, in the case of public services, a defined catchment area.
Confidentiality	Restricting access to personal information to authorised people, entities and processes at authorised times and in an authorised manner.
Consent	An agreement based on an understanding of the implications of a particular activity or decision and the likely consequences for the person.
Consumer	A person who uses or has used a mental health service.
Disability	A concept of several dimensions relating to an impairment in body structure or function, a limitation in activities (such as mobility and communication), a restriction in participation (involvement in life situations such as work, social interaction and education), and the affected person's physical and social environment.
Diversity	A broad concept that includes age, personal and corporate background, education, function and personality. Includes lifestyle, gender identity, sexuality, sexual identity, ethnicity and status within the general community.
Evaluation	Judging the value of something by gathering valid information about it in a systematic way and by making a comparison. The purpose of evaluation is to help the user of the evaluation to decide what to do, or to contribute to scientific knowledge.
Integration	According to the needs of people, continuity of care is maintained over time and across different levels of services.
Interdisciplinary team	Care or a service given with input from more than one discipline or profession.
Intervention	An activity or set of activities aimed at modifying a process, course of action or sequence of events, to change one or several of their characteristics such as performance or expected outcome.

Involuntary Treatment	Refers to a person being treated for their illness without their consent, in two ways, either in hospital or in the community. This may occur when mental health problems or disorders result in symptoms and behaviours that lead to a person's rights being taken away or restricted for a period of time.
Mental health	Mental health refers to the capacity of individuals and groups to interact with one another in ways that promote subjective wellbeing, optimal development and the use of mental abilities (cognitive, affective and relational), and the achievement of individual and collective goals consistent with the law.
Mental health practitioner	A worker within a mental health service who provides treatment, rehabilitation or community health support for people with a mental illness or psychosocial disability.
Mental health problems	A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.
Mental health professional	A person who offers services for the purpose of improving an individual's mental health or to treat mental illness. These professionals include (but are not limited to) psychiatrists, psychologists, social workers, occupational therapists and mental health nurses. See also Practitioner(s).
Mental health services	Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.
Monitor	To check, observe critically, measure or record the progress of an activity, action or system on a regular basis to identify change.
Non-government mental health sector	Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.
Outcome	A measurable change in the health of an individual, or group of people or population, that is attributable to interventions or services.
Peer worker	A person who is employed in a role that requires them to identify as being, or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary

People	The term 'People' refers to anyone who is currently using, or has previously used, a mental health service and includes people who have accessed general health services for a mental health problem. For the purposes of this document, this term includes those with emerging or established mental illness for which they have not yet sought treatment, or for whom treatment has not yet been provided.
Practice	Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their health profession. Practice is not restricted to providing direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services (adapted from AHPRA 2012).
Prevention	Interventions that occur before the initial onset of a disorder.
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to people.
Recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.
Recovery-oriented mental health practice	Refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations (Commonwealth of Australia 2012).
Rights	Something that can be claimed as justly, fairly, legally or morally one's own. The term can also refer to a formal description of the services that people can expect and demand from an organisation.
Risk	The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood.
Seclusion	The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of time out, where a patient is requested to seek voluntary social isolation for a minimum period of time.
Self-determination	The right of all people to 'freely determine their political status and freely pursue their economic, social and cultural development' (article 1 of the International Covenant on Civil and Political Rights). Self-determination is a collective right (belonging to a 'people' as a group) rather than an individual right.
Service provider	A person, usually with professional qualifications, who receives remuneration for providing services to people who have a mental health problem and/or mental illness.

Services	Products of the organisation delivered to people or units of the organisation that deliver products to people.
Social inclusion	Contemporary concepts of disadvantage often refer to social exclusion. Social inclusion refers to policies that result in the reversal of circumstances or habits that lead to social exclusion. Indicators of social inclusion are that all Australians are able to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.
Social and emotional wellbeing	An holistic Aboriginal definition of health that includes: mental health; emotional, psychological and spiritual wellbeing; and issues impacting specifically on wellbeing in Aboriginal and Torres Strait Islander communities such as grief, suicide/self-harm, loss and trauma.
Standard	Degree of excellence etc. required for a particular purpose; measure to which others conform or by which the accuracy or quality of others is judged.
Support services	Direct services and interventions provided for a person with a mental health problem and/or mental illness and associated disability aimed at reducing handicap and promoting community tenure, for example, assistance with cooking and cleaning. Support services do not necessarily have a treatment or rehabilitation focus.
Treatment	Specific physical, psychological and social interventions provided by health professionals aimed at reducing impairment and disability and/or the maintenance of current level of functioning.
Values	Principles and beliefs that guide an organisation and may involve social or ethical issues.

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There are a range of titles for peer workers in use. One of these is 'lived experience worker'. It is acknowledged that some stakeholders have a preference for the term lived experience worker over peer worker. However, as the literature, project documentation, and new national qualification all use the term 'peer worker', this is the term that is used in this report.

Appendix A – Case study sites

Jurisdiction	Organisation	Site visit or telephone interview
ACT	Woden Community Service	Site visit
NSW	Richmond PRA CAN Mental Health	Site visit Site visit
NT	Team-Health	Telephone interview
QLD	Metro North Mental Health – Royal Brisbane and Women’s Hospital FSG Australia	Telephone interview Site visit
SA	NEAMI Uniting Care Wesley	Site visit Site visit
VIC	Northwestern Mental Health Mental Illness Fellowship of Victoria MIND ARAFEMI The Compassionate Friends Victoria ADEC* GROW	Site visit Site visit Site visit Site visit Telephone interview Survey returned Site visit
WA	Richmond Fellowships RUAH Community Services* Mental Illness Fellowship of WA Peel and Rockingham Kwinana Mental Health Service	Site visit Survey returned Telephone interview Site visit and telephone interview

*Note that two services, ADEC and RUAH Community Services, returned a survey but it was not possible to organise a time to visit or interview them.

Other key informants:

- Department of Families, Housing, Community Services and Indigenous Affairs.
- Department of Health and Ageing.
- Mental Health Council of Australia.
- Mental Illness Fellowship SA (part of the Peer Work Project in South Australia).
- NSW Consumer Advisory Group.
- Community Mental Health Australia.
- Psychosocial Research Centre.

The seventeen case study organisations involved in this study deliver a range of services in one or more state or territory. The only jurisdiction where a service was not interviewed was Tasmania (although it should be noted that GROW Victoria's Manager is also responsible for GROW Tasmania). Information from the initial questionnaire indicated that most of the organisations offer metropolitan based services (38 per cent), with a number of organisations offering regional and state wide services (24 per cent and 29 per cent respectively). 82 per cent of the services have some level of peer involvement in service delivery, with 18 per cent being described as solely peer run and operated, 29 per cent are partially peer run and operated, and 35 per cent have aspects of the service peer run and operated. Sites indicated that their organisations target a wide range of populations, and that their peer workers work across a number of those populations.

Community Mental Health Australia (CMHA) classifies community managed mental health services into seven key service types (2012). The types of services visited and interviewed in the preparation of this study varied widely, and included all CMHA's seven types and additionally, public mental health services. A private mental health service was approached, but unfortunately was unable to participate. Some services involved in the case studies were large, with multiple programs, and others were smaller with a narrower focus. Programs that were frequently offered included Personal Helpers and Mentors Service (PHaMs) and Day 2 Day Living (D2DL). Other programs included vocational and housing support, and group-based rehabilitation services.

Below is some information on the organisations that were visited or interviewed, to illustrate the range of services in which peer workers are currently involved. As some services offer multiple programs, the discussion below may not capture the complexity of the work undertaken by an individual organisation.

Service type examples at case study sites

Employment and education

Richmond PRA is a large provider of psychosocial mental health recovery support services in New South Wales and Queensland, and has an explicit commitment to employing suitably skilled and qualified staff with a lived experience of mental illness and recovery. Programs offered by Richmond PRA include PHaMS, D2DL, Hospital to community transition, Housing and Accommodation Support Initiative (HASI) and employment services.

Richmond PRA owns and runs a number of businesses and social enterprises. An example is Prestige Packing, a training and employment service with factories in Marrickville, Harris Park and West Ryde. Peer workers provide support to people who are working and training in these factories, and work through the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) questionnaire with the client. This validated tool is designed to look at barriers to people's goals, and provides a focus for discussions about people's recovery aspirations. Peer workers provide a role model for both recovery and employment.

Accommodation support and outreach

Lack of appropriate supported accommodation can be a significant issue for people with severe mental illness. Prevention and Recovery Care Services (PARCS) in Victoria are one example of a step up, step down service. The aim of PARCS is to improve mental health outcomes for people with a severe mental illness who become acutely unwell, and to prevent avoidable admissions to acute units and avoidable readmissions following an acute episode.

MIND provides a comprehensive range of services to people with mental health issues in Victoria and South Australia. Services are individually tailored, person-focused, and responsive to the changing needs of people over time. MIND employs a number of peer workers in services including PHaMS, and Youth Prevention and Recovery Care (YPARC). Peer support training developed by MIND is delivered both internally and externally, including to international audiences.

Another accommodation initiative is the Doorway Demonstration Project being undertaken by Mental Illness Fellowship Victoria. This project supports people with mental illness who have been unable to secure adequate and stable housing. The project is operating in partnership with health services, real estate agents, and property owners, to assist people in obtaining private rental accommodation. The Doorway project is one Mental Illness Fellowship's project that involves peer workers, others include home-based outreach and support, PHaMS, vocational support and training for peer workers.

In Queensland, FSG provides services for people moving from long-stay psychiatric facilities into the community of their choice, through accommodation and lifestyle support. From the Gold Coast to the Sunshine Coast and West to Ipswich, the FSGA Realty manages over 70 properties including houses and low rise unit blocks.

Self help and peer support

Self-help groups are effective at helping people cope with, and recover from a wide variety of problems. Benefits may include increased self-esteem, empowerment, reduced stigma and improved social functioning.

GROW was founded in Sydney as Recovery Inc more than fifty years ago, and is now an international mental health self-help organisation. GROW provides peer support programs for people with a mental illness and those experiencing difficulties. A structured process is used, involving small groups of up to ten members that meet weekly. The groups are facilitated by a peer 'Grower', and may have a theme, such as alcohol and other drug issues or schizophrenia.

NEAMI operates in Victoria, New South Wales, South Australia and Western Australia. Programs include home-based outreach and psychosocial rehabilitation programs. NEAMI employs peer workers to run and deliver Flourish, a recovery-focused self development program. The approach involves fortnightly meetings over a 12 week period, with individual follow up between sessions.

Helpline and Counselling services

CAN Mental Health is a peer run and operated service that runs a Phone Connections program. Peer workers will ring individuals who have self-referred or been referred to Phone Connections. Often consumers may be isolated in the community, and worried about stigma associated with mental illness. This service provides them with support from someone with lived experience.

The Compassionate Friends (TCF) Victoria also operates a telephone support line, focused on assisting people affected by bereavement.

Leisure and recreation

Uniting Care Wesley SA operates a community mental health program at Port Adelaide. Peer workers provide a range of groups that focus on different areas including art therapy, gardening, and bush walking. Leisure and recreational activities promote social inclusion, and provide opportunities for meaningful engagement with other individuals, and with the broader community.

Information, advocacy and promotion

NorthWestern Mental Health (NWMH) is Victoria's largest public mental health service with 32 sites across north western and south western metropolitan Melbourne. NWMH has a strong commitment to peer workers in a range of areas. Information, advocacy and promotional peer work means that the concerns and interests of consumers and carers are part of a variety of processes and activities. At NWMH, this includes peer worker representation on some staff interview panels; and involvement in projects on issues such as management of clinical aggression and Electroconvulsive Therapy.

Queensland's Metro North Mental Health also employs peer workers. Their role includes information, advocacy and promotional work. This has extended to the publication of articles in professional journals looking at service users' views about what makes an excellent mental health worker.

Family and carer support

ARAFEMI offers a range of services to support individuals with a mental illness, and families, friends and carers. Consumer and carer peer workers are employed in a range of programs. One of these programs is COPES (Carers Offering Peers Early Support). Services include child and adolescent mental health services and adult services, and the role is designed so that peer workers, at times, are available outside normal working hours. This means that family members or carers who need to be at work can still see the peer worker at a mental health service when they are visiting in the late afternoon or evening. Carer peer workers offer emotional support, information, psycho-education and referral to families and carers.

The Compassionate Friends (TCF) is a service that offers support to families following the death of a child. TCF is a peer run service, operated by parents who have themselves lost a child. Impacts on parents and siblings following the death of a child can be severe, and include not only psychological distress, but also significant financial, employment and social consequences. Peer workers are involved in a number of programs including group sessions; events; health promotion and education; and a phone support line.

Mental Illness Fellowship in both Victorian and WA offers a range of services. 'Well ways' is a suite of programs that has been developed to increase the capacity of families, carers and friends to care effectively for themselves, other family members and their friends living with mental illness. The course is facilitated by carers and provides informal workshops involving group discussions, videos and practical demonstrations which are designed around adult learning principles.

Other service types

Not all service types fit neatly into the CMHA classification. Some other types of services that may involve a number of different activities are outlined below.

Personal helpers and mentors

The Personal Helpers and Mentors (PHaMs) service aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness. The Personal Helpers and Mentors, employed by service providers, support participants in their recovery journey, building long-term relationships and providing holistic support. They ensure that services accessed by participants are coordinated, integrated and complementary to other services in the community. A number of case study sites, including Richmond Fellowship WA, Team Health in (and around) Darwin, and Woden Community Services, deliver PHaMs.

A Personal Helper and Mentor:

- Helps participants to better manage their daily activities and reconnect to their community.
- Provides direct and personalised assistance through outreach services.
- Provides referrals and links with appropriate services such as drug and alcohol and accommodation services.
- Works with participants in the development of Individual Recovery Plans which focus on participants' goals and recovery journey.
- Engages and supports family, carers and other relationships.
- Monitors and reports progress against each participant's Individual Recovery Plan.

Health promotion

Peel and Rockingham Kwinana Mental Health Service in Western Australia uses peer workers in several different roles. Currently a worker has been specifically employed in a physical health promotion role. Activities include assisting individuals to visit the GP or dietician and working on exercise plans. Initially the position had a focus on assisting people with early psychosis, however, it has expanded to other groups.

Hospital avoidance- step up/step down

Transitions to Recovery (TRec) at Woden Community Services is a 12 week program for people either leaving hospital or at risk of admission. The program is currently being evaluated by the Centre for Mental Health Research at the Australian National University. Peer workers were involved at the beginning of TRec, and WCS has a strong commitment to peer work across its mental health programs. Currently further policy development is occurring in relation to using peer workers on TRec.

TRec operates in partnership with ACT Mental Health. Intensive outreach support is available in the community after hours (up to 9pm weekdays and weekends) and evening outreach and phone line access. In addition to outreach, TRec can link people with services and provide social support and assistance to attend medical appointments and community based programs. Psychosocial education and other support is also available.

Ethnography

The material earlier in this appendix describes the case study organisations, and some of the services that they deliver. Peer work in many respects rests on the interaction between the peer worker and the person using services, or family and carer. The project team has included material below provided by two workers about their role and work. A striking feature at the case study sites was the strong commitment of workers to their roles, and these narratives provide insights into perspectives on peer work from practitioners themselves.

Consumer peer worker from MIND Australia

"The work that I do supports learning and development for individuals and groups. People who take part in the peer training we offer through Mind say that it was a time in their lives that is a unique opportunity to celebrate and deepen their understanding of their lived experience. For many people this experience is often the first time they have been in a situation where they feel safe enough to share and explore their story and people say this experience is enhanced by being with their peers. Many people who have done the peer training experience a new found confidence and interest in their future. For some people it is a springboard into other areas of life such as taking up a new course, job, involvement with others in a common interest group or project and/or a rekindling of hopes, dreams and aspirations.

The training is conducted over 5 days and we give priority to establishing a learning environment that is safe, respectful of privacy and confidentiality, based around informed choice to participate and the unique needs of each group and participants. The design of the course allows for reflection and interaction around the content as well as plenty of opportunity to interact at a personal level as well as reflect on the group process and facilitation. It is a privilege and honour to be able to be part of a training program that is considered by the participants to be of value in supporting their recovery and wellbeing.

Feedback from people who have completed the course demonstrates that their recovery is supported through participation in the groups at a number of levels. Most of all it is in the valuing of people's personal experience and the connections they make with others as part of the experience of reflecting on lived experience and how to use this experience to support the recovery of others that participants describe. The opportunity to participate in supporting and developing an ongoing and iterative training program with my peers for people with a lived experience that enables a space for personal growth and that builds confidence in the individual and a fundamental platform for further possibilities and opportunities, is very exciting."

Carer peer worker from a rural public mental health service

"I have for many years been avoiding anything to do with mental health. My mother was diagnosed with schizophrenia when I was 18 months old. It wasn't until I became divorced with two young children under five that I realised how hard it must have been for my own mother to raise myself and older siblings. It was at this my most vulnerable time that I thought that I had enough lived experience from my childhood and my own life that I could be of benefit to others.

I have particular interest in families with parental mental illness, domestic violence and trauma experienced by children, partners and consumer trauma. I particularly find my work rewarding knowing that I am able to listen to people, their stories and support them as much as possible. Sometimes times you are the first person that someone has ever had the opportunity to tell their story to, this is very powerful and they realise that they are not alone. Its ok to feel, frustrated, angry, sad for the loss that many have experienced through caring for someone with mental illness. These things and many more make this work so rewarding and so important. Many carer consultants have skills that go unseen and are often underutilised.

Many carer consultants are also revisited by trauma emotions in their roles.

The aspirations I have for my role are to complete my social work degree, and specialise in trauma informed care to better support families and individuals."

Appendix B – Mental health peer workforce project online survey analysis

Data notes

In this analysis the peer workers referred to are those peer workers who responded to the online survey. The analysis is not representative of the whole workforce, but only discusses a sample of the mental health peer workforce. It is not known how many peer workers there are; therefore this survey is only representative of the sample size of 305 respondents.

All per centages that are reported are based on the number of peer workers that responded to each question. Response rates varied considerably for questions in the survey. This should be considered when interpreting or comparing data items.

Methodology

The survey was posted on HWA's Connect website (www.hwacconnect.com.au) during the month of June 2013. Respondents were directed to the survey through a number of channels including email notification, newsletter advice and word of mouth.

The survey asked 42 questions in a range of formats including likert scale and free text. The questions were asked under the following themes:

- About you and your organisation.
- About your role.
- Supervision.
- Job satisfaction.
- Experience, qualifications and remuneration.
- Training and development.
- Retention, career pathways and future change.

A full list of questions can be found in Table 5. A total of 305 responses were received over the four-week period, refer to Table 5 for the number of response to each question.

The information collected from the survey is summarised below.

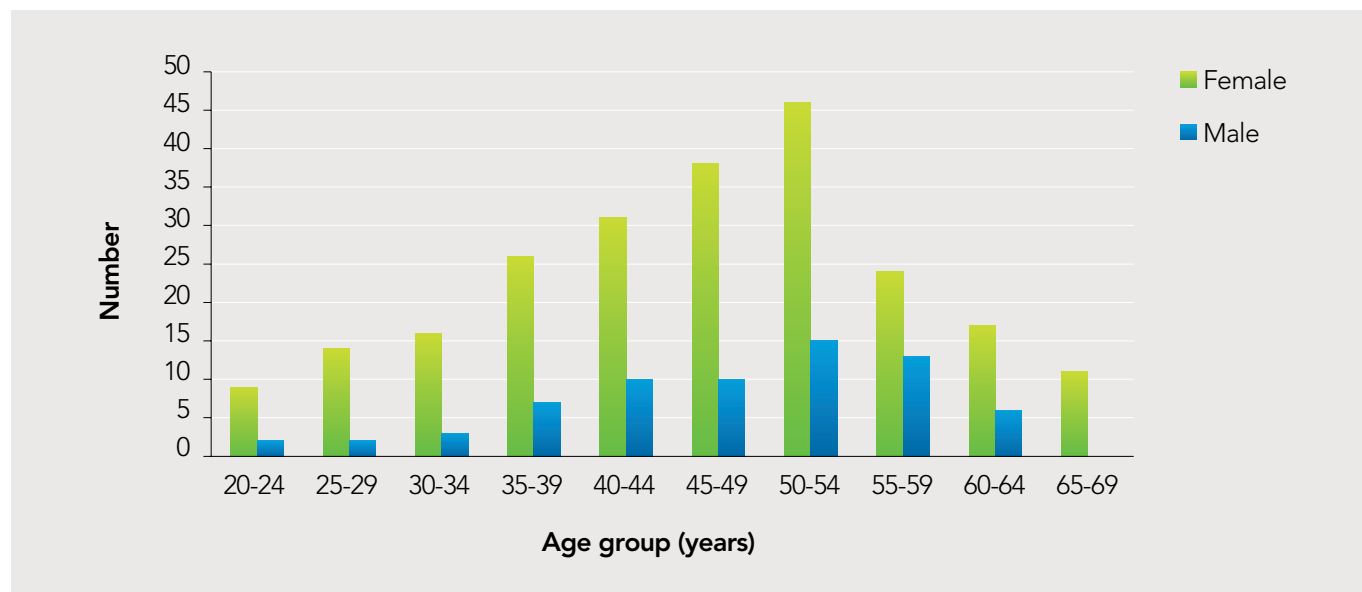
Characteristics of survey respondents

Information in this section provides a profile of peer workers who responded to the survey including their age, gender and location.

Age and gender profile

Over three quarters (77 per cent) of survey respondents were female, with more females than males across all age groups. Of those peer workers who completed the survey, the most common age group for males and females was 50 to 54 years. The proportion of female respondents was higher than males in all states and territories.

Figure 1 – Comparison of respondents' age by gender

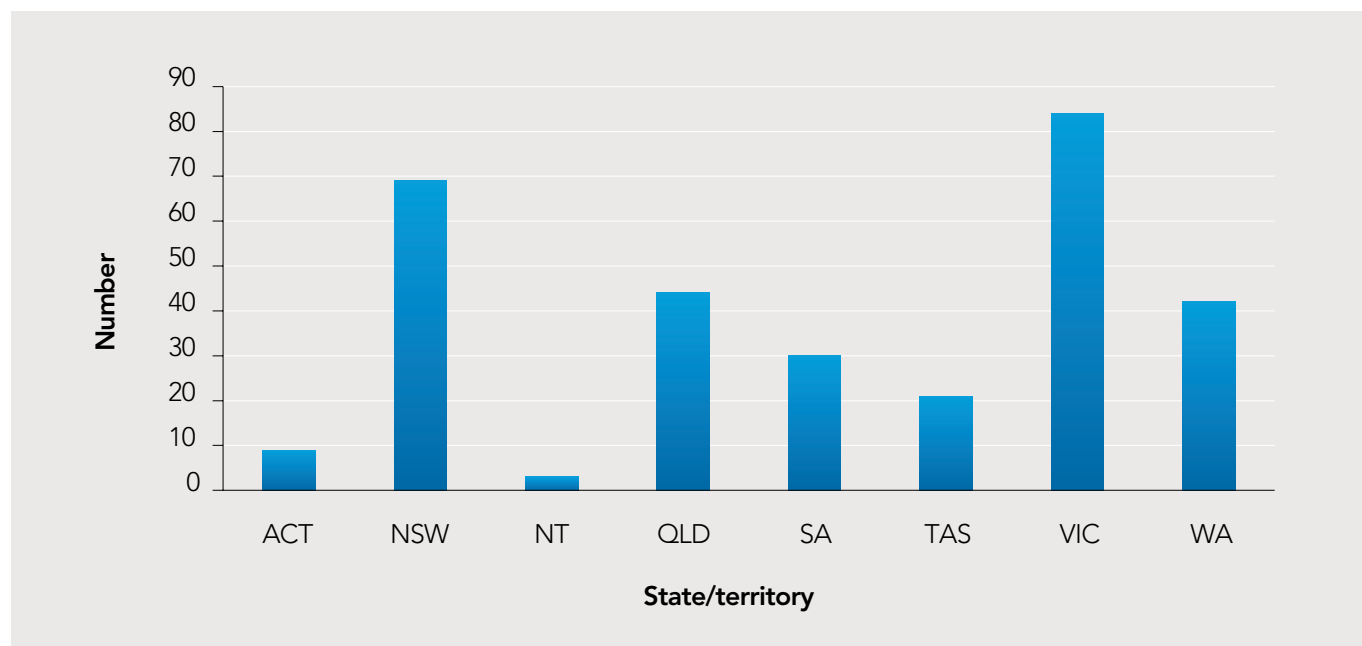


Note: Data includes only respondents that reported both their age and gender in the survey, 5 respondents did not provide responses to both of these questions

State and territory distribution

Most survey respondents were from Victoria (84), followed by New South Wales and Queensland (69 and 44 respectively).

Figure 2 – Respondents' location by state or territory



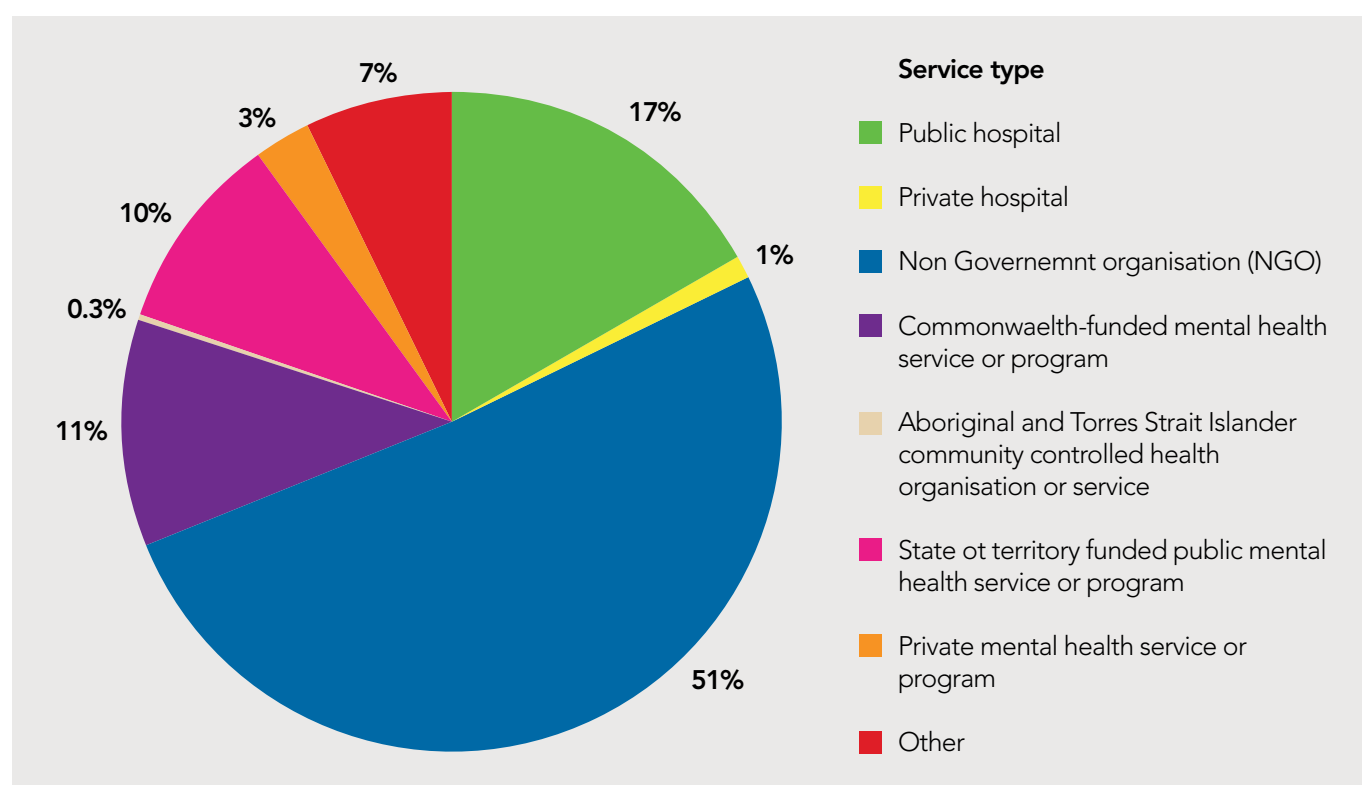
Note: 3 respondents did not provide their location; this data does not take into account population factors

Service type

Information was collected on the type of service peer workers are employed in. Service types included private hospitals, public hospitals, non government organisations and Aboriginal Community Controlled health service or organisation.

Of the survey respondents, approximately half (51 per cent) were employed by non government organisations, followed by public hospitals (17 per cent). Few respondents were employed in private hospitals (1 per cent) or Aboriginal Community Controlled health organisation or service (<1 per cent).

Figure 3 – Type of mental health service where respondents are employed



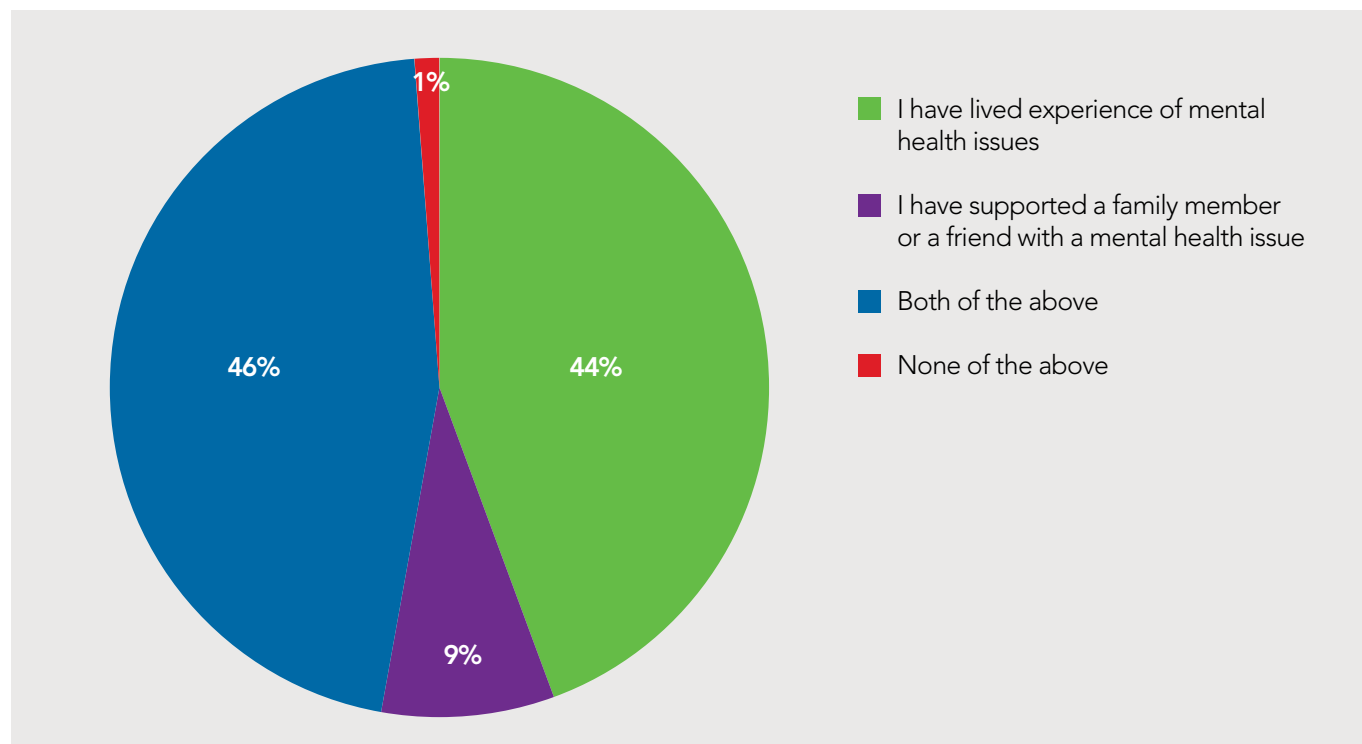
Note: 7 respondents did not provide their service type

Role

The literature scan identified that job titles and responsibilities can vary considerably across the peer workforce. The survey sought to identify the type of lived experience peer workers commonly have, as well as provide information on job titles used.

Forty-four per cent of respondents identified themselves as having lived experience of mental health issues. Forty-six per cent of peer workers identified that they had both lived experience of mental health issues and had supported a family member or friend with a mental health issue. Nine per cent identified solely as having supported a family member or friend with a mental health issue.

Figure 4 – Respondents' type of peer work role



Note: 57 respondents did not provide their identification of role

The title of peer work roles differs amongst the workforce and the survey asked respondents to identify their particular role title. Peer support worker was the most common response with 54 per cent of respondents identifying with this role title. The next most common was Consumer consultant (19 per cent) and Peer educator (18 per cent). The 'Other' category was represented by 14 per cent and responses included peer specialist, PHaMs worker and consumer peer support development worker.¹

To determine the level of formality around the role, respondents were asked if they had a unique job description specific to their role. Eighty-eight per cent of respondents stated that they did have a job description specific to their role.²

Respondents were also asked about their access to a range of resources including: a desk; fixed phone; mobile phone; work vehicle; computer, laptop; and a personally designated office space. This provided information about work environments and assists to determine whether peer workers have adequate resources to complete their job properly.

Job details

In addition to information about the job role, the survey also sought to identify particular details about the role, including length of service, employment conditions and tasks completed. This section presents the survey responses in relation to peer workers job details.

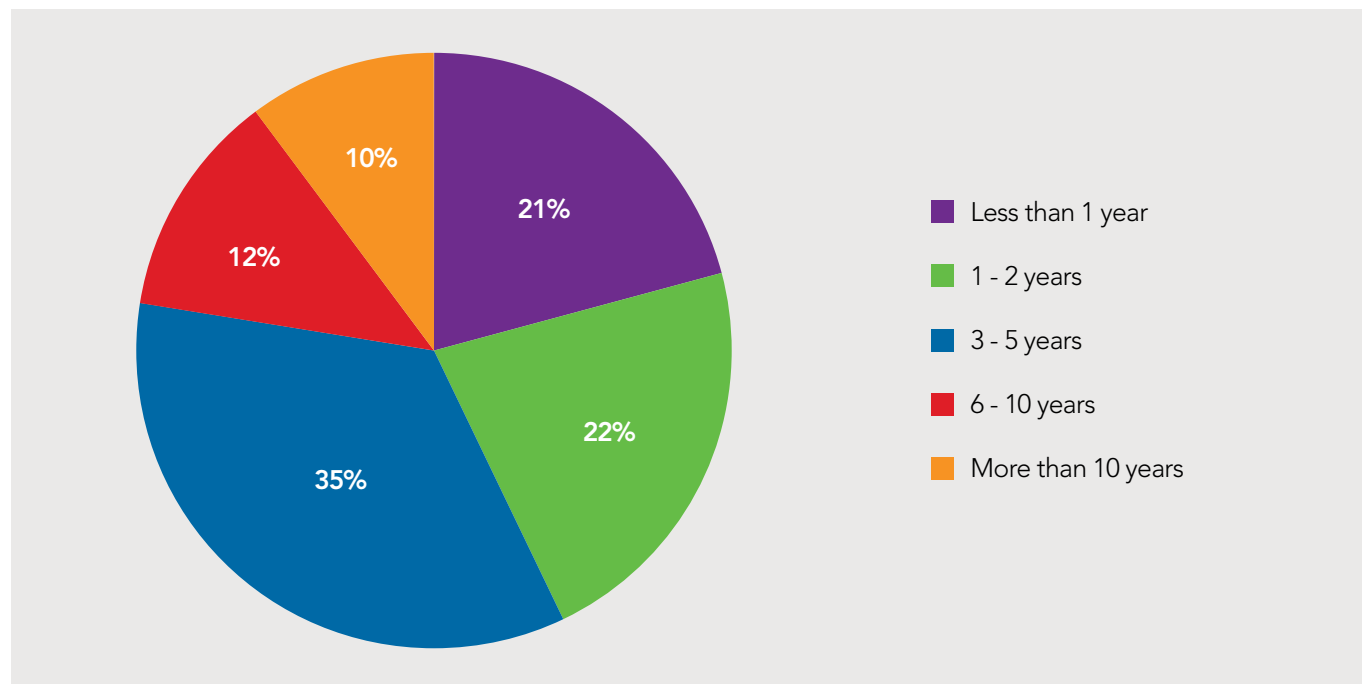
Years of experience

Just over one-third of respondents have been in their current role for 3 – 5 years; this is also the most common amount of time peer workers have spent in the peer workforce. Twenty-one per cent of respondents have spent less than one year in their current role. Eighteen per cent of respondents have spent less than 1 year in the peer workforce.

¹ Fifty-five respondents did not provide their job title

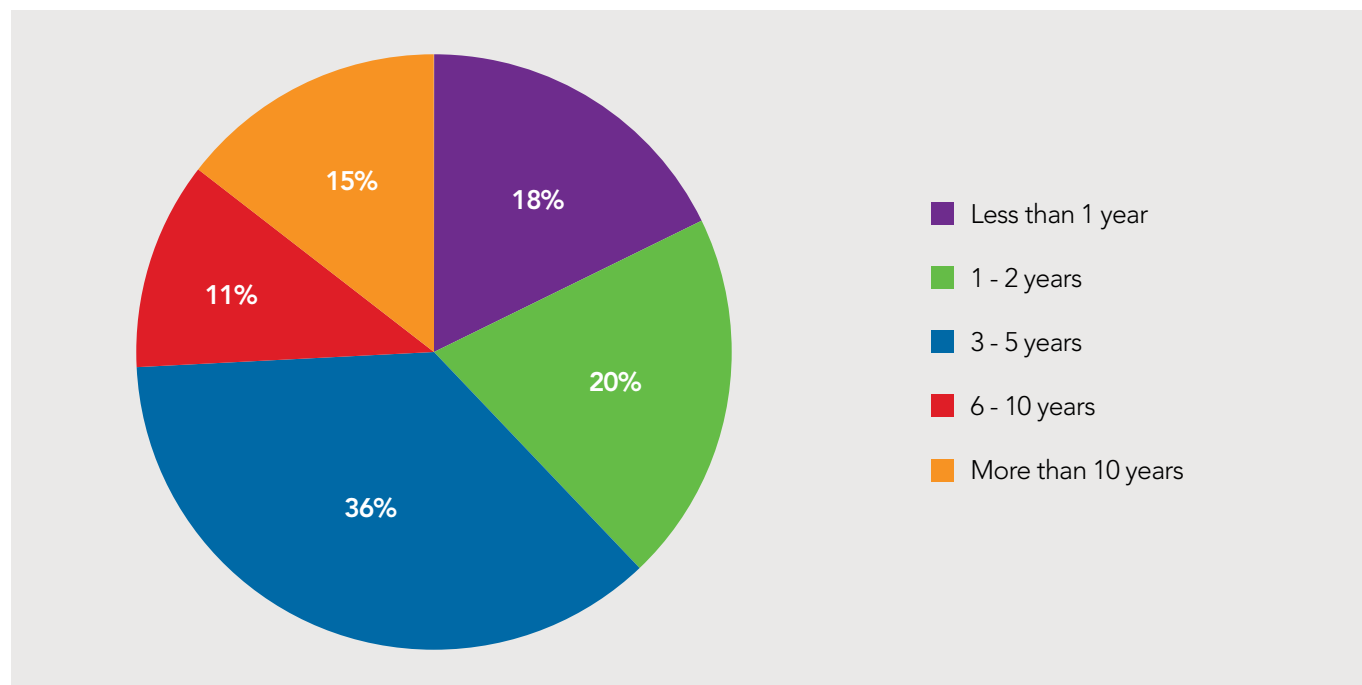
² Sixty respondents did not state whether they had a job description specific to their role

Figure 5 – Respondents' years of experience in current role



Note: 60 respondents did not provide their years of work in current role

Figure 6 – Respondents' years of experience in mental health peer workforce



Note: 57 respondents did not provide their years of work in the mental health peer workforce

Employment type

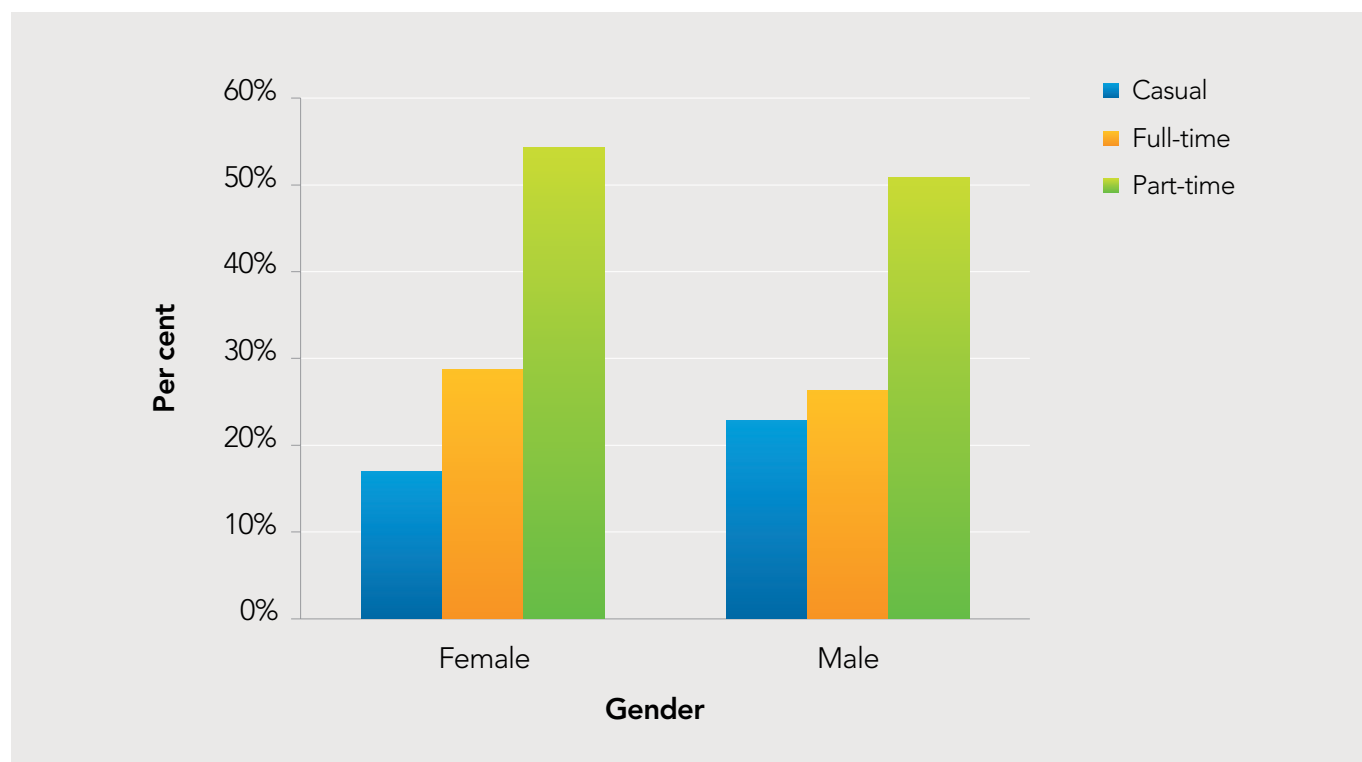
Of the survey respondents who provided information on their employment type, respondents were most commonly employed in part time roles (53 per cent). This could be related to the nature of work and peer workers themselves balancing their own recovery with work commitments. Twenty-nine per cent are employed on a full time basis and 18 per cent are employed on a casual basis.

Part time work was the most common type of employment amongst female and male survey respondents. However a higher per centage of males were employed casually (23 per cent) compared with females (17 per cent).

The basis of this employment was also dominated by a permanent employment category, with 81 per cent of respondents selecting this criterion.³

Respondents were also asked about how often they work as a team with other health professionals. The most common response was working with a team on a daily basis (41 per cent), followed by a few times a week (22 per cent).

Figure 7 – Respondents' employment type by gender



Note: 58 respondents did not supply their gender and employment type

The following definitions apply:

Full-time – employees who work 35 hours or more a week and are entitled to either paid holiday leave or paid sick leave (or both)

Part-time – employees who work less than 35 hours a week and are entitled to either paid holiday leave or paid sick leave (or both)

Casual – employees who are not entitled to either paid holiday leave or paid sick leave

³ 76 respondents did not provide their employment type

Type of tasks performed

Respondents were asked to identify how frequently they performed a range of tasks (see Table 1). The most common task was advocacy where 89 per cent of respondents said they did this 'everyday,' 'sometimes' or 'more than sometimes'. The next most common task was training and education 85 per cent, followed by networking with other peers 82 per cent and referral to other services 79 per cent. The least performed role by respondents was respite support (21 per cent) and comorbidity programs (39 per cent).

Table 1 –Common tasks undertaken by respondents

Task	Percentage (%)
Advocacy	89
Training and education	85
Networking with other peers	82
Referral to other services	79
Peer facilitated groups	78
Telephone support	77
Public awareness services	73
Health education advice	72
Committee representation	63
Conferences	59
Face to face assessments	58
Research	58
Vocational support	55
Home visits	42
Comorbidity programs	38
Respite support	21

Note: Percentages represent respondents that performed the tasks 'everyday' or 'sometimes'

Area or program focus

Respondents were asked what area or program they focused on. Adults (25 – 64 years of age) were the most common group (89 per cent of respondents) where respondents provided services; this was followed by young adults⁴ (60 per cent) and older people⁵ (41 per cent)⁶.

4 Young adults includes 18 – 24 year olds

5 Older people includes 65 years and over

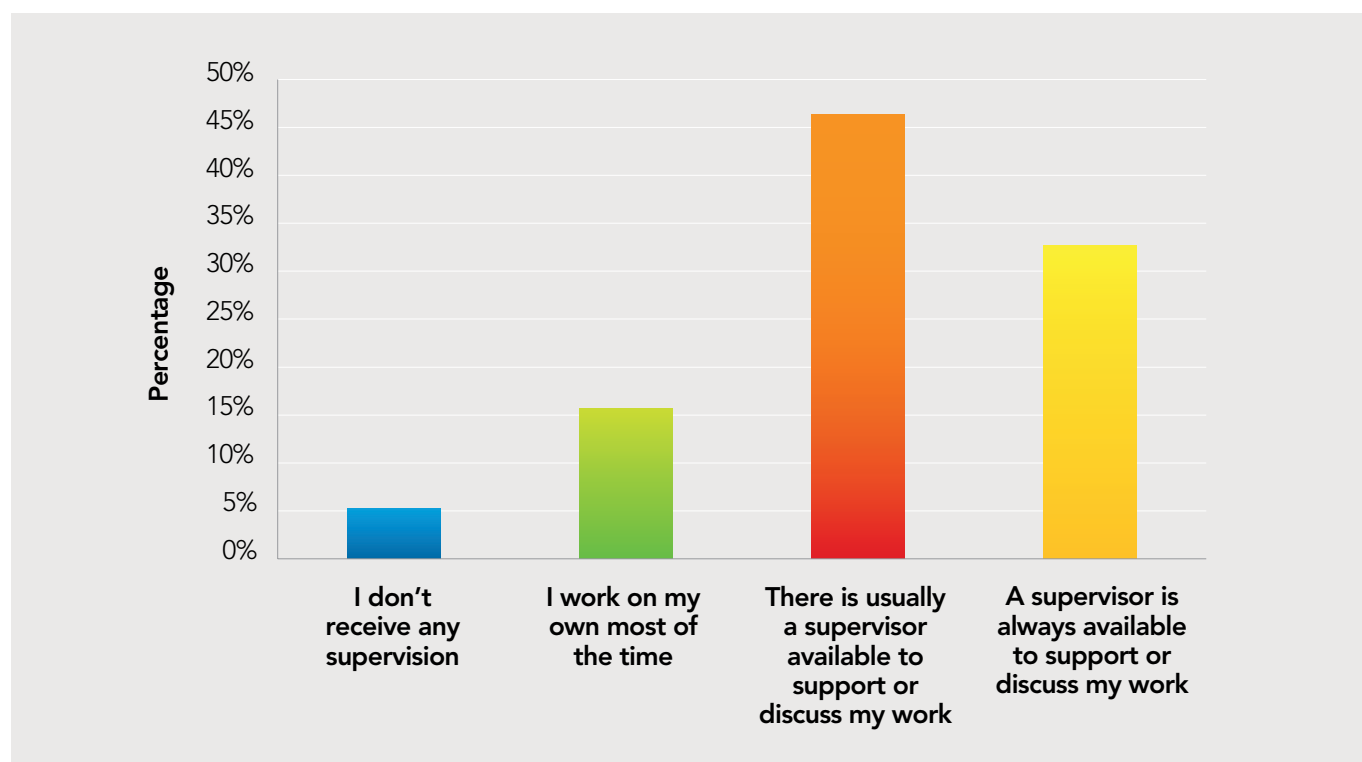
6 Respondents could select more than one answer, 58 respondents did not provide their area or program of focus

Supervision

Respondents were asked about the type of supervision they receive and the frequency of supervision. Most respondents answered that there is usually a supervisor available to support or discuss their work (46 per cent). A further 33 per cent reported that there is always a supervisor available to support or discuss their work. 5 per cent of peer workers indicated that they do not receive supervision.

Information was also collated on the particular person who conducted the supervision. Mental health peer workers were identified as supervisors by 30 per cent of respondents and Social Workers were identified by 25 per cent. It was found that face to face supervision occurred most commonly once a month (43 per cent) followed by irregularly and once a fortnight (23 per cent and 22 per cent respectively).

Figure 8 – Level of supervision received of peer workers

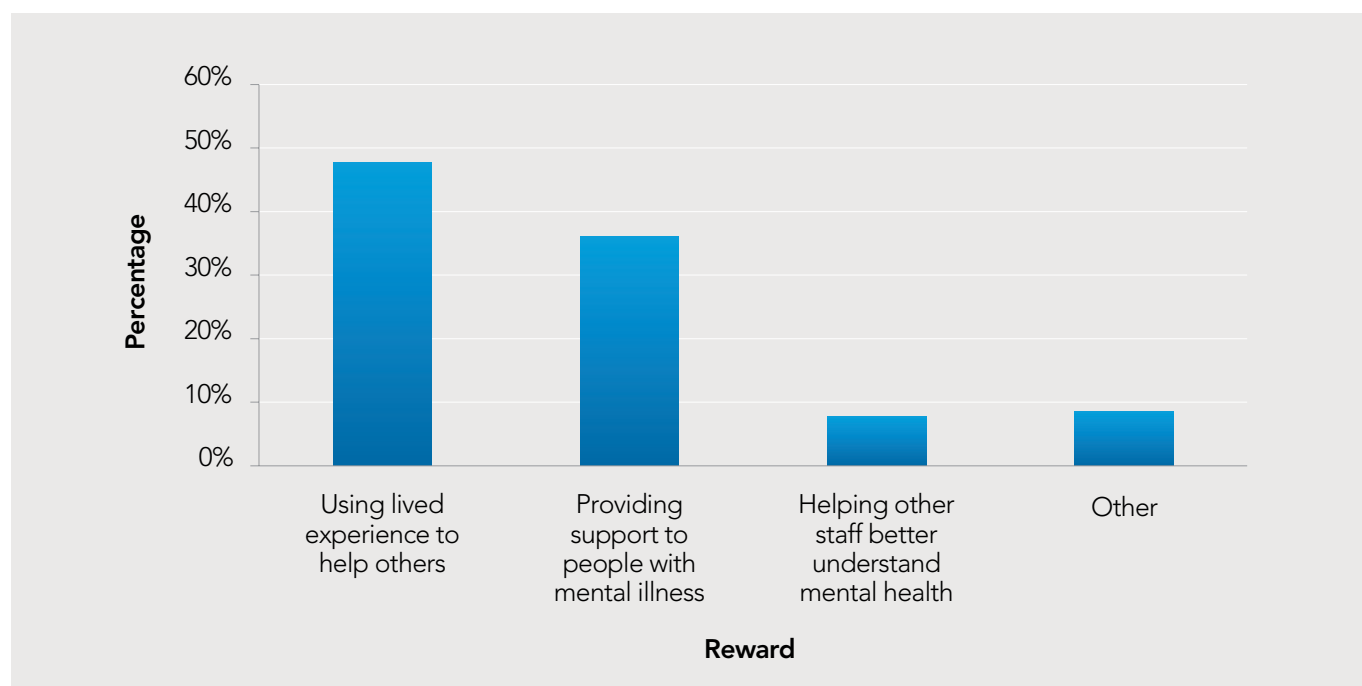


Note: 57 respondents did not provide their supervision arrangements

Role satisfaction

Respondents were asked what the most rewarding thing about being a peer worker was. A number of options were presented, including using lived experience to help others, providing support to people with mental illness and helping other staff to better understand mental health. The most common response was using lived experience to help others at 48 per cent.

Figure 9 – Most rewarding thing about being a peer worker



Note: 58 respondents did not provide an answer

Respondents were also provided with the opportunity to write additional information. Many responses summarised that providing support to others with the belief that they would recover was the most rewarding aspect of their role. Respondents believe that they are making a positive impact in reform and recovery education through their roles as peer workers.

Respondent's comments included:

"My mental health has improved greatly since starting this role. I feel I am actively contributing to society and using a huge negative in my life to assist others making it all worthwhile". Peer Support Worker, TAS.

"Creating system changes internally to organisation and externally to the sector." Peer Support Worker, WA.

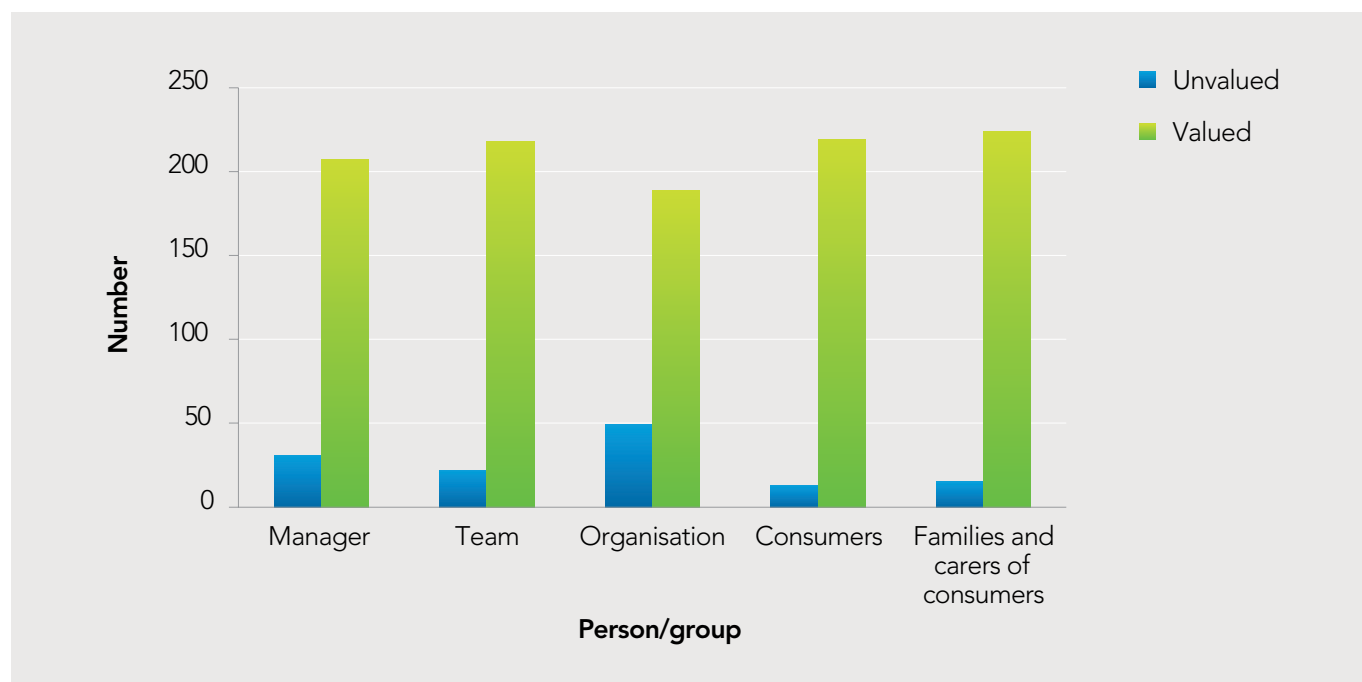
"Being a respected member of the mental health team where my contribution is valued." Peer Support Worker, ACT.

Respondents were asked about their satisfaction levels with areas including their position, their contribution to the organisation and integration into the team. When asked how satisfied respondents were with their position the most common response was satisfied (50 per cent). Seven per cent of respondents stated they were unsatisfied with their position. Fifty-seven per cent of respondents stated that they were satisfied with the contribution they were making to the organisation.

Respondents were asked to rate different groups of people in terms of how they think their expertise and knowledge is valued. As shown in Figure 10, the group who respondents felt valued their expertise and knowledge the most was consumers of mental health services and families and carers of consumers (both 94 per cent).

This information has been broken down into responses from consumers and carers to further identify the value of respondents expertise and knowledge by certain groups of people. This can be found under the 'Consumer and carer comparison' section.

Figure 10 – Level respondents believe their expertise and knowledge is valued



Note: Unvalued includes extremely unvalued and unvalued, Valued includes valued, highly valued and extremely valued.

Training and education

There is no nationally agreed definition of a peer worker, nor are there required qualifications for peer workers, although the Certificate IV in Mental Health and Certificate IV in Mental Health Peer Support are highly relevant qualifications. The survey sought to assess how many respondents have formal qualifications.

Respondents were surveyed on the requirement to have certain qualifications, including Certificate IV in Mental Health and Certificate IV in Mental Health Peer Work prior to being employed in the position. The survey also asked what other qualifications the peer worker might have obtained themselves without it being a requirement of the organisation. While response rates were low for these questions according to the responses given, thirty-eight per cent of organisations (as reported by respondents) required peer workers to have or obtain the Certificate IV in Mental Health prior or during employment as a peer worker. Nine per cent of respondents reported that they had obtained this qualification themselves, without the organisation requiring it.

Respondents were also asked about other qualifications they hold. Responses included qualifications in community services, disability services, aged care, nursing, social science, business administration, accounting, psychology, engineering and education.

Table 2 – Qualifications required by respondent’s organisation

Qualifications required	Number	Per centage (%)
Certificate IV in Mental Health	56	38
Certificate IV in Mental Health Peer Support	12	8
Other	94	64

Table 3 – Qualifications respondents have obtained

Qualifications obtained	Number	Per centage (%)
Certificate IV in Mental Health	46	22
Certificate IV in Mental Health Peer Support	7	3
Other	192	91

The survey also asked what skills, experiences or attributes respondents think should be essential for a mental health peer worker. Most respondents stated that lived experience was essential (94 per cent), followed by orientation to the organisation (65 per cent). Fewer peer workers thought that qualifications in mental health and qualifications in peer work were essential (41 per cent for each).

Questions were asked about induction and orientation received when entering into the organisation, 83 per cent of respondents stated that they did receive an induction and/or orientation with the most common length of time for this being more than four days (44 per cent). Seventy-four per cent of responses suggested that respondents knew there were additional training opportunities they could undertake as part of their role.

Recruitment and retention

As an emerging workforce, it is important to know what attracts and retains people in their role. The survey asked respondents to identify a number of key components that attract and keep them in the mental health peer worker role.

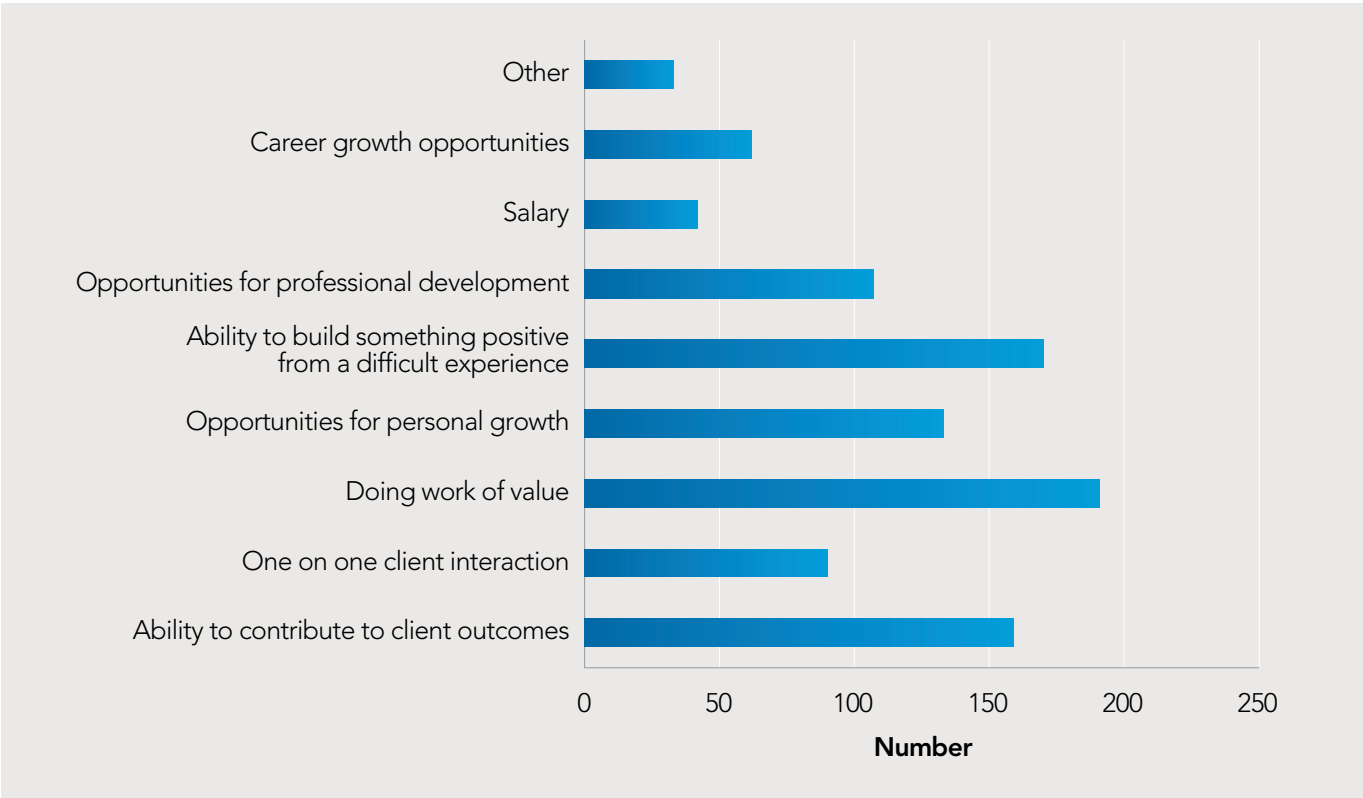
Doing work of value was the most common reason given for attracting respondents to their current role (82 per cent). Making a contribution to positive client outcomes was reported as the most common factor which keeps respondents in their roles (81 per cent), followed by opportunities for personal growth (61 per cent) and opportunities for professional development (55 per cent). Only 18 per cent of respondents said the salary attracted them to their current role.

The survey asked if respondents had ever considered moving into another discipline; 51 per cent of respondents answered yes and 49 per cent answered no. It was also asked whether respondents felt there was an opportunity to progress their career within their organisation either in their current role or another field. Sixty-two per cent of responses indicated that respondents didn’t feel there was opportunity to progress within their current role or organisation.

Respondents were asked what they thought would attract more people to the mental health peer worker role, they were given a range of options including better salary, more training and development opportunities, more flexible working conditions and changes to workload. The most common response was better salary (71 per cent) followed by more training and professional development (67 per cent)⁷.

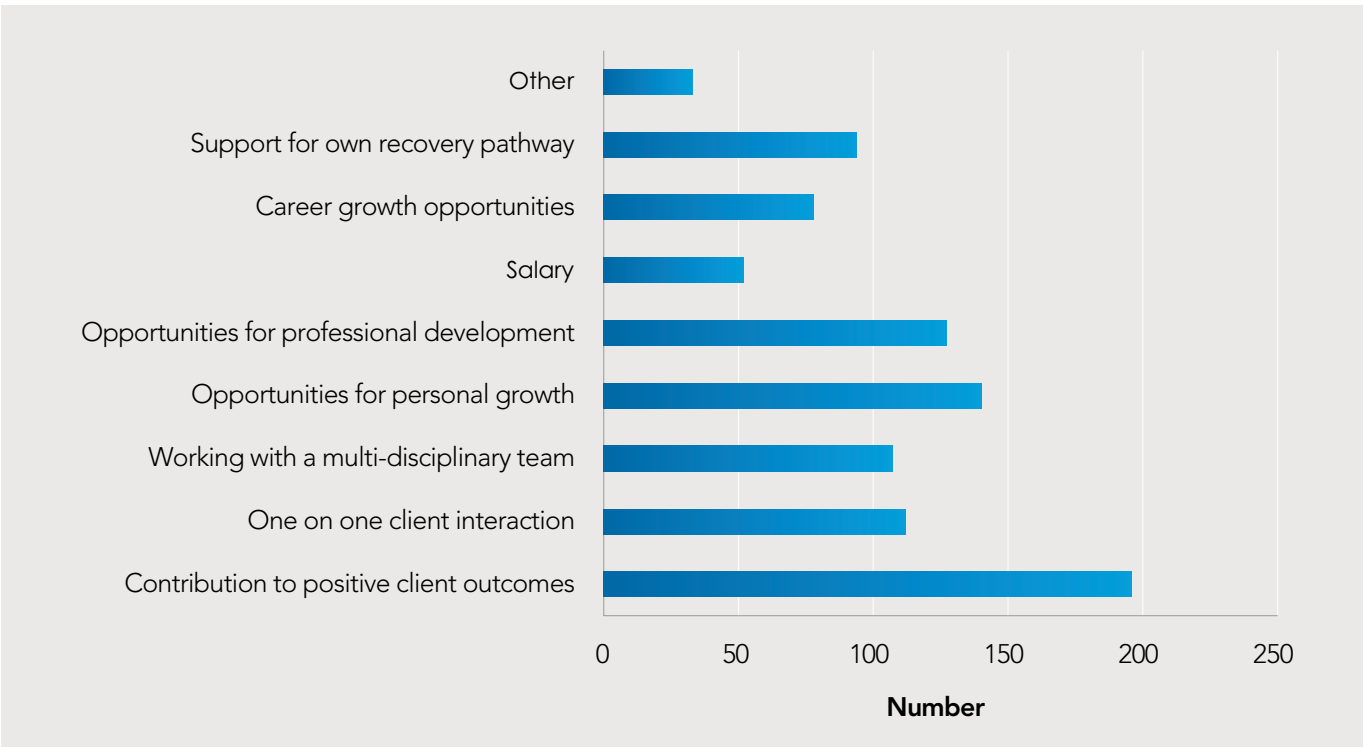
7 76 respondents did not respond regarding what they thought would attract more people to the role

Figure 11 – Respondents attraction to mental health peer worker role



Note: 72 respondents did not state their attraction to the role

Figure 12 – Respondents reasons for staying in the mental health peer worker role



Note: 74 respondents did not state what kept them in the role

Barriers and challenges

There are a number of barriers and challenges, which come with the mental health peer worker role. Respondents were asked to describe the challenges and barriers they face. The following information summarises the themes that were recurrent in the information collected.

Respondents were asked whether they encountered difficulties in their role. Options were provided including colleagues' lack of understanding of the peer worker role; low perceived value of the peer worker role in their organization; and drawing on lived experience to understand and support their clients. The most common response was pressure of working in the mental health profession (27 per cent). A number of other options were listed including lack of resources and infrastructure, working out the boundaries of the role and dealing with the stigma of mental illness in the workplace⁸.

Respondents were asked to further describe barriers and challenges that they face in their roles, the responses have been grouped into themes.

Training

Respondents described the lack of training opportunities available. In particular, respondents discussed their desire to undertake the Certificate IV in Mental Health Peer Work, however, limited funding within the organisations they are working in did not allow for this.

"It is hard to receive training that you wish to have." Peer Support Worker, WA.

Cultural changes

There was also a strong response regarding cultural challenges within the organisations the respondents were working within. Respondents described their challenges with staff at all levels and the need for acceptance of peer workers as an important role in a multidisciplinary team.

"Dealing with a system that is unsympathetic and is not supportive of the role of peer workers." Consumer Advocate, QLD.

"Attitudes that undervalue the contribution consumers can play in the reform process in particular around the need for cultural change at all levels." Consumer Advocate, VIC.

Leadership

Respondents discussed the need for leaders in the peer workforce to enable the peer worker role to be seen as an important component of the mental health workforce.

"We need more high profile leaders to engage the existing mental health workforce and advocate for inclusion." Peer Support Worker, ACT.

Support

The need for additional support from respondents' organisations was highlighted in a number of forms throughout the barriers and challenges section. Respondents discussed the need for more support in areas such as supervision, personal, team and workload support.

⁸ 59 respondents did not respond to whether they encountered difficulties in their role

Personal support was a strong theme as respondents discussed the challenge of managing their own mental health condition whilst providing services to consumers.

"Managing my own mental health in order to better cope with my workload." Peer Support Worker, QLD.

"Maintaining my mental health wellbeing when working many hours and having a family to support."
Peer Support Worker, SA.

"Maintaining own health, continuing hours when feeling slightly unwell, lack of peer workers in organisation to communicate with, lack of supervision." Peer Support Worker, VIC.

"As I am the only peer worker in my organisation, I feel disadvantaged that I don't have 'peers' to work on ideas or projects with. I believe I could accomplish more with another peer." Peer Support Worker, QLD.

Limited career pathway

Many respondents spoke of the barriers in progressing in their career as a peer worker. Respondents discussed the limited options to progress along a career pathway in the peer workforce.

"Barriers are around a lack of career progression, I love peer work but have not advanced my career since starting peer work 6 years ago." Peer Specialist, SA.

Team acceptance

Respondents discussed the challenge of being accepted by team members within their organisations. Many staff members are still unaware of the role of peer workers and do not understand their place in service delivery.

"Constant need to explain to others who you are and for people to understand the value and benefit of peer work."
Peer Support Worker, QLD.

Rural and remote challenges

A number of respondents discussed barriers and challenges in the relation to the location in which they work. Respondents said a challenge of working in rural and remote locations is isolation, and the lack of networking opportunities with other peer workers for support.

"Working in a remote town as part of a small team, I am a lone part-time worker with no other peer workers to share and work with." Consumer Consultant, QLD.

Funding

There was a strong theme of funding being a barrier to peer work by respondents. Issues highlighted include funding being available for part time positions when workloads require more than this as well as challenges around remuneration levels.

Workload

Many respondents felt that there was a demand for peer workers to meet a certain workload which they found difficult to meet. The issue of workload also ties in with lack of support and funding.

"Workload – the demand for services far exceeds my ability to provide them." Family/Carer Advocate, NSW.

Consumer and carer comparisons

Table 4 – Consumer, carer and consumer and carer data breakdown

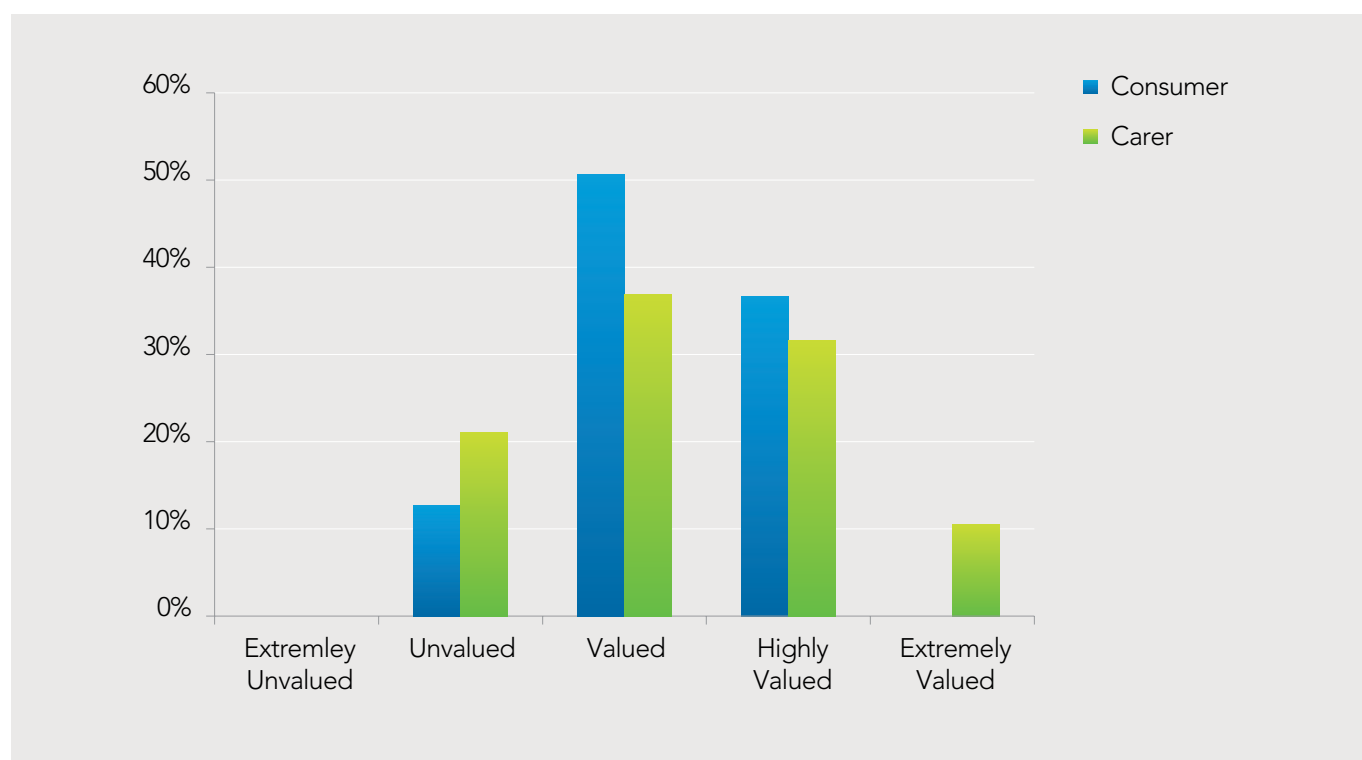
Criteria	Consumer Responses	Consumer (%)	Carer Responses	Carer (%)	Consumer and Carer Responses	Consumer and Carer (%)
Gender						
Male	35	32	1	5	21	18
Female	73	66	20	95	93	82
State						
ACT	0	0	0	0	4	4
NSW	28	25	7	33	22	19
NT	0	0	0	0	1	1
QLD	21	19	3	14	12	11
SA	10	9	3	14	10	9
TAS	5	5	0	0	9	8
VIC	33	30	4	19	33	29
WA	10	9	4	19	23	20
Service type						
NGO	62	56	10	48	55	48
Public hospital	22	20	6	29	14	12
Private mental health service or program	2	2	0	0	3	3
State or territory funded mental health service or program	7	6	3	14	11	10
Commonwealth funded mental health service or program	12	11	1	5	16	14
Aboriginal Community Controlled health organisation	0	0	0	0	1	1
Other	5	5	1	5	10	9
Employment type						
Full time	29	26	13	62	35	31
Part time	61	55	6	29	55	48
Casual	20	18	2	10	22	19
Qualifications						
Certificate in Mental Health	6	5	2	10	7	6
Certificate in Peer Work	0	0	0	0	2	2
Other	77	70	13	62	68	60
Total respondents	110		21		114	

Note: 60 respondents did not answer or did not relate to either consumer, carer or both. Not all questions from the survey have been reflected in this table.

Value of expertise and knowledge

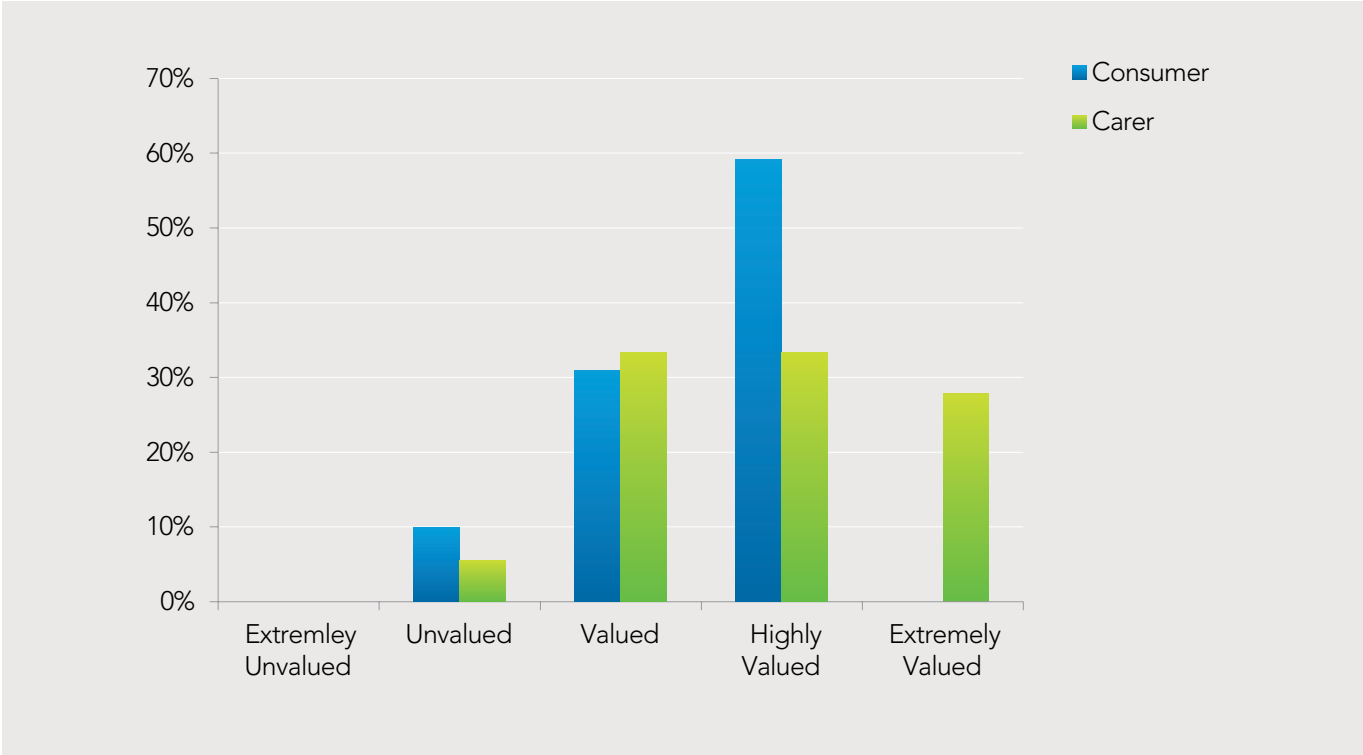
Respondents were asked to rate different groups of people in terms of how they think their expertise and knowledge is valued. This information has been broken down further into the categories of consumer and carer respondents to analyse the difference between these two groups. Overall, responses indicate that both consumer peer workers and carer peer workers feel valued, in particular by the people with whom they worked. Some respondents indicated that they felt their expertise and knowledge was not valued; and this was more common in regard to the organisation, than it was in regard to managers, consumers or families.

Figure 13 - Level respondents believe their expertise and knowledge is valued by the organisation



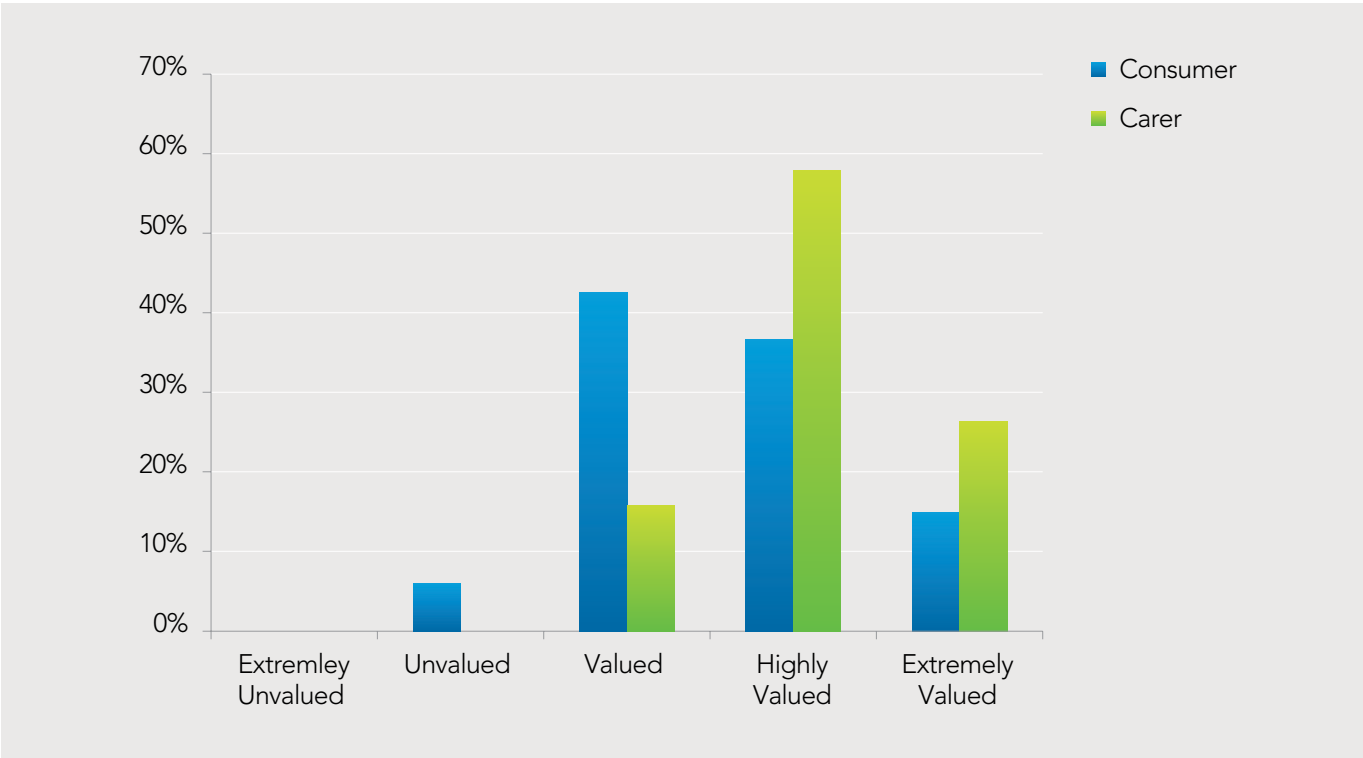
Those respondents that identified themselves as consumers responded with 'valued' as their most common response to how they feel the organisation values their expertise and knowledge (51 per cent). Those respondents that identified as carers responded with 'valued' as their most common response (37 per cent).

Figure 14 - Level respondents believe their expertise and knowledge is valued by Managers



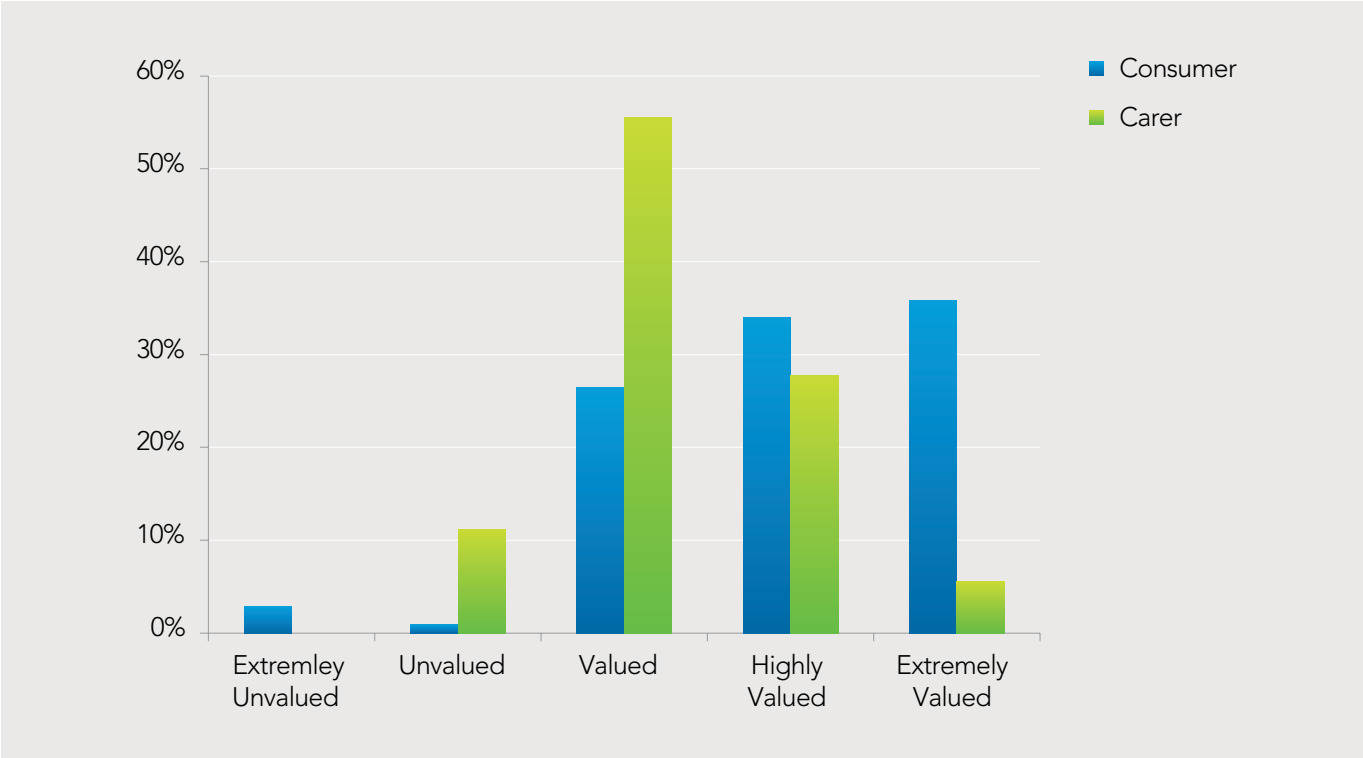
Respondents that identified with being a consumer selected ‘highly valued’ as the most common response (59 per cent) when asked to rate how they feel their manager values their expertise and knowledge. Respondents that identified themselves as carers selected ‘valued’ as the most common response (33 per cent).

Figure 15 - Level respondents believe their expertise and knowledge is valued by Families and Carers



Respondents that identified with being a consumer selected 'valued' as the most common response when asked what level families and carers value their expertise and knowledge (43 per cent). Those respondents that identified with being a carer selected 'highly valued' as the most common response with 58 per cent.

Figure 16 - Level respondents believe their expertise and knowledge is valued by Consumers



Respondents that identified with being a consumer selected 'extremely valued' as the most common response when asked what level consumers value their expertise and knowledge (36 per cent). Those respondents that identified with being a carer selected 'valued' as the most common response with 56 per cent.

Summary

Whilst it is unknown how representative the data collected in this survey is due to the workforce being unmeasured, the findings are consistent with the information produced in the literature scan and the case study site visits.

Table 5 - Survey questions and responses

The total number of survey respondents was 305.

Number	Question	Responses
1	Which category includes your age?	304
2	What is your gender?	300
3	What is your cultural background?	295
4	Which location do you mainly work in?	302
5	What type of mental health service do you work for? If more than one, select the service where you spend most of your time	298
6	Which of the options below do you identify with most: I have lived experience of mental illness, I have supported a family member or friend with a mental health issue, both of the above, none of the above	248
7	Which job title best describes your role? You can tick more than one	250
8	How many years have you worked in your current role?	245
9	Throughout your entire career, how many years have you spent as a mental health peer worker?	248
10	What was your job or main form of income before you became a mental health peer worker? Please provide detail even if it was not in the health sector	247
11	What is your current type of employment? Full time, part time, casual	207
12	What is the basis of your employment? Permanent, temporary	229
13	How many paid hours per week do you provide direct client support?	244
14	How often do you work as part of a mental health team with other health professionals? Never, every day, a few times a week, once a week, once a fortnight, once a month, other	245
15a	When you work as part of a mental health team, how many other staff do you usually work with?	234
15b	Which other mental health professionals are in your team?	239

Number	Question	Responses
16	What roles do you undertake: a) Face to face assessments: b) Respite support: c) Training and education: d) Advocacy: e) Vocational support: f) Referral to other services: g) Peer facilitated groups: h) Home visits: i) Telephone support: j) Health education advice: k) Public awareness services: l) Comorbidity programs: m) Committee representation: n) Conferences: o) Networking with other peer workers: p) Research:	239 233 237 236 233 236 239 236 234 236 237 232 240 237 238 239
17	Which areas or programs does your role focus on? Children, adolescents, young adults, adults, older people, families, Aboriginal and Torres Strait Islander people, forensic clients, recent arrivals and refugees, homeless people, other	247
18	Do you have a job and person specification or position description?	245
19	Do you have access to the following resources? a) Desk: b) Fixed phone: c) Mobile phone: d) Computer: e) Printer: f) Laptop or iPad (for use out of office if need be): g) Internet access: h) Personally designated office space: i) Interview/private room: j) All staff amenities: k) Tea/lunch room: l) Work vehicle: m) Employee Assistance Program or similar: n) Security swipe card/access card:	244 243 244 203 236 239 242 241 234 240 241 238 238 241
20	What type of supervision occurs in your regular work?	248
21	If you receive supervision who is your main supervisor?	239
22	If you receive supervision, how often do you have a face-to-face meeting with your supervisor?	240
23	What is the most rewarding thing about being a peer worker?	247
24	Do any of the following options cause difficulties in your role? Colleagues lack of understanding of the peer worker role, low perceived value of the peer worker role in my organisation, drawing on lived experience to understand and support my clients, pressure of working in the mental health profession, other	246

Number	Question	Responses
25	Overall, how satisfied are you with your position?	243
26	How satisfied are you with the contribution you are making to the organisation?	241
27	How satisfied are you that your colleagues and organisation understand the peer worker role and the expertise that peer workers provide?	241
28	How satisfied are you that your expertise are respected by the team you work with?	243
29	How satisfied are you with your integration into the team?	242
30	How satisfied are you that the service you provide is of value to the people you are working with?	240
31	How recognised do you feel from your? Manager: Team: Organisation: Consumers: Families and carers of consumers:	238 240 238 232 239
32	Does your workplace require any of the following qualifications? Certificate IV in Mental Health, Certificate IV in Mental Health Peer Support, other	148
33	Do you have any of the following qualifications? You can tick more than one. (If you have other qualifications in addition to those listed please provide them. Note – these qualifications do not have to be limited to health qualifications) Certificate IV in Mental Health, Certificate IV in Mental Health Peer Support, other	211
34	What skills, experience or attributes do you think should be essential for a mental health peer worker?	243
35a	Did you participate in an induction and orientation process when you started your role?	244
35b	How long did this training go for?	102
36a	Are you aware of any other training opportunities that you could undertake?	245
36b	How supportive is your employer in providing time and money for these training opportunities?	79
37	What drew you to your current role?	233
38	What keeps you in the role?	231
39	Have you ever considered moving into another discipline or profession? Please tell us why?	228
40	Do you feel that there is enough opportunity to progress in your career within your organisation, either in your current role or in another field such as research or project work? Please describe:	226
41	What do you think would attract more people to the mental health peer worker role?	229
42	What are some of the barriers or challenges that you face in your role as a mental health peer worker?	208



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