
Peer Work Strategic Framework



WAAMH

**Western Australian Association
for Mental Health**

Peak body representing the community-managed
mental health sector in Western Australia

Western Association for Mental Health
Lotteries House, 2 Delhi Street, West Perth WA 6005

ABN: 15 165 640 637

T: (618) 9420 7277 F: (618) 9420 7280 E: reception@waamh.org.au W: www.waamh.org.au

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for Mental Health

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Acknowledgements

The Peer Work Strategic Framework was funded by the Mental Health Commission WA. A project advisory group was established for the purposes of providing input, gathering best practice examples and guidance into this resource. The WA Association for Mental Health would like to thank and acknowledge the wisdom and expert guidance which we received during the development of this framework.

Members of the Advisory Group

Name	Agency
Nadia Adams	WA Country Health Services
Rhianwen Beresford	Consumers of Mental Health WA
Angela Corry	WA Network of Alcohol and Drug Agencies
Muireanne Daly	ARAFMI
Coralie Flatters	WA Association for Mental Health
Tammy Ford	Mental Health Commission
Louise Howe	Mental Health Commission
Suzanne Helfgott	Drug and Alcohol Office
Louise Grant	WA Substance Users Association
Sharon Karas	Mental Illness Fellowship of WA
Vivien Kemp	University of Western Australia
Leanne Mirabella	Palmerston Association
Seamus Murphy	Consumer
Wendy Rose	Ethnic Disability Advocacy Centre
Melissa Sagers	Polytechnic West
Frankie Valvasori	WA Substance Users Association
Suzanne Velarde	WA Association for Mental Health

WAAMH would also like to thank all of those who attended the consultations and a special thankyou to WA Substance Users Association, Womens Healthworks - Body Esteem Program (BEP), Cyrenian House, Palmerston Association and the Freedom Centre who contributed to the best practice case examples of Peer Work occurring in the Western Australian Community Services Sector.

LIST OF ABBREVIATIONS

AOD - Alcohol and Other Drug

ASIST - Applied Suicide Intervention Skills Training

BEP - Body Esteem Program

CaLD - Culturally and Linguistically Diverse

CEPS - The Centre of Excellence in Peer Support

CoMHWa - Consumers of Mental Health WA

DAO - Drug and Alcohol Office

EDAC - Ethnic Disability Advocacy Centre

HR - Human Resources

LGBTIQ - Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or questioning

MHC - Mental Health Commission

MIFWA - Mental Illness Fellowship of WA

NCETA - National Centre for Education and Training on Addiction

OH&S - Occupational Health and Safety

PHaMs - Personal Helpers and Mentors Program

SMART Recovery - Self-Management and Recovery Training

TC - Therapeutic Community

WAAMH - Western Australian Association for Mental Health

WANADA - WA Network of Alcohol and Other Drug Agencies

WASUA - WA Substance Users Association

Peer Work Strategic Framework

EXECUTIVE SUMMARY

Peer work has been provided by community organisations, consumer, family and carer led-groups for decades. In recent times, peer work has been recognised as an integral part of quality service delivery, with the result that many organisations are formalising and integrating peer work into service delivery through designated peer worker roles.

Peer workers are now an emerging and evolving workforce and there is growing interest in the value of the peer workforce in sectors such as mental health and Alcohol and Other Drug (AOD) services.

As with any service innovation, introducing peer workers is a complex undertaking requiring managers, peer workers and non-peer staff to challenge long held beliefs and practices. There is an extensive body of research and practice-based evidence for developing and supporting peer work. The evidence provides a clear and consistent set of directions for creating an effective and sustainable peer workforce.

The work that was undertaken by the Western Australian Association of Mental Health (WAAMH) draws on this evidence and experience to develop a 'Peer Work Strategic Framework' to encourage the further and continued embedding of peer work into the community mental health and alcohol and other drug sectors. The Framework was to focus on four areas; defining peer work, peer worker support and development, system support for peer workers and developing the peer worker. It also includes online references for information, toolkits and other resources to support organisations to successfully introduce peer work roles into their programs and organisational structures.

The development of the Peer Work Strategic Framework was supported by an Advisory Group which included consumer representatives and agency representatives from WA Country Health Services, Consumers of Mental Health WA (CoMHWA), WA Association of Mental Health (WAAMH), WA Network of Alcohol and Other Drug Agencies (WANADA), ARAFMI, Ethnic Disability Advocacy Centre (EDAC), WA Substance Users Association (WASUA), Mental Health Commission (MHC), Drug and Alcohol Office (DAO), Mental Illness Fellowship of WA (MIFWA), Palmerston Association, University of WA School of Psychiatry and Clinical Neurosciences and Polytechnic West.

The Project used an asset-based approach to draw on and learn from the experience and knowledge of the various stakeholders involved in the Project and utilise the strengths and resources that were already available.

There are many perspectives on what a peer worker is. For this Framework, peer workers are people who identify as having lived experience of mental ill-health and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated roles within the public or non-government sector. They use their common experience to support and inspire hope and recovery in others (Gallagher and Halpin 2014). The following definition is used as a guide:

Peer workers are defined (whether paid or unpaid) as those who are engaged to utilise their lived experience to inform their work. A prerequisite of peer work is recognition by the target group as a peer.

The Project involved:

- Two separate surveys of WAAMH and WANADA members and organisations;
- Two cross sector forums, one held in November 2013 at the start of the project and attended by 32 participants to define the scope of the Framework and a second forum in July 2014 attended by 54 participants to review and provide feedback on a draft Framework;
- A series of case examples of organisations involved in peer work;
- Consultation with a sample of organisations and individuals involved in peer work in Western Australia; and
- Review of peer work literature, documents, resources and resource material.

The Framework presents the peer workforce as a critical and integral foundation of service delivery in mental health and alcohol and other drug services.

The purpose of the Framework is to support a consistent approach to developing and supporting peer work in Western Australia, whilst encouraging flexible responses to specific agency needs and circumstances. The Framework focuses on work roles whereby an explicit component of the workers role is to use their lived experience as a tool for supporting those they are working with. The Framework also provides guidelines to support consistent development of the peer workforce.

The Framework is in four parts:

- Part A provides the background, context and evidence base for peer work.
- Part B provides guidance to inform and support organisations that want to introduce peer workers (however described) into their service arrangements. To illustrate the diversity and extent of peer work approaches in WA.
- Part C provides examples of peer work undertaken by a sample of Western Australian non-government organisations.
- Part D lists resource material and references to support organisations that employ peer workers, or that are planning the implementation of peer worker roles.

PART A: CONTEXTUAL AND BACKGROUND ISSUES

1 Background and Concept of Peer Work

Peer workers are an emerging and evolving workforce in the community services sector. There is growing interest in the value of the peer workforce in a variety of sectors, including mental health and AOD services. Organisations are working to create a stronger peer workforce, including more peer worker roles, in recognition of the value of peer work initiatives.

Peer work has its origins in ideas of self-help and mutual support. People with lived experience of a physical illness, a mental health issue, or traumatic circumstances, who have faced adversity, are able to provide support, guidance, advice, wisdom, mentorship, expertise and hope to people facing a similar situation (Davidson 2012 cited in Health Workforce Australia 2014a).

Peer work has been provided by community organisations, consumers, and family and carer led-groups for decades in a number of fields, an example is HIV/AIDS and sexual health promotion, where peer education has a high profile and is demonstrated to be a successful strategy.

In recent times, peer work has been recognised as an integral part of quality service delivery. In many organisations peer work is integrated into service delivery through designated peer worker roles, although job related tasks vary considerably (Bell, Panther & Pollock 2014; Health Workforce Australia 2014; Palmerston 2013a and 2013b).

This Peer Work Strategic Framework recognises that there is no single model of peer work that can be applied to all service providers.

2 The Context for Peer Work

There is increasing acceptance and endorsement of peer work at the broader policy, program and service context. Support for peer work across a number of sectors is embodied in government policy and plans, workforce development strategies, consumer participation strategies and agency service delivery plans and programs. Peer work is consistent with contemporary human rights and social policy initiatives.

3 Government policy and plans

In mental health, peer work is a priority in national policy statements, plans and strategies such as the *National Mental Health Strategy*, *Fourth National Mental Health Plan 2009-2014*, *Roadmap for National Mental Health Reform 2012-2022*, *National Framework for Recovery Oriented Mental Health Services*, the *National Alcohol and other Drug Workforce Development Strategy* and the *2013 National Report Card on Mental Health and Suicide Prevention* (in particular recommendation 13). The *Fourth National Mental Health Plan 2009-2014* recommends the implementation of peer work and emphasises workforce development to increase the peer workforce in clinical and community settings.

At the state level, peer work approaches are endorsed in a range of policies and plans including the *Mental Health and Alcohol and Other Drug Services Plan 2015-2025*, The *Mental Health Bill 2013* (which includes a Charter of Mental Health Care Principles) and the

Mental Health Advisory Council's work. The WA Mental Health Commission's *Mental Health 2020: Making it Personal and Everybody's Business* calls for peer support and mentoring to become an accepted and valued part of mental health services.

The forthcoming *Mental Health and Alcohol and Other Drug Services Plan 2015-2025* is a major driver of peer work. The Plan provides for workforce reforms across mental health and alcohol and drug services and will result in more consumers, carers and families involved in service delivery as employed peer workers and as providers of training to professionals.

Recognition of the value of shared lived experience as part of the recovery journey in mental health care through the *National Framework for Recovery Oriented Mental Health Services* has been important in establishing the value of peer work. *This Framework* emphasises that the employment of peer workers is a key component of transforming mental health services to a recovery orientation (Health Workforce Australia 2014a), and programs such as the Personal Helpers and Mentors Program (PHaMs) have created recognition and provided funding for peer workers.

The PHaMs program has been an important catalyst for the employment of peer workers in mental health services. As of 30 June 2013, the Personal Helpers and Mentors program (PHaMS) included 217 peer workers nationally.

Workforce development

Developing the peer workforce is a major priority of the mental health and alcohol and other drugs sectors. Peer workers offer additional 'lived' experience that complements and enriches the existing workforce within community service organisations.

The Mental Health Workforce project being conducted by Health Workforce Australia is making a major contribution to the development of the mental health peer workforce. The Project provides policy advice on training and regulatory changes required to establish a career pathway for peer workers in the mental health sector. This project is providing a better understanding of the mental health peer workforce and identifying ways to develop and expand the workforce.

The Peer Workforce Project has produced a number of reports that have been instrumental in the development of this Framework, including a *Literature Review on the Mental Health Peer Workforce* (Health Workforce Australia 2014a), the *Mental Health Peer Workforce Study* which provides recommendations to strengthen the mental health peer workforce (Health Workforce Australia 2014b) and the *Draft National Mental Health Peer Work Development Guidelines*, which support consistent national development of the peer mental health workforce (Health Workforce Australia 2014c).

The *National Alcohol and Other Drug Workforce Development Strategy 2015-2020* is being developed by the National Centre for Education and Training on Addiction (NCETA) at Flinders University. The strategy will address improving consumer participation in AOD service provision, policy, planning and research. (NCETA, 2013)

The development of peer work training qualifications, such as the nationally accredited *Certificate IV in Mental Health Peer Work*, which is currently being piloted in a number of sites, including in Western Australia through Polytechnic West, is a critical initiative. Community Mental Health Australia is currently developing learning and assessment resources to support the *Certificate IV in Mental Health Peer Work*. The resources will be available to Registered Training Organisations which provide training to peer workers.

In Western Australia, a traineeship pathway for the above peer work qualification has been established and is now available to new and current peer workers.

Involvement and participation of service recipients and consumers

Consumer groups have long advocated for greater involvement and participation by service recipients, carers, family members and the wider community in decisions about planning, policy development, priority setting, service delivery and quality. As a result, the participation of citizens and service recipients is a shared goal across all community service sectors, including mental health and alcohol and other drugs (Anglicare 2010: Clarke and Brindle 2010: Beresford 2014).

Peer work is one approach to achieve the goal of involving citizens and service recipients in policymaking, planning and the design and delivery of services.

Human rights and social policy initiatives

Peer work approaches are consistent with international and national human rights declarations and obligations to involve representatives of vulnerable groups in the planning and delivery of human services.

Peer work is consistent with concepts such as person-centred individualised funding, and co-production, which are central to initiatives such as the NDIS and other social policy reforms. These changes require organisations to shift to an approach where they offer greater choice and personalised support and services to individuals and families. The peer workforce can play a role in making these policies a reality.

4. Definitions and Roles

A dictionary definition of a peer states that a peer 'is a person who belongs to the same age group or social group'. This is a useful starting point when trying to define what peer work is. However, as noted in the AIVL Discussion Paper, having experience or characteristics in common with other people, such as gender, age or cultural background, does not mean there is an automatic peer connection (AIVL 2010). Being a peer is not simply a decision of an individual, the dual process of identifying and being accepted by others as part of a group with shared and common experience is at the heart of peer relationships and peer work.

The complexity and diversity of peer work, and the difficulty involved in achieving a shared definition and common language, requires sensitivity to different ideas, perspectives and approaches to peer work.

This makes the development of a single definition and a "one size-fits-all framework" problematic (AIVL 2010: Bell, Panther and Pollock 2014). Imposition of a one-size-fits all approach to peer work, or the use of definitions and frameworks drawn from one field and imposed on another field, even if unintentional, will be counterproductive (Gillard et al 2014).

In broad terms and for the purpose of this framework, peer workers are people who identify as having lived experience¹ of mental ill-health and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated roles within the public or non-government

¹ Lived experience is the knowledge and understanding that people get when they have lived through something (SA Health 2014). For the purpose of the Framework, lived experience means living with mental ill-health and/or alcohol and other drug issues. People with lived experience include family or friends who support someone with mental illness and/or alcohol and other drug issues.

sector who use their common experience to support and inspire hope and recovery in others (Gallagher and Halpin 2014).

Peer work requires that lived experience is an essential criterion of job descriptions, although job titles, responsibilities and related tasks will vary. Bell, Panther and Pollock (2014) identify a number of features of initiatives delivered by people with lived experience that deliver benefits and outcomes, including:

- Providing hope through positive self-disclosure;
- Role modelling skills and self-care for negotiating a daily life;
- Peer workers are often more effective in establishing rapport more quickly and building trusting relationships with service users when compared to other staff.

Peer workers provide some services that are similar to those provided by non-peer workers and clinicians. The essence of peer work is not what kind of service is provided, but who provides it and how (Bell, Panther and Pollock 2014: Gallagher and Halpin 2014: Repper 2013). Peer work services are provided by a person who identifies as having shared circumstances and experiences as the person accessing services.

While people with openly acknowledged lived experience are employed in non-peer related work roles², this Framework focuses on people with lived experience employed in designated peer worker roles.

5. Guiding Values

Peer work is explicitly a values driven approach (Bassett et.al 2010; Bell, Panther and Pollock 2014: Faulkner and Kalathil 2012: O'Hagan 2011).

Peer work is based on a set of underlying assumptions, principles and values. It avoids stigmatising consumers, carries no assumptions of deficit, challenges existing power relationships and supports and empowers consumers to have greater ownership of their care and treatment (Gallagher and Halpin 2014).

Organisations employing peer workers must ensure that peer workers are not compromised by a lack of fit between the values inherent to peer work and the stated and unstated values of the organisation (O'Hagan 2011: Bell, Panther and Pollock 2014).

For peer work to flourish and to be effective, organisations should review and if necessary revise their organisation wide vision, purpose and values to confirm that they adequately reflect the guiding values for peer work, a commitment to peer engagement and to peer workers as employees and volunteers.

The following peer work values broadly reflect those of the Scottish Recovery Network. They have been adapted based on consultations with peer workers, other expert individuals, and representatives of government and non-government organisations.

Mutuality:

Peer work involves the giving and receiving of help and support based on recognition of shared and common experience, with those involved sharing a responsibility to make it work.

² In some organisations in the mental health sector and the alcohol and other drugs sector up to 60% of people employed in the agency have lived experience.

Voluntary engagement:

Peer work should be voluntary. That is, both the person giving and the person receiving support should consent to work together.

Self-determination:

Peer work recognises and respects people's rights to have control over their lives, to make decisions and have their preferences and aspirations respected.

Hope:

Peer work is underpinned by the reality of recovery³ and the beliefs that:

- *Peer workers are powerful role models and evidence of the reality of recovery.*
- *All people are unique individuals with hopes, dreams, and aspirations with the potential to be all that they can be.*
- *The peer relationship offers a unique healing environment and powerful way of promoting hope and optimism.*
- *It is possible to learn and grow from challenges and setbacks.*

Responsibility:

Wellness and recovery involves taking responsibility, which means:

- *Peer workers support people to achieve changes by "being with" rather than "doing for".*
- *Peer workers have a responsibility to ensure that the values of peer support are nurtured and developed.*
- *Peer workers should take responsibility for their learning and development.*
- *Peer workers have a responsibility to challenge stigma and discrimination encountered in their role.*

Empowerment:

- *Empowerment happens through drawing on strengths and abilities both individually and collectively.*
- *Peer work builds people's capabilities and strengths, rather than providing services based on their problems and deficits, and assists people to access resources that enhance their recovery goals.*
- *Having power and control comes from identifying our own needs, making choices and taking responsibility for finding solutions.*
- *Peer workers provide perspectives and information to support empowerment that are not always available to or recognised by other service providers.*

³ Recovery is a term with different meanings in each sector. In the alcohol and other drug field, recovery is a contested term and carries many years of 'disease model' and abstinence connections. In this Framework the term is used in the broader, holistic sense described in the article on Recovery in the alcohol and other drugs and mental health field by Sue Helfgott & Celia Wilkinson (2012) and by the WA Mental Health Commission and WA Association of Mental Health Sector Strategic Framework for the Community Managed Mental Health Sector 2013. In sectors other than mental health, the term can be used to apply to another values based approach that sees a positive future for the client group.

6. The evidence base for Peer Work

A recent review of the evidence base by Health Workforce Australia (Health Workforce Australia 2014a and 2014b) notes that whilst evaluation of peer work has lagged behind implementation, the evidence suggests that peer work can be as effective as other service approaches and delivers significant benefit to consumers, peer workers, families, carers and services.

Benefits to consumers

There is growing evidence to demonstrate the benefit of peer work for consumers and families where peer workers are well trained, well supported and where supervision is available (Repper 2013). The evidence is discussed more fully in a number of recent Australian reports (Bell, Panther and Pollock 2014: Health Workforce Australia 2014a & 2014b: Gallagher and Halpin 2014: O'Hagan 2011: Pound, Judd and Gough 2011). Only a brief summary is presented here.

A recent meta-review of eleven studies found that peer workers were able to produce outcomes comparable with non-peer colleagues in delivering the same functions and activities (Pitt 2013). Peer initiatives have been found to enhance consumer outcomes on various measures and indicators, and studies consistently show that all stakeholders involved in peer work initiatives - consumers, peer workers, carers, family members and other staff - identifies them as positive initiatives (Bell, Panther and Pollock 2014).

In mental health, peer work approaches are effective in reducing hospital admission rates, assisting people on discharge and supporting them to make a successful transition to the community and assisting people at risk of re-admission (Health Workforce Australia 2014a and 2014b).

Peer workers are particularly well placed to deliver on elements such as hope, empowerment, self-management and social inclusion (Repper 2013: Repper and Carter 2011).

Peer approaches empower consumers, support them to define their needs and take greater responsibility, teach self-management skills, support them to experiment with different strategies and increase their sense of independence (Health Workforce Australia 2014a and 2014b: Mendes 2014). Peer initiatives have proved successful in moving people from 'patienthood' to 'personhood'.

Consumers involved with peer activities have higher levels of community interaction and demonstrate improved social networks and social support and enhanced social skills and social functioning (Bell, Panther and Pollock 2014: Health Workforce Australia 2014a & 2014 b).

Peer workers can break down stigma and challenge barriers created by self-stigmatisation. For consumers, involvement in peer work activities can alter attitudes to illness and break down stigma (Gallagher and Halpin 2014: Health Workforce Australia 2014a & 2014 b).

Other benefits of involvement in peer work initiatives include feelings of acceptance, solidarity, belonging, friendship, decreased isolation, hope, inspiration and motivation and an increased ability to overcome problems (Bell, Panther and Pollock 2014: Health Workforce Australia 2014a & 2014b: Gallagher and Halpin 2014: O'Hagan 2011: Pound, Judd and

Gough 2011).

Benefits to Peer Workers

There are particular benefits for peer workers themselves, all of which enhance wellbeing (Bell, Panther and Pollock 2014: Health Workforce Australia 2014a, 2014b: O'Hagan 2011). These include:

- Shared identity;
- Increased self-esteem and confidence;
- Greater self-awareness and fulfilment;
- Development and sharing of skills;
- Greater knowledge of mental health;
- Employment and volunteering opportunities;
- Increased income and improved financial situation;
- Heighted aspirations; and
- Assisting with recovery and staying well.

O'Hagan emphasises the benefits of the 'helpers' principle' which asserts that working for the wellbeing and recovery of one's peers facilitates recovery for both. (O'Hagan 2011).

Benefits to services and the service system

Peer work has positive outcomes for services and service systems including:

- The presence of peer workers in services can lead to more effective and better quality services (Gallagher and Halpin 2014).
- Peer workers are able to facilitate better understanding between people providing services and people using services. Peer workers also assist people to engage with services (Repper 2013).
- Peer workers are able to influence the knowledge and attitudes of other workers, including clinicians and build meaningful relationships between staff and consumers (Pound, Judd and Gough 2011).
- Peer workers are able to use their lived experience to influence organisational policies and procedures and challenge entrenched beliefs and attitudes that undermine effective service delivery (Repper 2013).
- Peer workers can be a '*social movement for change*' by providing visible recovery exemplars, supporting and inspiring personal hope and cultural change. There is some evidence that larger systems of care in society can change when service organisations become more positive in their attitudes to consumers and recovery as a result of peer initiatives (Pound, Judd and Gough 2011).

Benefits to families and carers

Peer work has positive impact for families and carers by reducing stigma, decreasing feelings of burden and improving family functioning (Mendes 2014).

A positive influence for wider social change

Peer work approaches have contributed to wider social change. Peer work approaches have been instrumental in Australia's successes in HIV/AIDS prevention over the last three decades. The mobilisation of action by affected communities and the use of peer initiatives that draw on the lived experience of gay men, sex workers and injecting drug users have been central to the effectiveness of Australia's efforts to contain the spread of the HIV and other blood borne viruses. Australia's approach recognised the need to involve people with lived experience in policy, program development, implementation, monitoring and evaluation (Kippax 2013).

7. Peer Work Settings and/or Context

Peer work defies easy categorisation, and views about the best models vary widely (Bell, Panther and Pollock 2014). Rather, there exists a spectrum of settings in which peer work occurs. In Western Australia peer work typically exists in the following contexts:

- Self-help support networks and groups run by volunteers;
- Peer led organisations with peer-run programs and services;
- Designated peer workers employed in organisations; and
- Peer education.

Services and programs provided by staff and volunteers who combine lived experience with other qualifications are often included as an example of peer work in some settings. However, for the purposes of this Framework this is not included. The reasons for this are as follows: the requirement for lived experience is not a criterion for performing the work, the disclosure of lived experience is not an explicit part of the work, and the client relationship is traditional with a clear power imbalance rather than the equal peer relationship. It is recognised that lived experience can inform practice to the benefit of the client; however the engagement of the worker is primarily based on their qualifications and/or professional competencies.

The table below gives examples of peer work in the settings described above, and gives examples of this work in practice at a local level. It is important to note that peer work in many organisations crossover into one or more of these contexts/settings.

Context	Examples	Description
Self-help support networks and groups	GROW, Alcoholics Anonymous	Self-help and support groups run by volunteers with lived experience
Peer led organisations and peer-run programs	WASUA, Freedom Centre (WA AIDS Council), CoMHWA, Parent Drug Information	Organisations and programs led by and run by staff and volunteers who identify as peers and/or who are

and services, including peer education	Service (ADIS Branch), Magenta	identified by others as peers.
Designated Peer workers (or similar titles)	Palmerston Association (peer support facilitators), PHaMS services, Women's Healthworks Body Esteem Program	Peer workers employed in designated peer work roles (paid and unpaid) in various NGO drug and alcohol organisations, and mental health organisations and public mental health services

8. Issues and Challenges

In exploring the literature and through consultation with service providers and peer workers, a consistent set of challenges which may compromise the effectiveness and sustainability of peer work became apparent. Failure to address these challenges can hinder the successful development of peer work and peer workers. These challenges include:

Adequate and secure funding for peer work and peer workers

Peer work and peer workers require a secure funding base. Development of the peer workforce requires dedicated and secure funding that is equitable with other services. (O'Hagan 2011). Secured and recurrent funding is needed to provide for the growth and interest in peer work, and to address the need for defined career pathways and adequate pay and conditions for peer workers.

Job description, role confusion and conflict

The roles and responsibilities of peer workers are often unclear (Kemp and Henderson 2012). Lack of clarity about the peer worker role is a barrier to effective peer work (Workforce Australia 2014).

The absence of a clear job description can affect the peer worker's role and their relationships with other staff. Peer workers, managers, clinicians and other staff need a shared understanding of the peer worker's role and responsibilities. Essentially, they require clarity about what the job involves and what it does not involve (Bell, Panther and Pollock 2014).

Boundary issues can arise where peer workers are uncertain about boundaries between being a consumer and a staff member, or of being a friend to fellow consumers or carers while at the same time being a service provider (Health Workforce Australia 2014).

Peer workers often report pressure in managing competing demands on their role, for example tensions between the agency's demands on their time and the administrative requirements of the role, and the expectation they will build and maintain mutually supportive relationships with consumers and carers (Kemp and Henderson 2012).

Recruitment

Recruiting first time peer workers with the necessary combination of lived experience and job relevant values, skills and competencies, can be a challenge for organisations (Bell, Panther and Pollock 2014).

While recruitment of peer workers should be consistent with best practice recruitment processes, as for any staff member, there are some strategies that can be useful in recruiting peer workers; particularly as some applicants may have been out of employment for some time. These include a wider range of advertisement options, clarity about the essential criteria and the importance of lived experience, flexibility in the presentation of an application, and restructuring the interview and selection process to suit both the requirements of the role and the individual circumstances of the applicant(s) (Bell, Panther and Pollock 2014: Health Workforce Australia 2014).

Preparing the organisation

Preparing the organisation and its staff to incorporate peer workers into an existing team or service is necessary for the successful introduction of peer work (Health Workforce Australia 2014: O'Hagan 2011).

The attitudes of existing staff are critical and some staff may lack understanding about the philosophy and practice of peer work, and the roles and responsibilities of peer workers (Health Workforce Australia 2014). There is evidence that some staff do not value the peer worker role, or view it as tokenism (Health Workforce Australia 2014). It must be emphasised that peer workers are considered as equal members of the team.

Training for peer work

The provision of adequate training and professional development for peer workers is essential. Organisations need to consider whether to employ peer workers who have been trained prior to recruitment, or whether to access and/or provide training after recruitment (Workforce Australia 2014).

Some options include using a training package designed for peer workers, employing specialist peer work trainers or supporting peer workers to complete accredited training such as the Certificate IV in Mental Health Peer Work (Bell, Panther and Pollock 2014, Health Workforce Australia 2014).

Bell, Panther and Pollock note that while there is a high degree of consistency in the content and style of peer work training, there is less consistency regarding the length and depth of training (Bell, Panther and Pollock 2014).

Training is also required for non-peer staff to increase their understanding, receptiveness and support for peer workers, particularly where peer workers join established services and teams.

Disclosure and confidentiality

Management of issues of disclosure and confidentiality can be challenges for peer workers and for organisations involved in implementing peer work.

Kemp and Henderson found that peer workers were often unsure about issues of personal disclosure, for example how much to disclose, and to whom, and when it is appropriate to disclose personal information. Peer workers were also concerned about disclosing personal information to work colleagues (Kemp and Henderson 2012).

Attitudes to peer workers

The attitudes of staff and managers towards peer work and peer workers has a significant impact on the effectiveness of peer work. Stigma and non-peer staff attitudes that question the capacity of people with lived experience to contribute effectively to service delivery are cited by peer workers as a barrier (Health Workforce Australia 2014).

All non-peer staff will benefit from awareness and education about the purpose and benefit of peer work roles (Health Workforce Australia 2014).

Stigma

Stigma directed at the peer workforce is an issue raised consistently in the research evidence (Health Workforce 2014: Kemp and Masters 2014). Kemp and Masters suggest that many of the difficulties faced by peer workers are the result of the stigmatising attitudes of the non-peer workforce. Training of the non-peer workforce with regard to the benefits of integrating peer workers is essential to address these barriers.

Supervision and line management

Access to adequate professional supervision is critical in ensuring effective peer work practice (Kemp and Henderson 2012). The evidence indicates that regular high quality professional supervision improves peer work practice and reduces burnout and role stress (Bell, Panther and Pollock 2014). Resources need to be allocated to professional supervision for peer workers.

A designated manager should be responsible for peer workers and this should be a peer work champion, who is supportive and knowledgeable about the peer work role (Health Workforce Australia 2014).

Kemp and Masters (2014) suggest that supervision of peer workers is an area where stigma can be manifested. They report that peer workers cite micro-management, tokenism and permissive supervisory styles as actions by supervisors that impede their ability to work effectively.

Job structure and career pathways

Remuneration for peer workers can be a problem, with evidence that peer workers might receive less pay and unequal benefits compared to other workers (Health Workforce Australia 2014).

Career progression for peer workers is critical and this includes progression into more senior peer work roles, as well as progression into non-peer roles (Bell, Panther and Pollock 2014).

Opportunities for networking and support

Peer workers can experience role isolation and often suffer from a lack of opportunities for networking and support and professional development and mentoring with other peer workers. The provision of structures and opportunities for peer workers to have regular contact and networking opportunities with other peer workers, and to have access to peer mentors is important (Health Workforce Australia 2014: Kemp and Henderson 2012).

Part B of the Framework provides more detail on how to operationally address these challenge.

PART B: OPERATIONAL FRAMEWORK

1 Introduction, Scope and Purpose of the Framework

This document is the second part (Part B) of a project commissioned by the Western Australian Association for Mental Health to inform the development of a Peer Work Strategic Framework for mental health and alcohol and other drugs services.

The scope of the Framework is paid and unpaid peer workers, employed as designated peer workers (with a range of job titles and descriptions) in mainstream services and/or peer led organisations in the mental health and/or alcohol and other drugs sectors.

The purpose of the Framework is to:

- (1) inform and support organisations that want to introduce peer workers (however described) into their service arrangements; and
- (2) provide guidelines to support a consistent approach to the development and support of the peer workforce, while encouraging flexible responses to specific sector and organisational needs and circumstances.

There are many perspectives on what a peer worker is. For this Framework, peer workers are people who identify as having lived experience of mental ill-health and/or alcohol and other drug issues who are employed (either paid or volunteer) in designated roles within the public or non-government sector. They use their common experience to support and inspire hope and recovery in others (Gallagher and Halpin 2014). The following definition is used as a guide:

Peer workers are defined (whether paid or unpaid) as those who are engaged to utilise their lived experience to inform their work. A prerequisite of peer work is recognition by the target group as a peer.

Organisations that already have a peer workforce, should find the Framework to be a useful reference point for reviewing:

- the organisational processes in place to support peer work;
- the role and its effectiveness;
- how well the role is embedded in the organisation's culture and structures, and
- the extent to which it is positively influencing consumer outcomes.

Peer workers provide some services that are similar to those provided by non-peer workers and clinicians. The essence of peer work is not what kind of service is provided, but who provides it and how (Bell, Panther and Pollock 2014; Gallagher and Halpin 2014; Repper 2013).

Lived experience of mental ill health and alcohol and other drug issues is an essential criterion of job descriptions, although job titles, responsibilities and related tasks will vary. While people with openly acknowledged lived experience are employed in non-peer related work roles, the Framework focuses on people with lived experience employed in designated peer worker roles.

It is not a purpose of the Framework to provide a detailed evidence base for the value of peer workers, although a summary is provided in Part A. A recent review of the evidence base by Health Workforce Australia (Health Workforce Australia 2014a and 2014b) notes that whilst evaluation of peer work has lagged behind implementation, the evidence suggests that peer work can be as effective as other service approaches and delivers significant benefit to consumers, peer workers, families, carers and services.

There is no “one size fits all” approach or uniform strategy for peer work. The service sector, the service type, the social context, the culture and organisational values will influence the detail of how peer work is designed and implemented by each organisation. However, it is possible to identify some key processes that if followed, should enable organisations to adapt the Framework to their own context, and to succeed in implementing and embedding the peer worker role as an integral part of their consumer support and service delivery.

Organisations operating in other sectors that want to implement similar roles into their practice, should also find the guidelines to be adaptable to their setting.

Useful contextual pre-reading for organisations planning to introduce Peer Workers should be the recently released Health Workforce Australia’s National Mental Health Peer Workforce Development Guidelines, available from their website:

http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Study_LR.pdf

2 Starting Assumptions and Understanding

In planning to introduce peer workers, the starting assumptions and understanding should be that:

- well trained and supported peer workers will add value to the experience of consumers and will positively influence consumer outcomes;
- many organisations have now successfully introduced peer workers into their workforce, and their practices, experience and resources can inform the planning and implementation processes for others;
- the introduction of peer workers will result in changes to workplace culture and relationships between clinicians, consumers and families;
- established service structures and power relationships will be unlikely to change without some discomfort, and staff will need information, guidance and reassurance during the change process;
- the organisational requirements to make it a success should not be under-estimated;
- identifying and engaging with staff with the necessary skills and interest from the earliest discussions will contribute to success, because they will advocate for the change and support and model positive behaviours to colleagues during the implementation;
- if it is good practice for peer workers, it will be good practice for all staff – the less that arrangements for peer workers are different to those for other staff, the less the risk of stigma; and

- the greater the extent to which the role is integrated and embedded into organisational systems and policies and practices, the better that peer workers will be able to execute their role and the better the outcomes will be for peer workers, consumers and families.

3 Planning for implementation

The success of the peer work role in contributing to the achievement of the outcomes the organisation seeks through the introduction of peer workers, requires a methodical, staged approach to their introduction.

The literature consistently identifies that key factors in the success of the role for consumers, families, peer workers and other staff and the organisation as a whole are:

- strong supportive organisational leadership (the Board and the senior management group)
- thorough pre-implementation planning;
- organisational culture preparedness;
- support for peer workers (through thorough induction, initial training, supervision and development)
- the integration of the role into organisational policies and practices.

How planning and implementation of peer workers into an organisation is managed will depend on a range of organisational specific factors including, but not limited to:

- size and location;
- whether it is a stand-alone service or part of an organisation providing multiple services to multiple target groups;
- demographic and other characteristics of the target population;
- the organisational programs in which peer workers will be employed ;
- professional and community partnerships;
- management structure; and
- governance arrangements.

Regardless of these factors, and of the planning strategies utilised, those responsible for planning the introduction of peer workers into an organisation should ensure that:

- they (planners/managers) have a good understanding of peer work and principles for organisational change management, and access training to address any gaps in knowledge and skills at the commencement of their role;
- they (planners/managers) create opportunities for their service users to engage in the planning process;
- their (planners/managers) time is used effectively and efficiently by accessing available research, documentation, tools and resources to inform and assist their planning process, and to avoid “reinventing the wheel”;

- they explore opportunities to learn from the work of peak organisations and from the practical experience of other organisations in their networks that have already successfully introduced peer workers into their service delivery arrangements

Smaller organisations could consider planning strategies such as:

- using its management team, or supervisory staff to manage the process;
- temporarily reallocating some existing responsibilities to free time for one senior staff member to act as a special project officer;
- joining with another small organisation that wants to introduce peer workers, to share their knowledge, learning and resources and to plan collaboratively;
- being mentored in their planning by a trusted larger organisation in their network, that already employs peer workers and is achieving positive outcomes for their service users;
- inviting people external to the organisation to bring their various perspectives, experience and expertise in peer work to key points in the planning process, or to act as advisors;
- on their own, or jointly with other organisations, seek funding for an external consultant with experience in the peer worker role, and in program design and implementation, to assist them.

Mid-sized to large organisations, have additional options for the management of the planning process. One of these could be to convene a planning group to provide informed advice and make recommendations to senior management on what will be required for successful implementation, and how those requirements could most effectively be addressed.

Ideally, such a group would be broadly reflective of the organisation's structure and stakeholders. For example, members could be drawn from:

- the service's consumers;
- peer worker representatives (which could be arranged in consultation with CoMHWA or WANADA);
- the organisation's senior management/leadership team;
- supervisors – if possible, those who will have supervision responsibility for peer worker staff; and
- colleagues - staff with whom the peer workers will have the most contact.

It is not the responsibility of a Planning Group to do all the work, but to identify what needs to be done and report this to the senior management group for endorsement of recommendations and making decisions about allocation of responsibilities and accountabilities.

When the senior management team (or in a small organisation, the CEO the Executive Director of a small organisation) has identified how the issues raised by the Planning Group will be addressed, the Group's attention should be refocussed on operational matters. At this stage, greater efficiency will be achieved if relevant managers (HR, Communications, Training and Development, OH&S etc), are invited to attend the group meeting when the

issue relevant to their expertise is to be discussed. Their specialist expertise will guide the discussion and operational recommendations to the senior management team or Executive Director.

Early training in peer work and if necessary, according to their experience and skills, also in the management of change, will ensure that Planning Group members start out with an informed and consistent understanding of what peer work is, the impact of change on organisational behaviours, and the major areas on which their organisation should focus to ensure effective implementation. The group's learning and development will continue as they review literature and consult with other organisations.

Through bringing together people from a range of experience and positions to advise senior management on organisational requirements, and to develop a plan to address those requirements, a committed group will emerge. What they learn about peer work in the planning stages will equip group members to become "champions" in promoting the benefits of peer work during the implementation period. They will be well placed to provide information, leadership, and where necessary, reassurance to the various stakeholder groups as the establishment of peer workers in the organisation proceeds.

In the context of the importance of leadership support being an identified factor for success in establishing peer work in an organisation, the group should report to the CEO or to the CEO's senior management nominee, with decision making (based on the Planning Group's recommendations) being a whole of senior management team responsibility.

The detail of the reporting arrangement will be different between organisations and according to the particular planning strategy that is to be used for planning, but the principle of senior management engagement with those responsible for planning and their endorsement of recommendations should be the same.

It should be the role of the CEO in all organisations, to ensure that the Board is regularly informed of progress, the issues being addressed and the organisational arrangements being made to facilitate the smooth introduction of the peer worker role.

4 Organisational preparation

Preparation of the organisation to embrace and integrate the peer worker role is a key success factor.

Active Leadership

An essential pre-requisite for success is that from the earliest stage, the senior management team⁴ is active in embracing the introduction of peer workers to the organisation. They must understand the peer worker role, and have a shared understanding of the role and their expectations of how the role will positively influence consumer outcomes.

As with any organisational change process, observing the senior management team's commitment as champions of the peer work role is important in securing the buy in of other staff.

Organisational culture

⁴ It is recognised that small organisations might not have a senior management team. In this event, staff recognised by their peers to be leaders (supervisors, team leader etc) should be engaged in ways consistent with that described for senior managers.

Every organisation is unique. Its culture is expressed through its values, beliefs, language, systems and policies and practices - rules that are both written and unwritten, and developed over time. A healthy culture is one that is dynamic and demonstrates a capacity to adapt to changing environments. Cultural change is generally achieved slowly over time, rather than by imposition over a shorter period. The greater the extent to which staff are prepared for, are kept involved and actively participate in the changes introduced preparatory to the introduction of peer workers, the more likely they are to embrace the role (and their new colleagues) over time.

Characteristics of an organisational culture, which is receptive to, and supportive of peer workers include that;

- It has a strong commitment to recovery based practice (or in sectors other than mental health, another values based approach that sees a positive future for the client group);
- the leadership team members are active advocates for the introduction of peer workers and model the organisation's values and expectations around the introduction of peer workers in their every day practices;
- there are shared and actively promoted values throughout the organisation about the importance of the role to enhancing consumer outcomes; and
- staff are engaged and encouraged to work in ways that are consistent with and give expression to the value that the organisation places on the role.

Understanding the culture and identifying the positive elements to be strengthened as well as those that need to change, is an essential requisite to peer workers being welcomed, valued, integrated and supported by existing staff.

Partnerships

Opportunities to learn from or work collaboratively with others should be explored.

There are many advantages to be had by establishing partnerships with other organisations to share learning in introducing the peer worker role. For example, an organisation that has already introduced the role and is succeeding with peer workers, might make a supervisor and peer worker available to speak at team meetings or professional development days, or have tools and resources that they are willing to share.

Smaller organisations might benefit from sharing the cost of introductory peer worker training for staff with another organisation in a similar position.

Environmental influences

Part A of this document identifies a range of challenges in implementing peer worker positions into organisations. An environmental scan to identify and understand the key issues, influences and challenges their organisation will need to take into account should be an early task for those with responsibility for planning the implementation. The scan should include the identification of organisations in their networks that have successfully implemented peer worker roles, and others that plan to do so.

Clarity around expectations of the role and job requirements

It is important to establish a description of the role and duties and the capabilities required for the new peer worker role, so that its impact on current roles, structures and work

practices can be assessed. With the role agreed, a reference point is established against which other implementation issues can be considered.

Build the knowledge and resource base

Partnering with others, as noted above, is one way to build a knowledge and resource base. The amount of quality information on peer work that can be accessed via the Internet has increased significantly over the past two years. On line research is another low cost high value strategy to gather evidence to support good organisational practice around peer work, and to access practical tools and support resources.

Minimise arrangements that are “different”

A challenge that is consistently identified by peer workers is that their organisation, usually with the best of intentions, creates separate arrangements for their role to that of other staff. Peer workers identify that when this occurs, they feel separated from their non-peer colleagues and sometimes, feel devalued and stigmatised by organisational arrangements that apply only to them.

An objective in organisational preparation should be to introduce only the minimum amount of change that is specifically about peer workers. Good work place practice in relation to peer workers is almost always good practice for all staff. It should be the exception that separate policies and practices are developed only for peer workers. Wherever possible, updating existing policies and procedures that are in place for all staff should be preferred. The more that peer work roles and expectations are incorporated into the policies and procedures that cover similar issues for other staff (what to do if a staff member becomes unwell at work, availability of flexible working hours, organisational response to unplanned/unreported absences, supervision arrangements, managing fluctuations in performance, code of conduct expectations, etc) the less likely it is that the peer workers will “stand out”. This will lower the risk of them being stigmatised through having different workplace rules, benefits, expectations etc, to that of their non-peer worker colleagues.

Organisations could consider externally facilitated “Introduction to Peer Work” by a recognised peer work trainer, with training for senior managers being the first conducted and then other staff. The literature consistently confirms that success in implementing peer work and integrating it into the organisation’s culture, values and structures requires the active support of existing staff with whom the peer worker role will intersect. Training for staff is a key strategy to achieving this.

Establish ways to monitor progress

In any new initiative it is good practice to be clear before it begins about how progress will be monitored and success measured. Organisations could identify a small number of easy to measure criteria that answer the question “What do we need to know to be sure that we are succeeding in our introduction of peer workers?”

5 Developing role expectations and position requirements

Most peer work roles and position requirements are customised to the requirements of a particular program, service setting, target group, etc. and sometimes to the requirements of a Service Agreement with a funding body. Organisations should expect to use the experience and documentation of others as a guide, not a template.

A range of Job Descriptions for peer work positions that align with the Framework's definition of peer work, and that are currently in place in organisations in WA in both the mental health and alcohol and other drug sectors, can be found in the Resources listed in Part D.

The internet is the source for a large number of job descriptions, role statements, and selection criteria for peer worker positions in different settings, which could also be useful reference points.

In their Peer Work Project commenced in 2009, Baptistcare SA and the Mental Illness Fellowship South Australia noted that Mind and Body (a peer-led Company in New Zealand) identified five qualities as necessary for peer workers to be effective. These are that peer workers should:

- 1) have integrated their experiences of mental illness into their lives so they see their experiences and do not feel ashamed;
- 2) be able to think critically and reflect on what they do and why they do it, and capable of making judgements based on reasons;
- 3) have values consistent with the peer support service for which they work;
- 4) have a good understanding of marginalisation issues, stigma and discrimination and;
- 5) be emotionally mature and objective.

With the role agreed, a reference point is established against which other planning and implementation issues can be considered. Smaller organisations without a dedicated human resources capacity could apply their existing practices for the development and review of other job descriptions.

6 Human resource management practices

Usually, best practice in human resource management for the recruitment, training and development of all staff provides a strong foundation for best practice for the introduction of peer workers into the organisation. What is good human resources practice in relation to other staff, will also be good practice in relation to peer workers.

Particularly in the area of human resource management, the introduction of policies and practices that are well intended but "different" to practices in relation to other staff, are likely to reinforce stigma and leave the peer worker feeling isolated from other staff. For example, if newly recruited peer workers are offered the opportunity to provide an Advance Directive to assist the organisation to support them in a health crisis, the same opportunity should be provided to all staff. Well-intended actions such as offering peer workers different arrangements for supervision, or more frequent breaks, will again identify them as being "different" and could unintentionally make their integration with their peers more difficult.

Similarly, actions to reduce any perceived risk in the employment of peer workers should be identified through processes which are applied to all new staff.

It follows from this that arrangements for the support of peer workers should be consistent with the support available to all staff. This includes staff whose circumstances mean that they might at times have special support needs in the workplace, whether it be living with a mental illness, caring for an aged family member, having a child with a disability, having a physical disability, etc. Support strategies should start with regular and consistent supervision by a supervisor who has been trained in the supervision of peer workers.

Other strategies to support peer workers include:

- enabling them to participate in external peer worker networks if they so choose; (in a similar way to that which other staff participate in their professional associations)
- ensuring ongoing opportunities for training and development;
- having peer worker representation on organisational committees and project teams;
- providing opportunities for career progression, both as a peer worker or, if they choose, into non peer work positions for which they meet criterion;
- organisational acknowledgement that peer workers are valued and appreciated; and
- encouraging participation in social events in which the organisation is involved.

It is important to ensure that all HR policies and procedures comply with current Equal Employment Opportunity and Anti-Discrimination laws. For organisations that are unclear of their obligations, the Fairwork Ombudsman provides education and assistance for employees and employers on preventing discrimination in the workplace. (Australian Government)

7 Monitoring and evaluating

As with all new initiatives, the implementation of peer workers should be carefully monitored at the organisational level. Indicators of success should be established in the planning phase and incorporated into strategic and operational plans or whatever documentation is in place to support service monitoring and evaluation. Keep the number of indicators at a minimum and focused on areas that are the most critical in demonstrating success. In deciding the indicators, refer back to the reasons the organisation has chosen to introduce peer workers into the organisation and the outcomes it wants to achieve. For example

- A stronger capacity to provide person-centred recovery-based support (or whatever other values-based approach is practiced) that results in positive outcomes for consumers.
- Peer workers will be respected role models who give hope and encouragement to consumers.
- Peer workers will add value to the work of other staff in achieving positive outcomes for consumers.

Against each of the outcomes the organisation is working towards, ask the question:

What information do we need to demonstrate that we are making progress towards achieving this outcome, and how will we collect it?

At an individual peer worker level, monitoring their performance should involve the same practices that apply to all staff. Typically, this would be through:

- regular documented supervision that notes personal work goals and success in achieving them; and
- regular performance appraisals linked to the requirements of their job description, which note strengths, achievements over the previous year and plans for the staff member's continuing training and development over the next year.

PART C: ORGANISATION EXAMPLES

To illustrate the diversity and extent of peer work approaches in WA, this section profiles a number of examples of peer work undertaken by Western Australian non-government organisations in the mental health and alcohol and other drug sectors. The sample was chosen to provide examples of different approaches to peer work. The support of the organisations in making this information available is a positive indicator of the extent to which both sectors are prepared to share information in the interests of further developing the peer worker role in WA.

Example 1 Freedom Centre

The Freedom Centre is a peer-run drop in centre for young people aged under 26, the majority of whom are young people who identify as LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or questioning). The Centre provides a youth owned space and offers the opportunity for involvement in activities, information provision, social interaction, support and assistance and referral

The Centre is auspiced by the WA AIDS Council and primarily funded by the Mental Health Commission.

The WA AIDS Council has a long history and an agency culture that supports and nourishes peer work and has employed people in peer roles for near on 30 years. In the late 1980's and 1990's, the AIDS Councils around Australia pioneered the use of peer education and peer outreach strategies to reduce the spread of HIV/AIDS among gay men and injecting drug users.

The Freedom Centre opens each Wednesday (5-8pm) and Friday (4-8pm) and every second Saturday (12-5pm). It also runs a number of monthly and bimonthly drop-in sessions for specific target groups, such as transgender young people.

The Centre employs a Co-ordinator, three part-time Peer Educators and twenty Peer Volunteers. People are peers by virtue of their identification as LGBTIQ and they are of the same age range as the participants.

Peer Educators must have been Peer Volunteers and most have some additional qualification, such as Cert IV, Youth Work or TAFE Community Work qualification.

Peer Volunteers are selected by application and interview process and receive 24 hours training. This includes AIDS Council orientation, 2 day Volunteer Training and Living Works' Safe Talk or Applied Suicide Intervention Skills Training (ASIST).

An essential feature of the Freedom Centre peer work model is the Participatory Evaluation debriefing held after each session (2-4 times per week), in which the Co-ordinator, Peer Educators and Peer Volunteers involved in each session participate in a 1-2 hour evaluation and debriefing session. The debriefing reviews the extent to which the objectives were achieved, discusses learnings and identifies strategies to improve practice in future sessions.

As well as the three times weekly Evaluation debriefings, the Coordinator, Peer Educators and Peer Volunteers have a monthly team meeting to review progress and

discuss or learn new skills or knowledge relevant to their roles and the centre's activities.

Example 2: Palmerston Association

Palmerston Association is a leading not-for-profit service that supports individuals and families in Western Australia who are facing issues with alcohol and drug use. Palmerston offers a range of services including counselling, family therapy, education and residential services. Palmerston was established as a research and rehabilitation service for illicit drug users in the early 1980's. From those early years, the organisation has grown significantly and is now one of the largest not for profit community services operating in the AOD sector.

Since its inception, the organisation has always valued the input of consumers and their families. For instance, Palmerston Association operates a Therapeutic Community (TC). This is a supportive residential environment where residents are encouraged to create positive changes in their lives and to develop new coping and life skills. The TC model facilitates personal growth within a community of concerned people working together to help themselves and one another. Residents in a Therapeutic Community play a significant role in the day to day operation of the community and in supporting each other.

Over the years, Palmerston Association has also hosted many community forums for family members, consumers and health professionals. These are events which aim to educate people about relevant AOD issues and give people with a lived experience an opportunity to share their stories.

In recent years, Palmerston has been focusing on developing post treatment programs that enable people with a lived experience (who are now living fulfilling lives) to use this experience to help others. One program that has been developed is a comorbidity peer support service that has trained peers to co-facilitate Self-Management and Recovery Training (SMART Recovery) groups alongside counselling staff. These groups welcome people with a co-occurring AOD and mental health issue and provide participants with practical support and solutions to address day-to-day issues. The groups focus on using a person's lived experience of living well to help others identify ways of achieving a healthy and fulfilling lifestyle.

Employing peers to work alongside counselling staff in these groups not only assists the clients of the service but also assists the peers in their ongoing recovery. The peers are employed on a casual basis and work in various sites, located from Perth to Mandurah. All peers have participated in a 60 hour intensive training program that covers mental health first aid, AOD issues, trauma informed care, vicarious trauma, how to use lived experience in practice, and Culturally and Linguistically Diverse (CaLD) and Aboriginal cultural awareness.

Recruitment of a pool of casual peer group facilitators involved three main activities:

1. Two recruitment information forums (one in Perth and another in Rockingham);
2. A group interview (to allow applicants to demonstrate their skills within a group setting); and

3. A face-to-face interview (to ascertain their motivation for applying for the position and their availability).

A new job description form was developed for the position and specified the importance of people living well in the community. This was an essential criterion as it is a person's experience of living well, and having strategies to maintain their wellness, that is most valuable in assisting clients with co-occurring AOD and mental health issues.

Palmerston Association has engaged in a continual learning process to inform its approach to engaging paid (and volunteer) peer workers within the organisation. This has been informed by extensive consultation processes, workshops, research and in-depth literature reviews. Palmerston Association is in its "pilot" phase of employing peer workers and as such recognises there are organisational practices that still need to be reviewed or developed. Policies and procedures need to be reviewed to be inclusive of peer workers, especially policies relating to supervision and code of conduct. Employing people with a lived experience of substance use (especially illegal substance use, who may also have a past criminal record) may have implications for organisational processes and policies such as police clearances and relapse/risk management.

Palmerston Association approaches all of these issues as an opportunity to learn new ways of working with a peer workforce. It is an exciting opportunity for this organisation and attributes its success to date to the support of all the staff involved in its advisory committees (from numerous mental health and AOD organisations) and the staff within the organisation who have a real commitment to working with peers.

Example 3: WA Substance Users Association (WASUA)

WASUA is a peer-led and peer-based non-government organisation that works directly with substance users. All of its work is informed by harm reduction and peer based approaches.

WASUA receives funding from Federal and State Governments to deliver harm reduction and health services to people who use drugs in metropolitan and regional WA, with a particular focus on illicit and injecting drug use.

As part of its philosophy of being a peer led organisation, current and former substance users are employed in many professional and volunteer roles within the organisation.

The organisation supports and maintains active peer involvement in the provision of all its services. Workers and volunteers with current and past-lived experience of substance abuse are the cornerstone of service delivery.

Workers with current and past lived experience of substance use are employed as paid staff and volunteers across all the organisation's programs- outreach, needle and syringe exchange, blood borne viruses and sexually transmitted infections, opioid replacement pharmacotherapy, Aboriginal, youth, peer Naloxone, administration and community engagement.

WASUA is the only peer based organisation in Australia to be accredited under the WA Network of Alcohol and Drug Agencies Standard on Culturally Secure Practice (Alcohol and Drug Sector) and has met all Good Practice Criteria.

Example 4: Cyrenian House

Cyrenian House is a non-government, non-profit organisation with more than 30 years' experience working with drug and alcohol issues. Cyrenian receives funding from Federal and State Governments to provide services throughout metropolitan and regional WA.

Services provided include non-residential treatment, residential treatment programs, women's and children's programs, Aboriginal programs and community drug service teams.

Since its inception, Cyrenian has employed people with lived experience of drug and alcohol problems, including former clients of the agency, in paid and unpaid roles.

Cyrenian draws on the lived experience of people in some of its programs, for example, family members/carers are involved in Family support programs and people with lived experience of drug use who are residents are involved as participants in the Rick Hamersley Therapeutic Centre Therapeutic community, a residential therapeutic community run by Cyrenian House.

Currently, in some its programs, up to 50% of staff are former drug and alcohol users.

Former clients and people with lived experience are not employed in roles designated as 'peer workers'. However, they may be employed in the agency if they have the qualifications, experience and capacity to meet the selection criteria and fulfil the responsibilities of the role and they have been drug free for at least 2 years

People are employed in clinical, direct service, administration and management roles across the agency. Lived experience as an alcohol and drug user is not an essential criteria, but is one criteria considered in staff and volunteer selection.

While lived experience is an important criteria for employment in a paid or volunteer role, the agency encourages and supports people to develop additional skills and knowledge through further training and/or completion of tertiary and other qualifications. This is to ensure that people are employed for their skills and capacity to carry out the responsibilities of the role, as well as their lived experience.

Example 5: Women's Healthworks

The Body Esteem Program (BEP) is a service provided by Women's Healthworks in Joondalup, (recently joined with Women's Health and Family Services, Northbridge), which offers support for women suffering from eating disorders, such as anorexia nervosa, bulimia nervosa, binge eating disorder and compulsive overeating. It forms part of a greater picture in Women's Healthworks' approach, (in conjunction with other key organisations) to increasing community capacity to effectively respond to the needs of those affected by eating disorders. The BEP was established in response to the lack of accessible and community-based services for women living with eating disorders in Perth, Western Australia.

The program supports and assists women to make informed decisions about their health and wellbeing and to make and sustain positive change through a recovery focused group based on the self-help model. The self-help model is different to a therapy group or a treatment group. Participants set their own goals, take responsibility for learning, and make changes at their own pace. There is a group for women who experience anorexia or bulimia and another for women who experience compulsive or binge eating. The BEP is for women aged 18 years and over. The group meets weekly for 20 weeks. All participants are required to access individual therapy in addition to the group, and must meet other requirements for inclusion in the BEP, because the program is not therapy based.

Participants in both groups are supported and guided in the process by facilitators, who are women with lived experience, and the other members of the group. The facilitator role in the BEP is unique in requiring that each facilitator has a personal experience of an eating disorder. The facilitators share their own stories, and offer support based upon their own experiences of recovery.

However, it is also a requirement that all facilitators participate in (or access) facilitation training as well as mental health first aid training, prior to delivering a program.

Facilitators are paid casual employees of Women's Healthworks, adding an important layer of professionalism and clear boundaries to the role that sets the BEP apart both from primary health care treatment programs and volunteer led peer facilitation programs. Facilitators must adhere to the guidelines of the program, attend frequent professional supervision and are encouraged to access individual personalised support throughout the time that they have face to face contact with participants. They are further supported through a comprehensive manual that sets out processes and guides all aspects of their role. The facilitator role must at all times be focussed on promoting recovery for participants.

Facilitators must be able to demonstrate that they have been progressing in their own recovery journey for a substantial period of time. It is a requirement that BEP facilitators are confident in overcoming any triggers they may face, and that they have confidence in their own resilience.

To facilitate in the BEP is to 'enable'. Co-facilitating the BEP requires each facilitator to:

- relate to and empathise with the participants in their struggle to overcome their disorder;
- be confident and strong enough to openly share their own experiences of an eating disorder with others;
- identify negative thought patterns and behaviours when exposed to a triggering situation and to access support and/or clinical supervision to manage these;
- be able to demonstrate a professional approach to their role and maintain professional boundaries;

- be able to motivate, enthuse, listen and respond to a diversity of participants, without favouritism or discrimination;
- enable and support their co-facilitator, in all aspects of the role; and
- be a competent and committed team member.

The BEP has been subject to rigorous external evaluation with outcomes that confirmed its success.

Example 6: The Personal Helpers and Mentors Program (PHaMS)

PHaMS is one of three programs that together comprise the Targeted Community Care (Mental Health) Program of the Australian Government's Department of Social Services. It is based on a recovery approach to assist people in the community whose lives are severely affected by mental illness to build personal resilience and to sustainably manage the impacts of their illness. The program has four aims:

- increase access to appropriate support services at the right time;
- increase personal capacity, confidence and self-reliance;
- increase ability to manage their daily activities; and
- increase community participation (both social and economic).

Principle 7 of the program requires that:

PHaMs workers have appropriate attitudes, backgrounds, experiences and qualifications to meet the needs of participants in their site and receive appropriate training, support and supervision. This includes engagement of paid peer support workers by PHaMs services.

Each PHaMs site must have at least one paid Peer Support Worker

The peer support worker is a specialist role within the PHaMs team, and is described in the Department of Social Security's Resource Kit for Personal Helpers and Mentors Activity.

PHaMS peer support workers are individuals with a lived experience of mental health issues. They engage with and encourage participants at a personal level, assisting or supporting them through their recovery journey using their own experience of mental illness and recovery. They do this in a way that no-one else can, because they have lived or shared a different, but similar experience, and learned how to get through it and regain better control of their life. Peer Support Workers can share their own recovery journey (the ups and the downs) to show program participants that recovery is possible. They can encourage participants to share their own stories and experiences, help them to reflect on their progress and provide them with hope and optimism for the future. They might also be able to provide practical ways to cope or manage difficulties based on their personal experiences.

The Peer Support Workers role has been designed to focus on:

- promoting a team culture where the views and preference of participants, family and carers for recovery are recognised, understood, valued and respected.

- educating the PHaMs team about the personal experience of living with a mental illness in addition to any clinical or text book knowledge of mental illness.
- representing the perspective of the participant to the PHaMs team to ensure workers understand how mental illness affects the participant, their family, their life and how they want PHaMs to help them on their recovery journey. The Peer Support Worker may provide support to participants where they are unable to clearly explain their thoughts or experiences to another team member.
- providing support to participants that comes from the perspective of someone who has already lived or experienced the recovery journey and can understand, support and encourage them.

The Peer Support Worker may also take an active role establishing and participating in participant support groups.

PART D: RESOURCE MATERIALS

The range of tool kits and other resource materials to support organisations that employ peer workers, or that are planning the implementation of peer worker roles, is growing rapidly and is readily accessible through on line searches. The Reference list for this project (which follows this section) includes only some of many that are a source for peer work tool kits and other resource materials.

It was not within the scope of the project to evaluate the large range of resources that are now available. The following should be regarded as an indicative, rather than a recommended list of organisations whose websites include tool kits and other practical resource materials related to the peer worker role and to the organisational requirements to support peer worker staff.

1 Defining Peer Work

Mind Australia

The Centre of Excellence in Peer Support (CEPS) which provides a centralised specialist clearinghouse and a comprehensive online resource directory for mental health peer support. Its website provides access to a wide range of research and resources for consumers, families/carers, mental health staff and service providers. A CEPS Project Officer is available to provide individualised information and support. CEPS can be accessed via the Mind Australia website above, or directly at <http://www.peersupportvic.org/>

Scottish Recovery Network

Experts by Experience: Values Framework aims to increase understanding of the peer worker role and ensure that it maintains the peer support ethos and can be found:

http://www.scottishrecovery.net/images/stories/downloads/srn_peer_values_framework_publication.pdf

Other Resources

Anex (2012) *Australian Drug Policy: harm reduction and 'new recovery'* (Discussion Paper and Draft for Consultation) Anex, Melbourne, Australia. <http://www.anex.org.au/wp-content/uploads/Australian-Drug-Policy-harm-reduction-and-new-recovery-April-2012.pdf>

Australian Injecting and Illicit Drug Users' Manual (2012) *New Recovery Harm Reduction and Drug Use Policy Statement*.

<http://aivl.org.au/wp-content/uploads/New%20Recovery,%20Harm%20Reduction%20%26%20Drug%20Use%20-%20AIVL%20Policy%20Position%20Paper.pdf>

Australian Injecting and Illicit Drug Users' Manual (date unknown) *'Just Doin what comes naturally': AIVL's views on Peer Education*.

<http://www.aivl.org.au/wp-content/uploads/resources/Just%20Doin%27%20What%20Comes%20Naturally%20-%20AIVL%27s%20View%20on%20Peer%20Education%20%28Presentation%20Notes%29.pdf>

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<http://canadianharmreduction.com/sites/default/files/Engaging%20PWLE%20-%20July%207%202009.pdf>

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<http://www.peersupportvic.org/what-is-peer-support>

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<http://www.together-uk.org/wp-content/uploads/2012/09/The-Freedom-to-be-The-Chance-to-dream-Full-Report1.pdf>

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O'Hagen M (2011) *Peer Support in Mental Health and Addictions: A Background Paper for Kites Trust*.

http://www.peerzone.info/sites/default/files/resource_materials/Peer%20Support%20Overview%20-%27Hagan.pdf

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http://www.peersupportvic.org/images/stories/PS_for_Women_Living_with_MH_Issues_-_Pound_et_al_2011.pdf

Repper J (2013) *Peer Support Workers: Theory and Practice*, IMROC Briefing 5, Centre for Mental Health and Mental Health Network.

http://www.centreformentalhealth.org.uk/pdfs/ImROC_peer_support_workers_theory_practice.pdf

2 Peer Work Support and Development;

Association of Participating Service Users and the Self Help Addiction Resource Centre- Straight from the Source: A Practical Guide to consumer participation in the Victorian alcohol and other drug sector

This report provides guidance and direction to alcohol and other drug services seeking to develop consumer and peer participation.

<http://sharc.org.au/wp-content/uploads/2014/02/NP69876-APSU.pdf>

<http://www.peersupportvic.org/resources-directory/resources-directory/establishing-an-effective-peer-workforce-a-literature-review>

Baptistcare SA, and Mental Illness Fellowship South Australia

Between 2005 and 2008 Baptistcare (SA) and the Mental Illness Fellowship of SA worked in partnership on a major Peer Work Project. The project was designed to support peer workers and the organisations that employ them.

It supported peer workers by developing and offering training, assistance in finding a suitable peer work position and workplace support. It supported organisations to develop their recruitment practice and to prepare their organisation for the commencement of the new peer worker staff.

One of the aims of the project was to develop practical resources for peer workers and organisations. Of particular interest to organisations considering the introduction of peer worker roles, will be the *Employer Tool Kit: Employing Peer Workers in Your Organisation*.

Unfortunately this project is no longer funded; however the resource developed is still accessible through the Centre for Excellence in Peer Support website:

http://www.peersupportvic.org/images/stories/MIFSA_PWP_toolkit_for_employers.pdf

Centre for Mental Health (UK)

The Implementing Recovery through Organisational Change (ImROC) programme aims to assist the NHS and its partners to become recovery focussed. ImROC have developed practical resources around the implementation of Peer Work:

Repper J (2013) *Peer Support Workers: A Practical Guide to Implementation*, IMROC Briefing 7 Centre for Mental Health and Mental Health Network. <http://www.imroc.org/wp-content/uploads/7-Peer-Support-Workers-a-practical-guide-to-implementation.pdf>

Mind Australia

Training modules which have been developed to support organisations or individuals in establishing and operating peer support services or groups. They are

Considerations when Setting Up a Peer Support Group.

Considerations When Setting Up a Peer Support Service.

Considerations When Operating a Peer Support Service.

The modules can be accessed from both the Mind Australia and CEPS websites.

<http://www.mindaustralia.org.au/resources/peer-work.html>

NSW Consumer Advisory Group (CAG)

The NSW Consumer Workers' Project, supported by NSW Health, includes a literature review, the development of a Framework for Consumer Workers, a report on best practice for delivery of consumer worker training, including professional development and a Code of Professional Standards for consumer workers ratified by the NSW Health Mental Health Program Council for implementation in NSW. The final framework (at the time of publication) is yet to be released however the work of the NSW CAG thus far is freely available from their website:

McDonald J (2010) *Consumer Workers Forum Project Discussion Paper: Roles Responsibilities Titles and Job Descriptions*. NSW Consumer Advisory Group (NSWCAG), Sydney. http://www.nswcag.org.au/files/our_work/discussion_paper_1a_-_final.pdf

The paper above is particularly helpful in looking at roles, responsibilities and job descriptions typically found within a peer workforce that can assist in defining and strengthening the peer worker role.

McDonald J (2010) *Literature Review on the Mental Health Consumer Workforce*. NSW Consumer Advocacy Group (NSWCAG), Sydney.

http://www.nswcag.org.au/files//our_work/cwf_literature_review_final.pdf

Oakley K (2011) *Final Consultation Paper Draft Framework for NSW Mental Health Consumer Workforce*. NSW Consumer Advocacy Group (NSWCAG), Sydney.

http://www.nswcag.org.au/files//our_work/projects/final_consultation_paper.pdf

Scottish Recovery Network

Experts by Experience: Guidelines to support the development of Peer Worker roles in the mental health sector and Values Framework for Peer Working Guidelines have been prepared to assist organisations and groups establish and ensure the effectiveness of peer workers in mental health services in Scotland. The Guidelines are in two parts. Part One Understanding Peer Support provides background to the peer worker role, articulates principles for peer work and identifies challenges and opportunities in developing peer work roles. Part 2: Implementing Peer Worker roles outlines a model for peer work and outlines the steps organisations should take to support the development of a comprehensive plan for the successful implementation of peer worker roles.

<http://www.scottishrecovery.net/View-document-details/328-Experts-by-Experience-Form-view.html>

The *Reviewing Peer Working: A New Way of Working in mental health, Experts by Experience* paper brings together a range of information and intelligence on peer working to improve understanding of the role and its benefits, and to encourage more organisations to develop paid peer worker roles as an integral part of their service provision and can be accessed at:

<http://www.scottishrecovery.net/View-document-details/385-Reviewing-Peer-Working-A-New-Way-of-Working-in-Mental-Health.html>

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http://www.dss.gov.au/sites/default/files/documents/04_2014/phams_resource_kit_april_2014.pdf

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Hinton T (2010) *Voices on Choices: working towards consumer-led alcohol and drug treatment*. Social Action and Research Centre, Anglicare Tasmania. http://www.anglicare-tas.org.au/docs/research/Voices_on_choices_-_working_towards_consumer-led_alcohol_and_drug_treatment.pdf

3 System Support for Peer Workers; and Health Workforce Australia

The Peer Workforce Project being conducted by Health Workforce Australia identifies ways to develop and expand the peer workforce and provides a set of recommendations to strengthen and develop the mental health peer workforce as an important component of quality, recovery-focused mental health services.

A set of reports has been produced including:

- a *Literature Review on the Mental Health Peer Workforce* (Health Workforce Australia 2014a -) - http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Literature%20scan_LR.pdf
- the *Mental Health Peer Workforce Study* which provides recommendations to strengthen the mental health peer workforce (Health Workforce Australia 2014b) - http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Study_LR.pdf
- the *Draft National Mental Health Peer Work Development Guidelines*, which support consistent national development of the peer mental health workforce (Health Workforce Australia 2014c). – Draft in development

The various reports will be a valuable resource document for organisations planning to

Mind Australia

Mind Australia supports peer work through a number of different initiatives, including:

A Charter of Peer Support which was developed to ensure that peer support services are available to consumers and carers when and where it was needed. The Charter has been written by people with lived experience of mental distress and recovery. It outlines the evidence base for peer work, and advocates for continued recognition and development of peer support services in mental health. www.swslhd.nsw.gov.au

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Australian Government. (n.d.). *Equal Employment Opportunity & Anti-Discrimination*. Retrieved October 13, 2014, from business.gov.au: <http://www.business.gov.au/business-topics/employing-people/Pages/equal-employment-opportunity-and-anti-discrimination.aspx>

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4 Developing the Peer Worker

Orygen Youth Health

In 2012, Orygen produced the *Training Family Peer Support Workers in an Early Intervention Mental Health Service: Facilitator's Training Guide*.

The manual describes training sessions developed within the Orygen Youth Health clinical program that have enabled family peer support workers to work alongside mental health clinicians, to support the needs of families new to psychiatric services. The final section also contains a session-based 'resource pack' for participants. Further information is available from Orygen and the Manual can be purchased through the Orygen website:

<http://oyh.org.au/online-store/training-family-peer-support-workers-early-intervention-mental-health-service>

and also the website of the Early Psychosis Prevention and Intervention Program (EPPIC)

<http://eppic.org.au/epnews/just-released-new-family-peer-support-training-manual>

Other Resources

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http://www.cshisc.com.au/media/101849/mh_peer_workforce_scoping_report_october_2010.pdf

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http://www.nrsdc.org.au/publications/doc_view/1289-lived-experience-project-prototype.html

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http://www.mentalhealthcommission.ca/English/system/files/private/document/Peer_Support_Guidelines.pdf

A checklist of what to consider in planning for the introduction of peer workers.

Following is a list of considerations that are typically helpful in the planning stage. They are suggested issues only. Not all are necessarily universally applicable. Organisations might identify others that reflect their service type and target group, organisational culture and service arrangements.

1. What strategy will be used to manage the planning process?
2. Do those responsible for implementation have a sound understanding of the peer worker role and of good practices in organisational change management?
3. Who can help us? Which organisations in shared networks who already have peer workers might be able to provide advice, what do peak organisation have to offer?
4. Are the organisation's current strategic and operational plans consistent with the priorities and changes that will come with the establishment and integration of the peer worker role?
5. Are organisational values consistent with and inclusive of the peer worker role and associated values?
6. How are we going to engage with our service users to understand their attitudes towards peer work and what services they would like?
7. Are we clear about what we're looking for – the qualities, skills and experience we want peer workers to bring to the organisation, the detail of the role expectations and duties?
8. How and when are we going to commence active engagement with staff about the introduction of peer workers? What communication strategies will be required?
9. How will the peer worker role complement and align with existing roles and how should this be addressed with staff in those roles?
10. What tools and resources are required? What can we learn from an internet search, about tools and resources that have proven effective and that we can access via the internet?
11. Are human resources and other relevant policies and procedures aligned with the planned role of the peer worker?
12. Are there other policies and procedures and structural arrangements that require revision for consistency and alignment with the peer worker role?
13. Are changes required to service design documentation, work force structures, (team arrangements, reporting lines, supervision arrangements) and how will those changes be managed?
14. How will recovery policies and practices (or what be embedded into practice in ways that will facilitate the peer worker's role and contribution?
15. What communication strategies will be used to inform and engage staff in being active participants in the introduction of peer workers?

16. Are there particular cultural sensitivities that need to be addressed in collaboration with specialist organisations working with people from the identified cultural groups?
17. Are arrangements in place for the peer workers' supervisors to be trained in peer worker supervision?
18. Are work practices are set up to support the supervision relationship?
19. What arrangements are required for the induction, early training, supervision and development of peer workers (and if this is to be different to that for other staff, is there clarity as to why - could the different arrangements benefit all new staff?)
20. Do any current practices for the induction of new staff require updating to be inclusive of peer workers?
21. What training arrangements are/will need to be in place for existing and new staff about the peer work role?
22. Is there a need for new or complementary refresher training for staff in related areas, for example, Principles of Recovery, Person Centred Practice?
23. What supports are in place/required for peer workers (and if they differ from what is in place for all staff, what is different and why?);
24. Are there other resources (internally and externally) that would contribute to the peer worker getting the support and development that they need, (for example, a local peer worker network) and how do we facilitate the linkage?
25. How and at what points will the success of the planning and implementation of the peer worker role be monitored and evaluated and what will be the criteria for measuring success?

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PART D: ATTACHMENTS

ATTACHMENT 1

Members of the Advisory Group

Name	Agency
Nadia Adams	WA Country Health Services
Rhianwen Beresford	Consumers of Mental Health WA
Angela Corry	WA Network of Alcohol and Drug Agencies
Muireanne Daly	ARAFMI
Coralie Flatters	WA Association for Mental Health
Tammy Ford	Mental Health Commission
Louise Howe	Mental Health Commission
Suzanne Helfgott	Drug and Alcohol Office
Louise Grant	WA Substance Users Association
Sharon Karas	Mental Illness Fellowship of WA
Vivien Kemp	The University of WA
Leanne Mirabella	Palmerston Association
Seamus Murphy	Consumer
Wendy Rose	Ethnic Disability Advocacy Centre
Melissa Saggors	Polytechnic West
Frankie Valvasori	WA Substance Users Association
Suzanne Velarde	WA Association for Mental Health

ATTACHMENT 2

List of Organisations and Stakeholders Consulted

Agency	Names
AIDS Council of WA	Danni Wright, Coordinator Freedom Centre
CoMHWA	Rhianwen Beresford, Project Officer
Cyrenian House	Carol Dawes, Chief Executive Officer
Drug and Alcohol Office	Suzanne Helfgott, Manager Workforce Development Stacey Child, Manager ADIS
Ethnic Disability Advocacy Centre	Nihal Iscal, A/g CEO, Jenny Au Yeong, Advocate
Mental Health Commission	Louise Howe, Consumer Advisor
Mental Illness Fellowship of WA	Joyce Vidot, Project Officer
Palmerston Association	Leanne Mirabella, Project Coordinator Palmerston Outcare and DAWN Capacity Building Project
Polytechnic West	Melissa Sagggers, Lecturer
2 Peers Consulting	Dr Sue Jackson Vivien Kemp
School of Psychiatry and Clinical Neurosciences University of WA	Vivien Kemp, Senior Research Officer Community Culture and Mental Health
WA Association of Mental Health	Suzanne Velarde, Consultant Sector Development Coralie Flatters, Manager Sector Development
WOMEN'S Healthworks (now part of Women's Health and Family Services (WHFS))	Mandy Stringer, Executive Director (now WHFS Joondalup Branch Manager)
WA Network of Alcohol and Drug Agencies	Angela Corry, Sector Development Manager Jill Rundle, CEO
WA Country Health Services	Nadia Adams, Senior Project Officer – Mental Health.
WA Substance Users Association	Louise Grant, CEO Frankie Valvasori, Drug Counsellor/Treatment Referral Officer

Stakeholder Interview Questions

The WA Association for Mental Health (WAAMH) has been funded by the WA Mental Health Commission to create a Peer Work Strategic Framework to assist organisations in the drug and alcohol and mental health sectors to embed peer work into their services. The Framework will focus on four areas; defining peer work, peer worker support and development, system support for peer workers and developing the peer worker.

The Framework is being developed by WAAMH and is guided by an Advisory Group comprising of representatives from across the sectors.

Consultants for the project were Barbara Gatter and Colin Penter.

A cross-sector consultation was held on November 7, 2013 in which representatives of both sectors came together to share their views and experience. This included establishing a common definition and models of peer work.

As a result of the consultation, and for the purpose of this Project, peer workers are defined (whether paid or unpaid) as those who are engaged to utilise their lived experience to inform their work.

The consultation also raised the following important point of note; a prerequisite of peer work is recognition by the target group as a peer.

The Scope of peer work

- Which organisations (does your organisation) employ peer workers in paid or unpaid roles?
- How many peer workers are there? What is the ratio of peer workers to other workers?
- Are the peer workers paid or unpaid? If paid what is the source of the funding?
- What is/are the models of peer work used? (Are there different and models of peer work in your sector/organisation?)

The Role itself

- Can you briefly describe the peer work role(s) within organisations and the nature of their work with clients (i.e. one-on-one, group etc.)? What are the main activities peer workers undertake?
- What distinctive or unique features does the peer worker role offer?
- How does the role fit in relation to other members of the team and the organisation as a whole? Do they receive support from clinically based services?

Management/agency issues

- Does the role(s) have a specific JDF? If yes, can you provide an example? If no, what have been the barriers to development of a JDF?
- What selection process and selection criteria are used? Do they differ from other positions?
- What award is the peer worker under? If not, how has the organisation decided on remuneration?
- Has the organisation built specific policies and procedures, including risk management, around the role? If so please describe?
- Who line manages the peer worker? What does line management of peer workers encompass? Is there a supervision process? By whom? Involving what?

Impact/Outcomes

- Does your organisation evaluate the impact of having peer workers on those receiving a service? If yes, please describe the measure and the impact? If no, what is the reason?
- What impact, if any, do you perceive the peer support worker/s have had on service users?

- What are the challenges/barrier/concerns, if any, of delivering a peer based program? (organisation, service users, professionals)? How are these managed
- What impact, if any, has the peer based program had on the work and the organisation as a whole?

Success factors/lessons learned

- What is it about the approach to peer work that makes the program successful? (What factors make it successful?)
- What lessons have been learned?
- Do you have any suggestions for other organisations about how their peer support worker role(s) or services could be improved?

The Framework

- How could a Peer Work Framework assist organisations- those with peer workers, those considering employing peer workers? What should the Framework contain and how should it be structured?
- Who would use the framework and how?

Case Studies/Examples

Any examples of good/innovative practice?

Are you aware of any resources, references, tools etc. that could be included in the framework or on a website?

ATTACHMENT 3: Survey about peer workers in mental health and alcohol and drug services

Mental Health Services

A brief survey was designed and incorporated into a survey monkey format and distributed to WAAMH members and Mental Health Commission funded organisations. Fifty (50) organisations responded. A summary of the findings is described:

- 93% of respondents were from mental health services.
- Of the organisations who responded nearly 50% had less than 20 FTEs. Of these, 23% have between 1-5 FTEs, 13% have 6-10 FTEs and 13% have 11-20 FTEs.
- At the other end, 23% of organisations who responded have over 100 FTEs.
- 54% of organisations who responded use peer workers.
- In total, the respondent organisations employed 59 paid peer workers. The number of these who are part time is not indicated. The most number of paid peer workers in an organisation is six.
- In total, the respondent organisations employ 51.1 unpaid peer workers. The number of these who are part time was not indicated. The most number of unpaid peer workers in an organisation is 10.
- 70% of organisations have a designated JDF for peer workers.
- 56% of organisations do not have a designated supervision process for peer workers.
- The most six common activities undertaken by peer workers are, conduct groups (82%), advocate on client's behalf (69%), assess clients (69%), educate staff (65%), assist clients with daily activities (60%) and work with clinical staff (60%).

Survey of Drug and Alcohol Services

The same survey, with some modifications, was incorporated into a larger 'whole of sector' survey undertaken by WANADA as part of a sector wide workforce study, undertaken in consultation with the Drug and Alcohol Office. After discussion with WANADA, the survey questions were modified for inclusion in the WANADA workforce study. Including the peer work survey questions in the AOD sector wide workforce survey was considered preferable to sending two separate surveys to organisations.

Of the eight (8) organisations that responded to specific questions about peer work, only one (1) organisation currently engages peer workers in a paid or unpaid capacity. The findings below are based on the response of that one agency:

- Peer workers include both paid and volunteer workers and may be previous clients. The agency does not employ current clients.

- The organisation has a JDF and defined supervision process for peer workers. Peer status is a pre-requisite for the JDF.
- The main tasks undertaken by the peer workers include, advocate on the client's behalf, assist clients with daily activities, conduct groups, mentoring work with clinical staff and provide support with employment and housing.

Respondents were asked what they thought was the value of employing peer workers. Reasons cited include 'personal experience- some consumers prefer workers with personal and professional experience' and 'potential future workforce'.

Reasons given by organisations for not engaging peer workers are:

- 'Concerns re confidentiality in a small town';
- Don't know/not sure; and
- 'Most of the rehab clients presented mostly affected by serious AOD issues and underlying mental health which stabilises when clients have been detoxed and admitted to rehab (alcohol and drug free environment)'.

ATTACHMENT 4: Outline of Cross Sector Forum held on Thursday July 17 2014

SESSION GOALS

The overall purpose of the workshop was to encourage informed debate and dialogue within the alcohol and drug sector, the mental health sector and other sectors about opportunities and challenges involved in expanding peer work and employing more peer workers. The workshop brought together a select group of stakeholders from across the sectors to:

- Encourage dialogue between sectors about peer work.
- Increase knowledge about the diversity of peer work currently occurring across the alcohol and drug sector, mental health sector and other sectors in WA.
- Build connections and networks between people interested and involved in peer work in the across sectors in WA.
- Discuss the proposed Peer Work Framework and its potential use by organisations.
- Field test ideas and elements from the proposed Peer Framework.
- Gather feedback to inform the development of the proposed Peer Framework.

The schedule for the program is shown below:

8.30-9.00am SET UP ROOM AND TABLES

- Set up room and break out spaces
- Facilitator to prepare and ensure break out spaces are arranged.

9.00-9.05 WELCOME, INTRODUCTIONS AND BACKGROUND

- Welcome/ introductory comments Background and purpose of the Framework (Suzanne, Coralie).
- Purpose of the session (Colin and Barbara) - We plan to use the presentations to inform group discussion and feedback comments about the Framework Working Draft.

9.05-9.35 SESSION 1: SESSION 4: OVERVIEW OF THE FRAMEWORK AND ITS ELEMENTS

- minute presentation by Barbara and Colin on the purpose and elements of the proposed Framework
- minutes for questions from the floor
- Clarify that there will be group discussion between 12-1pm on the Framework and we are hoping that the presentations and discussions planned during the Forum will inform your discussion about the Framework in that later session.

9.35-10.30 SESSION 2: KEY ISSUES FOR THE PEER WORK STRATEGIC FRAMEWORK; PERSPECTIVES ON PEER WORK

- Introduced by Barbara
- 9.35-10.00 Presentation by Vivienne Kemp (University of WA) on Lessons from WA research on peer work and training peer workers in WA in drug and alcohol and mental health sectors
- 10.00-10.30 Discussion and questions from the Floor: What are the key issues that need to be incorporated into the Peer Work Framework?

10.30-10.45. Morning Tea Break

10.45- 12.00 SESSION 3: KEY ISSUES FOR THE FRAMEWORK: LESSONS FROM THE FIELD IN WA (Presentations by people involved in peer work in WA)

- Chaired/facilitated by Barbara and Colin

- 4 X 10 Minute presentations from those involved in implementing peer work. Presentations will focus on 1) their approach to peer work and 2) key lessons and what you have learned that might be useful for others involved in developing and implementing peer work. Presenters will be representatives from 3 organisations involved in peer work including Palmerston Association, WA Substance Users Association and Joondalup Women's Health Healthworks and a Peer support practitioner working in the mental health sector.
- 30 minutes for questions, comments and discussion on the implications for the Draft Peer Work Strategic Framework

12.00-12.55 pm SESSIONS 5: GROUP DISCUSSION

- In small groups
- Use your own experience and the information from the presentations to assess the Framework in terms of:
 - Identify the most important gaps in the Framework and how these could be addressed?
 - Identify anything that needs to change and how you would change it?

12.55-1.00pm CONCLUSION/WHERE TO NOW

ATTACHMENT 5: Participants in the Cross Sector Forum held on Thursday July 17 2014

Artie Dogra	Community Services, Health and Education Training Council
Barbara Gatter	Facilitator/Consultant
Brad Pulella	Mercycare
Colin Penter	Facilitator/Consultant
Coralie Flatters	WA Association of Mental Health
Debbie Sandvik	Community First
Delese Betti	Carers WA
Heather Jacobsen	Drug and Alcohol Office
Helen Farrell	NEAMI National
Jane Berggy	Intework
Jeff Shaw	Anglicare
Jennifer Hughes	ARAFMI
Julian Gimpel	Health Training Australia
Kaizie Todd	Share and Care
Katherine Chapman	Changing Lives Australia
Kerry Hawkins	Mental Health Commission
Kylie Fryer	Consumer
Leanne Mirabella	Palmerston Association
Louise Grant	WA Substance Users Association
Louise Howe	Mental Health Commission
Lyn Mahboub	
Mandy Stringer	Joondalup Women's Healthcare
Manjit Kaur	
Marais Anderson	WA Association of Mental Health
Margaret Lawlor	GROW
Maria Franklyn	ARAFMI
Megan Perry	Partners in Recovery
Mike Seward	ARAFMI
Moira Redmond	Advanced Personnel Management
Pam Gardner	Board Member WA Association of Mental Health
Paul Fogarty	Richmond Fellowship
Petra Elias	North Metropolitan Mental Health Service
Rhianwen Beresford	COMHWA
Sharon Kiras	MIFWA
Stephanie Ransome	Intework
Suzanne Helfgott	Drug and Alcohol Office
Suzanne Velarde	WA Association of Mental Health
Tracie Booth	Peel and Rockingham Mental Health Service
Vivien Kemp	University of Western Australia

ATTACHMENT 6

Summary of Issues raised at the Cross Sector Forum held on Thursday July 17th 2014

Issues raised following presentations

Some of the issues raised by participants in large group discussion following presentations and in written and verbal feedback:

- Is their capacity within the Framework to capture the diversity of practice that goes under the peer work banner rather than just designated peer workers?
- The issue of volunteer peers- is this part of the Framework?
- Does the Framework fit and accommodate, and provide guidance to other types of peer roles, for example voluntary peer roles or the use of peers to train up other professionals as happens in the AOD sector?
- The issue of carer/family peers- it appears that the Framework focuses primarily on consumer peers rather than carer/family peers.
- The importance of a clear JDF and supervision.
- The Framework should be designed to ensure that any agency, not just mental or AOD organisations, can pick up the framework, make sense of it and apply in their situation
- Concern that organisations can take advantage of peers. This has to be addressed in Framework
- Specialised peers are included in the Framework but some roles may not be????
- Format of Framework- please change font and spacing as it does not read well and cannot see new paragraphs easily.
- Language on Section 6 is very problem focused- use positive solution focused. Positive slant not so negative language

What about the issue of peer work in public mental health organisations? The challenges of implementing peer work in public mental services are not well represented. The framework is NGO focused.

Results of Group discussion in Final Session

In the final session participants worked in small groups on two questions. The results of each group's discussion are shown in the table below.

Summary of each groups response to questions

Group	Identify the most important gaps	Identify changes needed and how you would change it
1	<ul style="list-style-type: none"> • NGO centric- public mental health sector is not well represented throughout. 	

	<ul style="list-style-type: none"> Terminology Part B: remove term 'peer support' and use 'peer workers' to include people in roles other than the peer support role (i.e. Lived Experience Practitioner (LEP) which includes all those who are informed by their lived experience, including Consumer and Carer Consultants, Consumer and Carer Representatives. Under Section 5 A Guiding Set of Core Principles need a statement about PSW's exhibiting respect of consumer's rights and beliefs. Section 7 Models of PW- last dot point- don't know what 'mainstream organisation' means. Would prefer distinction between community managed and public mental health sectors because they are vastly divergent in terms of their medico-legal responsibilities and obligations, bureaucratic processes and challenges and the way PSW's are utilised. 	
2	<ul style="list-style-type: none"> Peer support workers need mentoring/supervision from someone within the Peer Support Worker sector/level. Support from like-minded network rather than organisational. More peer support workers for better connection. Clearcut boundaries. Clear job descriptions. Peer Support Worker Leader. 	<ul style="list-style-type: none"> Them and Us- What's the difference Hub of Information and resources Information Sharing
3	<ul style="list-style-type: none"> Notion of case studies problematic- good practice exemplars (sensitivity around consumer movement issues "I am not a case to be studied"). Greater articulation of what models mean We challenge the notion that clinician co-facilitation is still peer run- what is 'therapeutic', 'clinical' and how power oriented are they? Definition- inclusive of AOD/Family space; reword 'worker' to 'practitioner name elements of workforce not just practitioners (also academics, consultants etc); Need to find elements of connectedness that define the 'peerness'; greater articulation of breadth and depth of peer specialist expertise. 	<ul style="list-style-type: none"> List peer worker training available List career pathway exemplars Funding issues address Greater articulation of family peers
4	<ul style="list-style-type: none"> Discussion and negotiation of language and openness to change is part of cultural change. Self-audit of readiness of an organisation to employ PSW is important as Vivien stated but it is missing in the framework. Equal opportunity- clear legal grounding. Document unclear whether it includes consumer/carer. 	
5	<ul style="list-style-type: none"> Page 2: In broad terms, peer workers are people with lived experiences of mental ill health as <u>consumers or carers and alcohol</u>. Page 2: Definitions and roles- Add Family Court Services. Document is looking at peers going into an organisation- not peer led organisations- which would be looking at a strategic framework coming from a different reference point. No use of peers as Evidence based Best Practice terminology. Funding for positions can be sourced internally. 	<ul style="list-style-type: none"> Wording is very consumer centric- need to look into phrases to include carers e.g. needs to be clear that it is a consumer/carer with a lived experience. Page 6: no mention of a model/type-carer representation. No use of peers as <u>evidence based practice-terminology</u>. Funding for positions can be sourced internally.
6	<ul style="list-style-type: none"> Specialised peer support i.e. trauma informed eating disorder, 	<ul style="list-style-type: none"> Table beginning page 6-

	<p>where that cohort has specialised needs. Including those that may not be fully recovered e.g. WASUA.</p> <ul style="list-style-type: none"> • Peer work can be embedded in different parts of organisations, on a number of different levels. • Policy and procedures around volunteer roles • Equal supports as to other staff including supervision. Whatever works for paid staff applies to volunteer and peers including induction. • Language- peer practitioner. • Same work, same pay; pay needs to be fair and equitable. • Carer peer workers need to be discussed and included within the framework, equally as consumer peer workers. 	<p>have model and description, not agency</p> <ul style="list-style-type: none"> • In the Exec summary or discussion say consulted with particular organisations. • Peer workers integrated as another service offered. • Preparing the organisation to include peers rather than preparing managers and non-peer staff (see page 9 of Draft). • Clear roles and responsibilities. • Discusses a lot of issues in a negative light. Problem focused rather than solution focused e.g. “peer workers often have feelings of lower status” change to “Organisations need to ensure that as with other staff roles are valued equally”
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