Lived Experience Workforce in SA Public Mental Health Services

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The Lived Experience Workforce in South Australian Public Mental Health Services

What we have learned, what we have achieved and future directions

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Overview

The 2010 National Mental Health Strategy states that consumers and carers should be actively involved in the development, planning, delivery and evaluation of services. In South Australia, a recovery focus has become a cornerstone of mental health with an emphasis on consumer and carer participation at all levels of policy, planning, service delivery and evaluation.

The South Australian Mental Health and Wellbeing Policy states:

> *Consumer and carer participation is valued at all levels (Principle 5.6):* Consumers and carers should be involved at all levels of policy, planning, service delivery and evaluation to set direction and ensure the best possible health outcomes.

Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012 states:

> *Recommendation 1:* People with a mental illness who are consumers of the state's mental health services should participate at all levels of the system. This will require innovative ways of ensuring their meaningful involvement in planning, organising and evaluating services.

The Framework for Recovery-Orientated Rehabilitation in Mental Health Care, South Australia (2012) states:

> It is essential that effective partnerships are formed at all levels of the mental health system. This includes representation of key partners including consumers and carers in policy-making, planning committees and their involvement in planning, implementation, evaluation and modification of service delivery.

In employing peer workers within mental health services there is an acknowledgement of the expertise of lived experience and how this can be used to offer hope, empower, support and educate consumers and carers who are navigating mental health services. The employment of lived experience workers either working with consumers or carers within acute rehabilitation and inpatient units may also assist mental health services to actively enhance recovery oriented service provision. Lived experience workers who work alongside multidisciplinary clinicians may have a role in educating staff and consumers, reducing stigma and assisting services to work in partnership with people with mental illness and their families.

The introduction of employees with a lived experience either as a consumer or as a carer is an example of innovative practice that adds value to the professionally trained clinical workforce as well as to consumers and their families.

The Fourth National Mental Health Plan (Australia 2009) has two actions that directly relate to the development of a peer (consumer or carer) workforce or lived experience workforce:

- Action 25: Develop and commence the implementation of a National Mental Health Workforce Strategy that that defines standardised workforce competencies and roles in clinical, community and peer support areas.
- Action 26: Increase consumer and carer employment in clinical and community support settings.

The overarching aim of the evaluation of the lived experience workforce within South Australian government mental health services was to assess the impact of the Mental Health Directorate's (MHD) Lived Experience Workforce (LEW) Program (carer consultants and peer specialists) in rehabilitation and acute inpatient units in South Australia in order to explore program strengths, challenges and future developments. The MHD's Lived Experience Workforce Program is made up of a non-clinical workforce who utilise their lived experience as either a consumer (peer specialist) or carer/family member (carer consultant) to empower, support and enhance clinical mental health service delivery in South Australia. The research assessed consumers, a small number of carers, as well as multidisciplinary clinical mental health service staff and managers perceptions of the peer specialist and carer consultant roles. The research also assessed peer specialists, carer consultants and the clinicians who supervise the LEW staff on particular units' perceptions of the roles and the program.

The study included Cedars North West, Rural and Remote and Inpatient Rehabilitation Services (Glenside Health Services); C3 (the Royal Adelaide Hospital); James Nash House Inpatient Forensic Unit, Cramond Clinic (the Queen Elizabeth Hospital); Woodleigh House (Modbury Hospital); Ward 1G (the Lyell McEwen Hospital); Eastern Intermediate Care Centre and Western Intermediate Care Centre.

There were six objectives of the evaluation:

- Explore the impact of the peer specialist role on consumers.
- Explore the impact of the carer consultant role on carers.
- Explore clinicians' perceptions of the impact of LEW roles on multidisciplinary teams and the mental health system overall.
- Assess peer specialists' and carer consultants' overall perception of the program and the roles.
- Explore supervisors' perceptions of LEW staff of the roles and the overall program and seek clarification on what's working well, what's not working as well as it could and how the MHD can enhance the program.
- Explore further the LEW's perceptions of their roles and the overall LEW program and seek further clarification on what's working well, what's not working as well as it could and how the MHD can enhance the program.

The incorporation of the peer work role has been very well received by consumers and carers in South Australia. Consumers feel that peer specialists increase their sense of hope for recovery, assist them in identifying their own coping strategies and assist them to manage their symptoms. Peer workers have a unique understanding of the challenges faced by consumers and carers and this service should continue to be promoted and offered to all consumers and carers accessing mental health services. Peer workers generally believed they are well supported in their position but some feel that the role is undervalued by some non-peer staff and that equality may be achieved if there is improved role clarity including a review of the job and person specifications. Other suggestions such as the creation of more full-time positions, recruitment of casual staff to cover backfill and opportunities for career development would ensure that peer workers felt valued within the organisation. On a service level, non-peer staff reported that they understand the benefits of peer workers in mental health units and generally have had a positive experience of working with the LEW staff. Supervisors have concerns about the lack of a supervision framework and performance management guidelines; both of these issues should be addressed to improve the structure of the LEW program.

This report provides a review of the current literature supporting peer work in mental health services, a summary of the research methodology employed in the evaluation, a detailed assessment of the impact of peer workers in public mental health facilities and recommendations for service improvement. The report concludes with a list of recommendations which will help to reconcile existing issues faced by clinicians, staff and peer workers involved in the LEW program. It is hoped that consideration of the recommendations put forth in the report will lead to an improved, sustainable LEW program which will continue to benefit consumers, families and clinical staff by facilitating recovery oriented service provision and combatting the stigma of mental illness.

Recommendations

The following recommendations were developed based on the qualitative and quantitative data from the LEW, clinicians, managers, carers and consumers as well as the qualitative data from the LEW and supervisors' focus groups.

The recommendations are focused into four areas:

- Role clarity.
- Training and development.
- Resourcing.
- Supervision.

1. Recommendation 1: Role clarity
    1.1. Increase education at a local level via regular in-services and at a service level with all orientation and staff training to include sessions on the roles of peer specialists and carer consultants within mental health service delivery.
    1.2. Develop print based advertising on the LEW within each unit that is visible to consumers, carers and staff. This may include posters, fact sheets and handouts.
    1.3. Further develop the LEW role, the hours and days they work and how to access them within each service.
    1.4. Further develop LEW specific policies and procedures including but not limited to supervision and medical records. To be developed in conjunction with all stakeholders and distributed via service wide bulletins and accessible via the intranet.

2. Recommendation 2: Training and development for the LEW
    2.1. Review of ongoing training and development programs involving LEW staff to provide more effective training and development which better meets the needs of the LEW.
    2.2. Develop an orientation program specific to the LEW and deliver to all new lived experience staff, clinical staff and managers.
    2.3. Develop an orientation and training manual for LEW staff in partnership with the LEW, clinical staff and managers.
    2.4. Use evidence based training and ongoing evaluation of training to review the effectiveness in supporting role development.

3. Recommendation 3: Staff resourcing and job and person specifications
    3.1. Review the current 0.5 FTE (full time equivalent) positions for lived experience staff to determine if services are adequately resourced.
    3.2. Review the current job and person specifications to better describe the LEW roles with adaptation to individual services employed.
    3.3. Explore further career development opportunities for LEW staff.
    3.4. Fill LEW staff vacancies as soon as possible to provide an ongoing service to consumers and carers with minimal interruptions.
    3.5. Involve supervisors and program coordinators to manage the selection process for new LEW staff.
    3.6. Develop a casual pool of LEW staff to cover absences.
    3.7. Involve lived experience staff in in-services and unit based development of policies, procedures and local work instructions.

4. Recommendation 4: Supervision and line management
    4.1. Implement lived experience specific supervision and mentoring. Consider the use of a peer buddy system to help orientate new staff.
    4.2. Utilise more experienced peer specialists and carer consultants to provide training and support to new staff.
    4.3. Develop procedural guidelines for documentation and supervision, including a clearer definition of supervisors compared to direct line management.

4.4. Enhance support offered to LEW staff when required, within a defined support structure. Procedures to be developed in conjunction with all stakeholders.

4.5. Enhance program management support from the coordinators of the lived experience program and enhance partnerships with the supervisors/line managers of LEW staff.

4.6. Provide supervision training to supervisors of lived experience staff by program coordinators. Consider reviewing other areas that provide lived experience specific supervision training as a resource to develop evidence based training and practice.

Recommendations implemented since completion of evaluation

Since the completion of this study significant work has been undertaken to implement the recommendations from this evaluation. The following section outlines what recommendations have been implemented in the four focus areas: role clarity, training and development, staff resourcing and supervision.

1. Recommendation 1: Role clarity
   - Education on the role of peer specialists and carer consultants is delivered as part of the Allied Health Intern Program across the four local health networks (LHN). Local level in-services are being delivered on the role of the LEW in some area and discussions are happening with unit managers for this to be a regular part of in-services in areas where lived experience staff are employed.
   - Some university programs include education sessions on LEW roles in mental health services.
   - The Learning Centre has now developed courses which are co-delivered with peer specialist staff.
   - Research findings have been presented to sector managers, executive directors and at the Mental Health Services Conference.
   - Posters and fact sheets of various forms have been developed and distributed.
   - Regular bulletins on the LEW have been published from the Executive Director, CALHN Mental Health.
   - A LEW web page is now part of the CALHN Mental Health intranet.
   - The LEW Working Group Terms of Reference have been redesigned and developed to reflect recommendations from the evaluation and expression of interest for membership has been requested.

2. Recommendation 2: Training and development for the LEW
   - Bi-monthly training days are now run for all lived experience staff across the LHNs and are designed and facilitated by the Coordinator Lived Experience Workforce in conjunction with lived experience staff.
   - An orientation program specific to new LEW staff has been developed and delivered to carer consultant staff recruited in 2013. Work has been undertaken to further develop the orientation program for the LEW.

3. Recommendation 3: Staff resourcing and job and person specifications
   - A review of the current job and person specifications has been completed in some areas and is under review in others in conjunction with unit managers. This process is being led by the Coordinator Lived Experience Workforce.
   - The Coordinator Lived Experience Workforce in conjunction with a unit manager coordinates the recruitment of LEW staff to vacancies as soon as they arise.

- The coordination role of the LEW has been reviewed. A lead coordinator position overseeing the peer specialist and carer consultant roles across the LHNs has been established. Clear support, line management, supervision and accountability have been developed for this role.

4. Recommendation 4: Supervision and line management

   4.1. The Supervision and Accountability Framework has been reviewed for lived experience staff in conjunction with supervisors and line managers. A second review to further develop this framework for both peer specialists and carer consultants will commence shortly.

   4.2. The Coordinator Lived Experience Workforce has established and convened LHN group supervision in each LHN for peer specialist staff to provide lived experience and peer to peer based supervision, mentoring and support.

   4.3. A monthly carer consultant state-wide meeting providing peer to peer mentoring and support has been introduced across the LHNs. This has been implemented in conjunction with carer consultants and the Coordinator Lived Experience Workforce.

1. Introduction

What is peer work?

During the past decade there has been massive growth in the employment of peer support workers across the United States, UK, New Zealand and Australia. In the US it has been reported that services run for and by people with mental illness and their families now number more than double the traditional medically and clinically oriented mental health services[1]. However, the employment of peer support within acute inpatient/government mental health services has developed more slowly, maybe impeded by stigmatic attitudes regarding people with mental health problems. The Recovery Oriented Framework for Mental Health Services that has developed more recently has emphasised the importance of peer support in clinical services. Peer support services have been found to be more successful than professionally trained staff at promoting hope and the possibility of recovery[1].

Peer work is defined by the fact that people who have life experiences may better relate and consequently may offer more authentic empathy and validation to consumers and families navigating mental health services[2 3]. Peer support has been conceptualised as involving one or more persons who have a history of mental illness and who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered not to be as far along in their recovery process[4].

Peer support either provided to consumers or carers/family members can be defined as relationships grounded in shared experiences which are mutual, reciprocal and equal and can promote relationships that foster responsibility and critical self-awareness[5 6 7]. Peer work assumes no medical model of mental illness; challenges traditional deficit based approaches to mental illness and asks service users to reflect critically and to have some ownership in their own mental health care treatment plan[5]. Peer support roles differ from other roles in mental health because they are based on different philosophical assumptions. They carry no assumptions of deficit or historical baggage about the social support and maintenance of the disabled[5].

In recent decades, peer work within mental health services has gained significant attention in Australia and internationally[1] as an effective approach to supporting people with mental illness on their journey to recovery. Importantly clinical staff from traditional mental health services benefit from lived experience workers as the roles may lead to shifting stigmatic and value based assumptions about people with lived experience of mental illness. Multidisciplinary clinicians who work alongside lived experience workers can grow and develop as clinicians and be assisted to move more towards the concept of personal recovery in their practices[8]. Implementing peer support services in mental health settings is messy and complicated work that brings about significant culture change in these institutions[2].

Evidence supporting peer work

A strong and definitive evidence base for the effectiveness of peer support is yet to emerge, most studies are descriptive, however, the literature is largely positive[6 7 9 5 2]. Peer support services have been found to be an effective part of mental health care[10]. Several studies have found that peer support services have produced similar results to standard clinic-based care[10 11 12]. Lawn et al., (2008) evaluated the first 3 months of operation of a South Australian peer support mental health service which provided early discharge support and promoted hospital avoidance. They found that there were three hundred bed days saved in the time period and concluded that peer support was a highly effective adjunct treatment[6].

Another study found increased community integration, quality of life in relation to daily living activities and a significantly greater level of employment, participation in education and lower levels of symptom distress for consumers involved with peer worker programs[13]. In a longitudinal study, Min (2007) followed 109 people who were involved in a peer support program and matched controls and reported that those who attended the peer support program were less likely to be hospitalised within the three year study period and spent longer in the community in between admissions[14]. An examination of an intensive peer support program reported that participants felt empowered and had improved attitudes towards recovery[15].

The National Centre for Mental Health Research, Information and Workforce Development in New Zealand (Te Pou) released a report which documented the level of peer work in mental health services in Australia, New Zealand, Canada, the United States of America, England, Ireland and Scotland[16]. It found that peer support services are effective in encouraging people to move from 'patienthood to personhood'. Across the board, other benefits included reduced rates of hospitalisation and mental health service usage, reduction of distress symptoms, increases in quality of life, improvement in social support and accommodation and an increase in volunteer work or employment. There were particular benefits for the peer workers themselves including increased self-esteem and a greater knowledge of mental health. Meaningful relationships with staff led to a more effective service. Several countries have training programs for peer workers that vary in structure. Factors which were found to strengthen peer support workers' effectiveness include clarification of staff roles and responsibilities, effective training, supervision and ongoing mentoring. At the same time, the factors which assist clinical staff to ease the transition of the introduction of peer support roles were information about the effectiveness of peer support workers, in particular information about how peer workers and clinicians can be mutually beneficial.

Consumer and carer participation in mental health services

The origins of peer work stem from the grass roots social justice and human rights movement coming from the voices of consumers and families experiencing mental illness, either as consumers or family members. Peer support grew out of a political and practical need to improve mental health service treatment across the world and is embedded in a "rights" movement around the shared experience of the consumer/survivor/patient movement[17]. Historically mental illnesses were considered permanent, disabling and degenerative[18]. For the best part of the last century families were shamelessly accused of being the root cause of the mental illness of their loved one. Once the biological basis of the illness was established such theories were academically rejected, however, many still see this as the case and it accounts for much of the stigma that families face around mental illness[19]. In recent years there has been a shift in focus from disregarding families of a person with a mental illness to a focus on collaboration with consumers and carers/families and on building their strengths and resources[19 20].

According to the Senate Committee on Mental Health (2006)[21], families and consumers reported that while they supported the deinstitutionalisation of mental health services and the acknowledgement of the role of families in the recovery journey, there was a lack of community based services to facilitate the transition. In recent years there has been a greater acceptance and acknowledgement of the role of family support for consumers and a focus on collaboration with families to build their capabilities as carers. The National Standards for Mental Health Services in Australia (2010) strongly recommended involving carers and families in the development of care plans[22]. To address the concerns of carers and families, the National Consumer and Carer Forum was created. The forum gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform. Empowering the family of the consumer to have an active role in their care has a direct impact on the recovery of the consumer. Increasingly, there is research which shows that carers have an important role in the recovery journey of individuals affected by severe mental illness and this evidence is being translated into practice by innovative health policy and legislation[23]. In South Australia, as in other states, the Carer Recognition Act SA (2005) demonstrates that state and national governments have a commitment to collaborating with carers and family members of a person with a psychiatric disability, to ensure the best outcome for the family and the service system.

Consumer and carer participation is the third standard of the 2010 National Mental Health Strategy[22]. The standard decrees that consumers and carers are actively involved in the development, planning, delivery and evaluation of services. Table 1 outlines the criteria for this standard. Consumer involvement in these areas of mental health services are considered to be highly beneficial and the South Australian Department for Health and Ageing has made a commitment to supporting the consumer workforce as an integral part of the health service.

Table 1: Criteria for the consumer and carer participation standard

Criteria	Statement
3.1	The mental health service has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs.
3.2	The mental health service upholds the right of the consumer and their carer(s) to have their needs and feedback taken into account in the planning, delivery and evaluation of services.
3.3	The mental health service provides training and support for consumers, carers and staff, which maximise consumer and carer(s) representation and participation in the mental health service.
3.4	Consumers and carers have the right to independently determine who will represent their views to the mental health service.
3.5	The mental health service provides ongoing training and support to consumers and carers who are involved in formal advocacy and/or support roles within the mental health service.
3.6	Where the mental health service employs consumers and carers, the mental health service is responsible for ensuring mentoring and supervision is provided.
3.7	The mental health service has policies and procedures to assist consumers and carers to participate in the relevant committees, including payment (direct or in-kind) and/or reimbursement of expenses when formally engaged in activities undertaken for the MHS.

The LEW in terms of the peer specialist and carer consultant roles, are intricately tied to concepts of consumer and carer participation. The Fourth National Mental Health Plan (Australia 2009) has two actions that directly relate to the development of a peer (consumer or carer) workforce or lived experience workforce:

- Action 25: To develop and commence the implementation of a National Mental Health Workforce Strategy that that defines standardised workforce competencies and roles in clinical, community and peer support areas.
- Action 26: To increase consumer and carer employment in clinical and community support settings.

In 2011 a National Mental Health Peer Work Forum[24] was held to identify and prioritise peer workforce development needs. The forum developed a number of objectives which were identified as key areas for improvement in peer workforces:

- Nationally recognised qualifications for peer workers.
- Guidelines regarding awards and remuneration.
- Clarification about career pathways.
- Clarification of roles.
- Development of organisational policies and procedures.
- Development of a code of ethics.
- Development of a code of conduct for peer work in Australia.

Since this forum, the Australian Government Department of Education, Employment and Workplace Relations, have developed a manual which described the knowledge and skills required to work collaboratively with peer workers to maximise their employment in mental health peer work. The skills described in this manual apply to managers and team leaders who are responsible for the recruitment, planning and ongoing management of peer workers in the mental health peer workforce[25].

In South Australia, carer consultancy roles to provide peer support to carers have been developed in conjunction with consumer peer specialist roles in acute and rehabilitation units. In 2012, there were 25 peer specialist and 8 carer consultant positions in South Australian public mental health services. The exact figures for Australia-wide data are unknown as there is variation in the way peer support services are set up within mental health services. There is also variation with positions such as the level of autonomy the peer workers have, the regularity of their work and the degree of partnership with clinical teams.

Concept of recovery in peer work

Recovery is defined in terms of the ability to lead a satisfying life despite the presence of mental illness. Recovery is underpinned by notions of hope and healing, positive identity, taking responsibility, control and choice and is a process or a journey which the individual undertakes. It is closely linked to the principles of consumer participation and empowerment where active consumers provide evidence to clinical workers that recovery is possible. Recovery exists on a continuum of improved health functioning. Recovery is enhanced when people are empowered through education and partnership with the mental health services to take ownership of their illness and play an active role in their recovery[18].

Slade (2009) argues that there is a difference between clinical recovery and personal recovery. Clinical recovery is conceptualised as a reduction of symptoms, improving social functioning and restoring the person to their original capabilities and daily life[8]. It is illness-based with a focus on psychopathology, diagnosis, treatment and relies heavily on the judgements of clinicians and is controlled by the service providers[8]. Personal recovery, on the other hand, is described as a deeply personal and unique experience which involves changing and shifting attitudes, reassessing values and developing personal goals. It is a way of living a satisfying and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the effects of mental illness. Personal recovery is value centred and focused on empowerment. The Personal Recovery Framework focuses on a person's strengths, hopes and dreams and is geared toward self-management and empowerment. The current National Mental Health Plan states that 'a recovery orientation should drive service delivery'.

Robert and Wolfson (2004) assert that narratives of recovery can assist to give people hope for the future by normalising shared experience and reducing stigma of mental illness. Peer workers can assist in this way by sharing their experiences and helpful strategies while demonstrating a positive example of the potential for recovery. Peer work is considered to be an amalgamation of the clinical and personal recovery frameworks when the peer worker is placed within acute public inpatient settings or rehabilitation facilities[26]. According to Slade (2009) 'peer work is the only mental health role to emerge that is grounded intrinsically in recovery'[8].

Challenges involved in peer support programs

One of the challenges in implementing peer support in Australia is that there have been limited numbers of peer support workers in paid positions within services[24]. A review of peer work in Australia found that the tasks of peer workers were unclear or vague and there were inconsistencies in responsibilities, training and remuneration[27]. Often consumer and carer consultancy roles and programs are not well defined or evaluated. Furthermore, consumer workers need to be provided with ongoing training and development as their non-peer colleagues receive. Miyamoto and Tamaki Sono (2012) reviewed the issues involved with peer workers and found that some clinical staff were concerned about peer workers becoming unwell, particularly if they had been a patient of the unit they were working in[28]. There is also role confusion for the clinicians who work with the peer workers and other staff in multidisciplinary teams. Kling, Dawes and Nestor (2008) reported that some service providers are unsure how to assimilate lived experience workers into their organisation and are sceptical of their value[9]. As the attitudes of staff are affected by the attitudes of the organisation's management it is imperative that services support, supervise and educate all non-peer worker staff as to the benefit and purpose of these roles. These challenges are said to have led to barriers for the consumer workforce and have hindered it from being embraced by mental health services.

Strategies for implementing peer support

A thematic review of peer support workers identified six aspects of successful peer support services that can be judged successful[5]. These aspects include:

1. A clear philosophy and guiding values which emphasises the benefits of peer support and differentiates it from other types of support.
2. The maintenance of the integrity of peer support. Threats to integrity include tokenism and disingenuousness. Peer workers need to be paid adequate remuneration and to be considered to be a genuinely effective member of that service. Furthermore, there must be clear opportunities for career progression and leadership roles.
3. Effective recruitment, including recruiting people with the right qualities for the job, and to recruit a sufficient number of peer workers to make the service worthwhile as well as the ongoing provision of training.
4. Training consistent with the role, particularly in-house training and development. Considerable concern has been expressed that some peer support workers receive little or no training and no supervision, and that peer support providers should demonstrate that their peer workers receive some level of credible and appropriate training.
5. An effective supervision structure. Supervision is critical to the success of peer support and it was felt this was the process in most urgent need of development. External, impartial supervision is necessary.
6. A fully developed organisation structure. The organisation should be able to demonstrate that it has sufficient technical and management capacity – recruitment policies, a supervision structure, financial systems, and comprehensive policies and procedures – to provide peer support.

Other reviews[2] found similar core factors of successful peer support services and also emphasised the importance of educating clinical and multidisciplinary mental health workers about the benefits of peer workers and to promote respectful attitudes to all co-workers.

Development of the lived experience workforce in South Australian government acute inpatient and rehabilitation facilities

In 1998 the first of the lived experience workforce peer specialists were employed in government-run mental health services. Initially employed as a pilot project, they were called peer support workers and were based within the North and North Western Mental Health Services. The project was a partnership with the Schizophrenia Fellowship of South Australia. The original project involved peer workers running groups including a seven week ‘moving on support group’ for young people experiencing psychosis and a seven week ‘relatives and friends group’, which provided support for the friends and family of consumers. The peer workers worked with clinical case managers in the Northern Mental Health Community Teams on home visits. They also provided consultation to an acute inpatient unit in the Northern Mental Health Service and provided one-on-one support to consumers.

In 2006, the program expanded and employed one peer specialist and one carer consultant for every 20 beds within the Central Northern Adelaide Health Service. They were provided with extensive training including a two week orientation and a week-long training program with recovery expert, Helen Glover, about recovery orientation based practice. In the first year, all staff were funded to gain a Certificate III in Community Services - Mental Health and in the second year were funded to study and obtain a Certificate IV in Training and Assessment. Job and person specifications were designed for both carer consultants and peer specialists with clear remuneration packages at a reasonable levels and opportunities for career progression were outlined.

Some of the activities that peer specialists were responsible for included planning, presenting and evaluating educational groups for consumers to increase psychological well-being; working individually with consumers to empower them to understand their illness; and working in groups utilising their lived experience of mental health to assist consumers to develop their own strategies for their personal journey of recovery. The role of peer specialist demonstrated recovery and also assisted with communication between the consumer and the treating team.

The carer consultants worked individually with carers of consumers with a mental health diagnosis to provide support and educate them about on mental health and the mental health system through written information and their own experience as a carer. Carer consultants also coordinated information sessions within the unit for families and carers and were involved with the clinical team in family meetings. Within this role carer consultants were available to carers at the beginning of an inpatient admission and during the admission, provided information and referrals to other services that support carers and assisted the carer through the treatment pathway in the acute care phase while working collaboratively within the multidisciplinary team.

The first evaluation of the LEW noted that most lived experience workers reported feeling accepted by the multidisciplinary team and were involved in all areas of the service. However, some had negative experiences and reported feeling excluded and unable to fully utilise their skills in their roles. To address these issues, extra support was provided to LEW and there was mediation provided for discussions between groups. Some staff were moved to more supportive wards for issues that could not be resolved at that time. Management continued to work with these wards to better enable future success for the lived experience roles. Support was provided by direct supervision from clinical services coordinators, a senior social worker for carer consultants of each ward, monthly staff meetings and mentoring was offered from Mental Illness Fellowship Australia (MIFSA).

2. First evaluation of the lived experience workforce in South Australian government acute inpatient and rehabilitation settings

An evaluation of the impact of introducing peer specialists and carer consultants in acute mental health units in South Australia was published in 2008[9]. A consumer, carers and staff questionnaire was developed and administered to ascertain perspectives of peer specialists or carer consultants. Overall, results were positive; most consumers felt that peer specialists helped the consumer feel supported, identify coping strategies and increase their sense of hope for recovery. Carers had a positive appraisal for carer consultants saying they made carers feel supported and helped carers build on their strengths in the caring role.

The perceptions of staff members before the introduction of peer specialists and carer consultants was also evaluated and compared attitudes six months after the LEW had been working in the service. Interestingly, staff members rated peer specialists and carer consultants less favourably after six months in terms of the benefit they had for consumers, their ability to foster hope for recovery and encouragement of personal responsibility. Staff felt less confident to make referrals or offer support to the peer specialists or carer consultants and did not feel the LEW benefited other unit staff. Focus groups were set up to explore the negative attitudes held by non-peer staff toward the LEW. It was found that although staff understood the role of peer specialists and carer consultants better after six months, there were difficulties with selection, training and management of the new lived experience staff, and the roles of peer specialists and carer consultants were reported as misunderstood and under-utilised.

In 2009 the Adelaide Health Service (Central and Northern) Mental Health Directorate undertook accreditation through the Australian Council of Healthcare Standards (ACHS). This accreditation acknowledged the excellence in consumer and carer participation within mental health services in South Australia. The accreditation was based on EQUIP (Evaluation and Quality Improvement Program) health service accreditation and included the National Standards for Mental Health Services (see Table 1.) The LEW program received positive feedback from the ACHS:

> *"There are clearly documented procedures for recruitment, orientation and training of peer specialists and carer consultants. These are the lived experience employees in the Directorate and there was evidence from the surveyors that most units visited had one or more lived experience staff members who were integrated into the health team and were committed, enthusiastic and optimistic about their role".*

A number of modifications to the peer worker program were made in light of the challenges identified in the first evaluation. The positive feedback from the ACHS suggested that the program may have improved since the first evaluation. Thus, it was necessary to undertake a second evaluation of the current LEW to evaluate any differences in the service over time and improve the evidence base of peer work in mental health settings.

3. Current program

Currently, 25 peer specialists and eight carer consultants work in the LEW program. Most LEW staff are employed on a part-time basis - approximately 18.5 hours per week, however, three carer consultants worked fulltime split over two units. At the beginning of 2010 a number of new LEW staff were recruited so an orientation program was developed to engage and train new staff. Ongoing training is provided every eight weeks and staff meetings are held bi-monthly. Clinical service coordinators (nursing staff) provide line management and fortnightly supervision for peer specialists and clinical service coordinators provide line management for care consultants while the senior social worker provides supervision. The senior peer specialist coordinator and carer connect coordinator in collaboration with unit clinical supervisors are responsible for performance reviews and ongoing development of the LEW. The senior peer specialist coordinator is a full-time lived experience role, unlike the carer connect coordinator who was not in a lived experience role and was part time (15 hours week).

Method

A team of two lived experience workers (senior peer specialist coordinator and a peer specialist) with support and advice provided by Professor Cherrie Galletly (Professor of Psychiatry, Adelaide University and Consultant Psychiatrist, Mental Health Service), agreed to evaluate the current program to explore the changes in attitudes and values towards lived experience workers over time. The study used qualitative and quantitative methods of data collection and analysis. A direct comparison of quantitative data with the previous study was not possible as the original raw data from the previous study was lost. The study was approved by the Royal Adelaide Hospital Research and Ethics Committee. Initially the research included Cedars North West, Rural and Remote, Inpatient Rehabilitation Services (Glenside Health Services); Ward C3 (the Royal Adelaide Hospital); and James Nash Inpatient Forensic Unit. The research study and initial findings from the research was presented at The Mental Health Services (TheMHS) Conference in Adelaide. The interest generated at this conference led to the study being expanded to include Cramond Clinic (the Queen Elizabeth Hospital), Woodleigh House (Modbury Hospital), Ward 1G (the Lyell McEwen Hospital), and the Eastern and Western Intermediate Care Centres. Ethics approval was obtained from the Queen Elizabeth, Modbury and Lyell McEwen Human Research Ethics Committees.

Participants

The study attempted to gauge an understanding of the LEW program from a variety of stakeholders.

Mental health staff

Clinicians (nursing, social work, psychology, occupational therapy, psychiatry), clinical service coordinators in inpatient units and other clinicians who supervised LEW staff (N=58) participated in the survey. The researchers contacted team leaders at each site to discuss the involvement of staff in the research. Staff were presented with the research aims during handover when they were invited to participate in the research. Information sheets were placed in staff pigeon holes. Questionnaires, consent forms and a sealed and labelled box were left in staff rooms for staff to complete and place in the box. The questionnaire, consent forms and information sheet were also emailed to all staff members.

Consumers

A total of 29 consumers in mental health inpatient units or community settings participated in the survey. Researchers met with consumers to explain the research in detail and distribute information sheets. Consumers who wished to participate completed a survey and a consent form. Peer specialists were enlisted to distribute information sheets, consent forms and the survey to consumers. Consumers were eligible to participate if they remembered working with a peer specialist, were aware of a peer specialist working on the unit and they were offered a service from a peer specialist.

Lived experience workers (peer specialists and carer consultants)

Lived experience workers in acute mental health inpatient units or community settings (N=12) were also surveyed. All LEWs were invited to participate. They were provided with an information sheet, consent form and the questionnaire and responded by returning the survey into a sealed, labelled box.

Carers

A small number of carers and family members of consumers in mental health inpatient units or community settings were consulted (N=5). Carer consultants were provided with a letter which explained the purpose of the study to distribute to carers as well as an information sheet, consent form and the questionnaire. Carers were provided with reply paid envelopes if they wished to participate in the research and send the questionnaire back. Carers were able to participate in the research if they were aware of carer consultants and if they were offered a service from a carer consultant.

Procedure

Questionnaire

The research was conducted in a 12 month period from August 2011 to August 2012. The study used mixed survey methodology with a specifically designed questionnaire for each group in the study (clinicians, managers, consumers, carers and lived experience staff). Information sheets were distributed to all participant groups which explained the research in detail. The information sheet included contact numbers for researchers and the ethics committee for participants who wanted to discuss the research in more detail. Participation was voluntary and no incentives were offered to participate. Data was analysed using the Statistical Package for Social Sciences (SPSS, IBM Corp, 2010). See Appendix A, B, C and D for a copy of each of the questionnaires.

Focus groups

Focus groups were designed and carried out to explore the perceptions of the LEW and ward supervisors about the program. Two different focus groups were held, one with the LEW and another with supervisors of the LEW. Five peer specialists and four carer consultants attended the LEW focus group. The aim of the group was to explore attitudes toward ongoing training and development; perceived support by lived experience staff; role definition and how they could be better supported as lived experience staff. This focus group was designed and facilitated by a peer specialist rather than the senior peer specialist coordinator and this was thought to enable staff to be as open and honest about their roles and perceptions as possible.

All supervisors (N=13) who had worked with lived experience staff were invited to attend a focus group and of these 10 people responded saying they would attend but only two people attended the formal focus group in person, one being a clinical services coordinator and the other a senior social worker. A number of supervisors provided a late apology to the focus group meeting meaning this could not be rescheduled. The senior peer specialist coordinator who led this focus group contacted all invited supervisors individually and all supervisors who didn't attend on the day provided feedback in writing addressing the same questions discussed in the focus group. The aim of the group was to explore what is working well, what areas could be improved and how those improvements can be made.

Results

Objective 1: Explore the impact of peer specialist role on consumers

The questionnaire consisted of eight statements designed to gauge an understanding of consumers' attitudes towards the peer specialists. Participants responded via a Likert Scale and circled the option that best applied: 1 = very poor, 2 = poor, 3 = acceptable, 4 = good, 5 = very good. The statements, mean score and standard deviation are shown in Table 2.

Overall, peer specialists scored highest in the areas of increasing consumers' hope for recovery, helping consumers feel supported and helping consumers identify their own coping strategies.

Two open-ended questions were included at the end of the questionnaire to further explore attitudes towards peer specialists by consumers:

1. Did you find anything different/special about working with a peer specialist in comparison to other staff?
2. What would make the peer specialist service even better?

Table 2: Mean (M) and standard deviation (SD) of consumer responses to the questionnaire

Statement	M	SD	N (%) who rated item as good or very good
The peer specialist helped increase my understanding of the symptoms I experience.	4.32	.77	15 (53.6%)
The peer specialist shared their positive coping strategies with me.	4.24	.79	15 (51.72%)
The peer specialist helped me to identify my own coping strategies.	4.00	.67	24 (85.7%)
The peer specialist increased my sense of hope for recovery.	4.46	.64	26 (92.9%)
The peer specialist helped me in feeling supported.	4.45	.83	25 (86.2%)
The peer specialist encouraged me in managing my own symptoms.	4.11	.80	22 (81.5%)
The peer specialist helped me connect with community resources.	3.96	1.14	20 (71.4%)

Consumers perceived that peer specialists provided a unique form of empathy which stemmed from their lived experience. *"The peer specialist talked to me on the same level, I was treated like an intelligent, normal person."* Consumers generally held a positive regard for peer specialists. One person stated, "*Peer specialists are easy to talk to"*. In general, consumers reported that they did not perceive the peer specialist any differently to clinicians on the mental health team. Overall, the mean score was 4.22 (between good and very good), for all items which indicates a generally positive response to peer specialists. The lowest mean score was for the last item regarding connecting consumers to resources in the community. This has been identified as an area for improvement. It is noted that some consumers were from a forensic mental health unit where they were unable to be referred to community support. The results show an increase in positive perceptions of the role of peer specialists in comparison to the previous evaluation[9]. The positive appraisal of peer specialists by consumers suggests that suitable people are being employed in the LEW program. The positive comments from consumers about the empathy and helpfulness of peer specialists, demonstrates their positive impact on the recovery journey for consumers.

Some suggestions for how the service could be improved were a better understanding of the role of peer specialists and a need for more time with peer specialists. Some consumers commented that they didn't know about the peer specialists until they were directly approached which suggests that there needs to be greater promotion of peer specialists by staff in individual facilities.

The sample size was small and constrained by the amount of time staff had to visit the wards and talk to consumers about the research. As the hospitals were located far away from each other this further reduced the time researchers had to spend with consumers due to travel time. Future research may consider using a mail out to consumers to increase the sample size.

Objective 2: Explore the impact of carer consultants on carers

Five carers responded to the questionnaire but the results for two people were excluded because they commented that they had not yet had contact with a carer consultant. Participants were asked to circle which alternative best applied to them in terms of how good the carer consultant was at six different activities. The responses were rated on a Likert Scale from 1 = very poor, 2 = poor, 3 = acceptable, 4 = good and 5 = very good. Results are shown in Table 3.

Table 3: Mean (M) and standard deviation (SD) of the carer attitudes toward carer consultants (N=3)

How good was the carer consultant at ...	M	SD
Assisting you to learn about the hospital system.	5.00	.00
Explaining the Well Ways program.	5.00	.00
Helping you feel supported.	5.00	.00
Increasing your sense of hope for your relatives or friends recovery.	5.00	.00
Reducing distress by sharing their coping strategies.	4.67	.58
Helping you identify and build upon your personal coping strengths in your caring role.	4.67	.58

The results show an overwhelmingly positive attitude by three carers toward carer consultants. They suggest that carer consultants are an effective addition to the mental health workforce and support carers of consumers with mental health issues. The results support previous literature which has reported that people with a lived experience of caring for someone with a mental illness can provide education and support to fellow carers[29].

This section of the research is limited by the small sample size. It was difficult to get carers involved because they infrequently visited the inpatient units. Initially, to overcome this barrier it was decided that carer consultants would discuss the research when they had community visits with carers. However, this method was not readily adopted by carer consultants. Future research would benefit from a mail out to carers.

Objective 3: Explore clinicians' and managers' perspectives of the impact of LEW roles in multidisciplinary teams in the mental health system

Clinical staff and managers were asked to participate in the research by completing a questionnaire comprising of seven statements relating to the benefits of peer specialists and six statements about carer consultants and their understanding of these roles. Responses were via a Likert Scale ranging from 1 = strongly disagree to 5 = strongly agree. Results are shown in Table 4 and 5.

Table 1: Clinicians' and managers' attitudes toward peer specialists (N=58)

Statement	M	SD	N (%) of participants who rated item as agree or strongly agree
The peer specialist helped increase my understanding of the symptoms I experience.	4.32	.77	15 (53.6%)
I see the benefit of peer specialists working with acute/rehabilitation units.	4.29	.92	46 (79.3%)

I understand the role peer specialists have in promoting consumer recovery.	4.21	.85	46 (79.3%)
Peer specialists model personal recovery and positive coping strategies.	4.09	.96	45 (77.6%)
Peer specialists enhance a consumer's connection to community resources and the clinical team.	3.95	.96	40 (69.0%)
Peer specialists working in acute/rehabilitation mental health units benefit other staff.	4.00	1.13	41 (70.7%)
Peer specialists sharing positive coping strategies reduce consumer distress.	4.09	1.01	43 (74.1%)
Peer specialists help consumers navigate mental health services.	4.03	.92	43 (74.1%)

Table 5: Clinicians' and managers' attitudes towards carer consultants (N=44)

Statement	M	SD	N (%) of participants who rated item as agree or strongly agree
I feel positive about carer consultants working within acute/rehabilitation mental health units.	4.23	.91	36 (81.8%)
I understand the role carer consultants have in promoting consumer recovery.	4.20	.88	38 (86.4%)
Carer consultants sharing strategies reduces carer distress.	4.00	1.01	32 (72.7%)
Carer consultants help carers navigate mental health services.	4.11	1.02	34 (77.3%)
Carer consultants enhance a carer's connection to community services and the clinical team.	4.05	.91	35 (79.5%)
Carer consultants working within acute/rehabilitation mental health units benefit other unit staff.	4.11	1.14	35 (79.5%)

Overall, the results demonstrate that the majority of clinicians and managers could see the benefit of peer specialists and carer consultants working in the mental health units. This is demonstrated through 79-81% of participants agreeing or strongly agreeing with the comment, "*I see the benefit of peer specialists and carer consultants working within the inpatient units*".

The majority of clinical and managerial staff members understood the role peer specialists and carer consultants have in promoting consumer and carer recovery. This was significantly demonstrated by 79-86 % of clinicians and managers either agreeing or strongly agreeing with the statement, "*I understand the role peer specialists and carer consultants have in promoting consumer recovery*".

Further to the positive theme, clinicians and managers believed that peer specialists benefited consumers and carers and had a positive benefit for other staff members on the unit. 70-79% of staff responded positively to the statement, "*Peer specialists and carer consultants benefit other unit staff*".

Responses to the statements listed below further demonstrate that clinicians and managers see the positive impact that peer specialists have for consumers in their daily work. All questions rated highly with a majority of staff agreeing or strongly agreeing with the statements adding further evidence of the effective of peer specialist roles within the services.

- "Peer specialists model positive coping strategies" (77.6%).
- "Peer specialists share positive coping strategies" (74.1%).
- "Peer specialists help consumers navigate mental health services" (74.1%).
- "Peer specialists enhance a consumer's connection to community resources and the clinical team" (69%).

The positive impact carer consultants have on the support mental health services are able to provide to carers is also demonstrated through the clinicians and managers results. Responses to the following questions demonstrate that clinicians and managers view the carer consultant role as having overall a very positive impact on supporting carers of consumers in mental health services. This is clearly shown by a majority (over 70%) of clinicians and managers surveyed agreeing or strongly agreeing with the statements below. This further supports the evidence that carer consultants' contribution to clinical services enhances the support provided to consumers and carers with mental health services.

- "Carer consultants sharing positive coping strategies reduce carers' distress" (72.7%).
- "Carer consultants help carers navigate mental health services" (77.3%).
- "Carer consultants enhance a carer's connection to community services and the clinical team" (79.5%).

46 clinicians and managers responded to the qualitative section of the questionnaire. The three open-ended questions they answered were:

1. Have any benefits resulted from having peer specialists and carer consultants working within acute and rehabilitation units?
2. Have any difficulties arisen from having peer specialists and carer consultants as part of multidisciplinary teams within the acute and rehabilitation mental health units?
3. If difficulties have arisen, how do you perceive these difficulties could/or have been resolved?

Additionally, respondents had the option to provide any other comments in regards to the peer specialists and carer consultants.

Based on the responses, LEW staff were perceived as improving families and clinicians ability to work within a recovery framework. For example, "*The benefits have been numerous with peer specialists helping improve outcomes of admission, improved consumer journey of recovery and understanding of mental health".* While another clinician commented that they (LEW Staff) *"… provide advocacy for consumers at an individual and service delivery level*".

Clinicians and managers also felt that LEW staff supported families to better understand mental illness, eased their distress and enabled them to allow increased consumer input into their own care and treatment. Many of the comments referred to LEW staff improving communication between consumers, families or carers, individual clinicians and the mental health team overall. In general, clinicians and managers attributed the benefits that LEW staff provided to their unique lived experience. For example, "*They can provide firsthand knowledge of the recovery process, coping strategies and navigating the mental health system. Consumers, I believe, feel assured that advice from carer consultants and a peer specialist is valid and not patronising*". Clinicians and managers believed that LEW staff did a good job at mentoring recovery and wellness to consumers, carers and other clinicians. A particular benefit perceived by some clinicians was that "*LEW staff increased clinicians' understanding of the peer specialist role and its benefits to co-workers*". Overall, most clinicians believed that LEW staff enhanced their capacity as clinicians to treat consumers by improving communication and understanding of mental illness and recovery.

Even though clinicians and managers were asked to highlight any perceived difficulties in relation to LEW staff, the qualitative responses primarily expressed no difficulties and/or challenges that could not be managed. Many clinicians, in response to this question, reiterated the positive influence on clinical mental health service delivery arising from the LEW program. For example the following comments, expressed in relation to difficulties, "*Not at all, but I believe they should be able to document without a signature by staff*". Another said, "*I have not experienced any*", and further supporting this theme one participant commented, "*Not on this unit, nothing that can't be solved*".

The main challenges according to clinicians that needed to be addressed were role clarification for both the LEW staff and clinicians and education of clinicians regarding function, purpose, benefits and scope of the roles. Some clinicians felt that they and others did not fully understand exactly what peer specialists and carer consultants did in their roles and how they fit with existing clinical/medical model mental health service delivery. Some clinicians strongly expressed the need for education about the roles.

For example, "*However, I believe many members of the multidisciplinary team are unaware of the benefit and clear role of peer specialists and carer consultants and how to utilise them in acute units*."

The need for enhanced role clarity and education for LEW staff as well as clinicians was also expressed in the following comment, *"The major issue has been with carer consultant's role and the social worker's role. In some units social workers believed carer consultants were broaching their role"*. To further support this theme one participant made the following statement, *"Carer consultants have often taken on the peer role with clients as there is not enough carer work for a fulltime carer consultant"*. Staff reported that conflict has arisen between clinicians and LEW staff regarding giving advice which opposed the direction of the treating team. For example, *"We have had experience of the peer specialist discouraging taking medication"* and *"Peer specialists give staff advice rather than follow the direction of staff within the unit"*. Clinicians and managers suggested that these difficulties could be overcome with clearer role descriptions and more education for clinicians and LEW staff.

Summary

Overwhelmingly, of the 46 clinicians and managers that responded to the qualitative questions, the responses were positive. LEW staff were perceived as improving outcomes for individuals and their families through providing additional support to consumers and carers and providing a unique empathy and understanding. Most clinicians also perceived peer specialists and carer consultants as being able to role model and mentor recovery and wellness for consumers and families as well as the clinicians themselves. Many clinicians also articulated the view that peer specialists and carer consultants had enhanced clinicians' abilities to carry out their roles in a recovery oriented framework through increasing their understanding of consumer and carer perspectives and improving communication between clinicians and consumers and clinicians and carers. The main challenges that needed to be addressed according to clinicians were role clarification for the LEW staff as well as clinicians and education for clinicians regarding function, purpose, benefits and scope of the roles.

The results from both the survey, filled out by 58 clinicians/managers, and the qualitative data provided by 46 clinicians/managers, illustrates that peer specialists and carer consultants were perceived as enhancing service delivery and are a valued part of South Australian mental health service delivery. Feedback illustrates the positive impact they have on consumer care and the support provided to carers/families. Some clinicians and managers have particularly highlighted the impact they have had on specific services and how this has enhanced service delivery and therapeutic care. The qualitative data supports the positive results in the quantitative data, providing further evidence of the effectiveness of the LEW within mental health services, with a significant increase in the perceived value of the LEW program since the initial evaluation[9]. These positive results support findings from other studies[12 6 9].

Objective 4: Assess peer specialists' and carer consultants' overall perception of the program and roles

To understand the perspective of peer specialists and carer consultants towards the LEW program, a questionnaire was distributed to a sample of LEW staff members with questions that explored any issues that had arisen in their experience. Participants (N=12) were asked to circle the alternative that best applied to them in regards to a number of statements on a 5 point Likert Scale ranging from 1 = strongly disagree to 5 = strongly agree. The statements and results are shown in Table 6.

Table 6: Questionnaire responses from LEW staff about their roles and the program

Statement	M	SD
The lived experience orientation program adequately prepared me for my role within the acute/rehabilitation unit settings.	3.75	.75
As part of my role I receive ongoing training and development: this enhances my skills, knowledge and abilities to carry out my role.	3.83	1.19
I am well supported within my role by the unit I work on and from the program as a whole.	4.50	.67
As a lived experience staff I am valued as a member of the multidisciplinary team within the units where I work.	4.17	.84
As lived experience staff my role is understood by the clinical team, consumers and carers within the units I work.	3.58	.90

From Table 6, it is clear from the high mean value that LEW staff felt supported by the wards they worked in and felt valued within the multidisciplinary team.

The results from the questionnaire also demonstrate that peer specialists and care consultants on the whole feel well supported by the LEW program within mental health services. Initial orientation on commencement of the roles is an area that LEW staff felt needed to be improved with some staff reporting that the orientation program didn't adequately prepare them for their roles within mental health services.

Ongoing training and development is another area that LEW staff felt there was a need for further development to improve their work within mental health services. This demonstrates a need for the LEW management to review current training and development in conjunction with LEW staff and their supervisors on the units to more adequately meet their needs. All training and development should also be evaluated continuously to better inform ongoing development.

The final area for improvement from the LEW staff perspective is how they felt their roles are understood by the clinical team, consumers and carers. To enhance this, the LEW program needs to review ongoing staff training about the roles of LEW and how they fit within the multidisciplinary team. Promotion of the role through the use printed media and communications should also be considered.

Objective 5: Explore lived experience workforce strengths, challenges and future development

A critical aim of the research was to pool together the opinions of all stakeholders to provide an overall picture of what is working well and what areas could be enhanced. To address this aim, separate focus groups of supervisors and LEW staff were established.

LEW staff focus group

Topics explored during the focus group included:

- the orientation program for LEW staff
- ongoing training and development
- whether the LEW felt well supported in their roles within the units and the program
- whether the LEW felt they were a valued part of the multidisciplinary teams
- whether the LEW felt their roles were clearly defined and understood by clinicians, consumers and carers
- how the LEW program could better support staff in their role.

Methodology

All peer specialist and care consultant staff were sent a formal invitation to attend the focus group and a copy of the questions that would guide the discussion. When staff arrived, the purpose of the focus group was clearly articulated and participants were assured that their feedback would be totally confidential with no identifying information being collected. All participants were told their participation was voluntary and that they were free to leave at any time. Participants were told that the findings from the focus group would be utilised to assist management to further develop and improve the program in the future. Each participant was given a series of printed questions with space provided to respond. A discussion was held on each question with the facilitator writing comments on a white board as each area was discussed. The facilitator then asked people to consider the comments discussed and to write the ones important to them on their worksheet.

The facilitator offered the opportunity for LEW staff to facilitate one or more of the questions and one carer consultant and one peer specialist took up this offer and facilitated questions. This worked well as everyone felt involved and everyone who wanted the opportunity to facilitate one or more of the questions got to do so. In total six peer specialists and four carer consultants attended and participated in the focus group.

In terms of what is working well, participants reported that the LEW staff orientation program was beneficial in preparing them for their roles and for facilitating working relationships with other lived experience workers. The ongoing education program provided an opportunity for staff to meet their LEW colleagues, provide peer to peer support and to enhance their skills.

Areas that were identified as needing to be improved were a lack of job/role clarity, for example, the orientation program did not cover how to facilitate groups or how to work as part of the multidisciplinary team. Additionally, it was suggested that the program could be improved if there was a peer specialist or carer consultant manual developed to guide practice, and to develop a unified program that LEW workers could access and utilise at any time. Participants felt that there was a lack of evidence-based practice utilised within the program across the multiple units as well as a need to evaluate the work LEW staff do on a daily basis.

With respect to the ongoing training program there was no agreement about what topics should be covered as staff have different levels of knowledge.

In terms of feeling supported in their roles both peer specialists and carer consultants who attended the focus group reported that they were unsure who to get assistance from if they were having difficulties with their roles and required extra support. Some LEW staff reported they felt unsupported and undervalued by the senior lived experience worker as well as their day to day supervisors on the units. Some staff were unclear on whose role it was to support them when struggling with their roles. There was a particular emphasis on a lack of ‘hands-on’ guidance. One person suggested that this could be overcome with a peer worker buddy system, such as a mentoring program.

One person commented that the unit or ward she worked in was not informed about her role and they were not prepared for her to start working with them. LEW staff felt they understood their roles themselves and appreciated the flexibility in the role, but also suggested that this may be a reason why other non-peer staff do not understand the role. One suggestion to deal with this was a revision of the job and person descriptions and another was education of clinical staff across mental health services. There was also a consensus that a clear pathway for communicating with senior staff and supervisors should be established to resolve ongoing issues. This was particularly important for supervision, as most participants felt that the definition of supervision was not clear and that it should be regular and consistent. Most participants believed there was a lack of career development opportunities for LEW staff and this was a financial and personal concern.

Overall, in response to how they felt within the multidisciplinary team, most LEW staff felt supported, however, some believed that their role was undervalued by some supervisors. Some felt that particular staff members were reluctant to work with them and that their role was not being explained to all consumers, thus not all consumers were given the opportunity to access LEW staff. One particular suggestion was that there should be ‘backfill’ casual staff to cover holidays and sick days. Currently, there is no one to cover if a LEW staff member is away which makes them feel as if their role is not valued.

Discussion of overall findings from the focus group conducted with peer specialists and carer consultants within the MHD

The purpose of conducting a focus group with peer specialists and carer consultants was to explore LEW staff's perceptions of their roles and the overall LEW program and seek further clarification on what's working well, what's not working as well as it could and how the MHD can enhance the program. The focus group highlighted similar results to the qualitative findings from the research. However, the focus group has provided more detail on the areas the service needs to focus on for future development of the LEW program and staff.

Overall recommendations from LEW staff to enhance the LEW program

1. Provide orientation for all new staff.
2. Develop a peer buddy system for new LEW staff.
3. Review of ongoing training and development to be designed, in conjunction with all stakeholders including LEW staff and clinicians.
4. Explore evaluation and evidence based practice.
5. Provide enhanced support when needed, including the development of clear support structures, documented as guidelines, in conjunction with all stakeholders.
6. Offer a choice of training topics.
7. Develop a training manual.
8. Facilitate LEW staff peer to peer training in order to utilise own lived experience and enable LEW staff to feel confident in their roles.
9. Provide training in running groups and working with individuals, such as sharing recovery stories in empowering ways and how to work in partnership with other service staff.
10. Enhance support for those that require it and provide clarity over whose role is it to support LEW staff. For example, line managers, ward supervisors or managers of the overall program.
11. Provide an improved supervision structure and support for both supervisors and LEW staff to ensure supervision is effective and useful.
12. Educate all clinical multidisciplinary team members regarding consumer participation and the LEW.
13. Consider implementation of a casual pool to provide backfill. Shift work to be considered.
14. Review job and person specifications in consultation with LEW staff, supervisors and clinicians to ensure it is relevant to the needs of the unit a lived experience worker is engaged in.
15. Enhance career development opportunities for LEW staff.
16. Increase opportunities to be engaged in service improvement of the program and mental health services overall.

Supervisors' focus group

Topics explored during the focus group included:

- LEW as valued members of the multidisciplinary team
- understanding of the LEW's roles by clinicians, consumers and carers
- supervision and accountability
- their role as a supervisor of LEW staff
- how well the LEW roles are defined
- how the MHD can better support the LEW.

Clinical service coordinators (CSC) who supervise peer specialists and senior social workers who supervise care consultants were invited to attend the focus groups. They were provided with a copy of the questions intended to guide the discussion and given the opportunity to respond via email if they wished. Two supervisors attended the focus group and six others provided feedback via email.

CSCs' articulated a belief that LEW staff add value to the team when they have a good knowledge base and have clear boundaries about their role. There was a consensus that staff who felt that the LEW role was not valued or understood was a result of a lack of information about the LEW role and some people felt the LEW role was not well integrated into the team. Suggestions for how the value of LEW could be better conveyed to all staff included greater partnerships between LEW staff and the program management team and more detailed resources which explained the role.

One particular area of feedback was regarding appropriate documentation by peer workers to communicate who they are seeing and what information was being discussed in their group sessions.

Some participants reflected that the supervision process for LEW workers could be more inclusive and include the LEW staff member, a senior peer specialist or carer consultant and the unit manager. There was a consensus that while some supervisors believed they were working well in an informal capacity there needed to be a formal supervision framework. Supervisors noted that there needed to be clear, formal performance management guidelines. Some units experienced long periods of time without a LEW staff member as there were no guidelines regarding who was responsible for managing backfill of staff and what process that involved. Supervisors emphasised that all vacancies should be filled as soon as possible so as not to interrupt the service provided by LEW. Supervisors reflected that generally mental health services' supported peer workers if they became unwell, but there should be more encouragement for the LEW staff and other non-peer staff to access the Employee Assistance Program if they needed support.

Supervisors suggested they should be involved in the selection process for new LEW staff. They felt that this may improve the job-person fit if suitable staff were selected by the supervisors for the specific ward. Supervisors suggested that LEW staff should be on the interview panels for all staff employed by the service and present at all levels of service planning and delivery to provide a consumer perspective. They thought that the service would benefit from the development of full-time positions as this would provide greater access for consumers and other staff.

Overall recommendations from supervisors of LEW staff to enhance the LEW program

1. Enhance role clarity and provide further education to staff on the role of the LEW.
2. Improve documentation procedures for LEW staff.
3. Enhance the LEW program management support and partnership with supervisors.
4. Develop printed media resources (for example, posters and fact sheets) on the role of the LEW.
5. Increase allocated full time employment (FTE) of LEW staff for each service.
6. Improve vacancy management for the LEW and provide clear guidelines on backfilling positions.
7. Review and redevelop the supervision framework for lived experience roles including LEW specific supervision.
8. Improve the definition of supervision of the LEW and how this differs from line management.
9. Improve integration of the LEW as part of the multidisciplinary team and partnership with other staff.
10. Involve supervisors in the recruitment of the LEW in their units.
11. Increase involvement of LEW staff in planning and developing mental health services.

4. Conclusion

The LEW, made up of peer specialists and carer consultants, assists consumers and carers to develop skills and strategies to support them, or the person they care for, on their recovery journey while providing hope that it is possible to live a meaningful life in spite of having a mental illness. Clinical staff benefit as the introduction of peer workers may challenge their intrinsic beliefs and assumptions of people with mental illness. Clinicians who work alongside peer workers can be assisted to move toward the concept of personal recovery in their practice[8].

This research demonstrates that peer specialists and carer consultants in the LEW have been successful in providing support for consumers with mental illness and their carers. The focus of this research was to ask people who have experience of the LEW program to evaluate the program as people using the system can offer sensible advice about how to make it better. This research builds upon a previous evaluation of the peer workforce which concluded that non-peer staff had difficulties with the selection, training and supervision of peer workers and that the peer worker role was underutilised and misunderstood.

The current research found that non-peer clinical staff had a positive appraisal about the program but there was still a need for further clarification about the role of LEW and what role they have within the multidisciplinary team. Role clarification is strongly tied to education to all staff about what services LEW can provide as this will assist in the further integration of the LEW into the multidisciplinary team. There were some concerns raised by clinical staff about the ongoing wellness of LEW and their access to medical records. These concerns could be dealt with more effectively within a structured supervision system in which open communication can occur.

From the point of view of LEW staff, most feel that their work is valued by consumers and the majority of clinical staff. The areas that they would like to see improved include ongoing education and training, an ongoing mentoring system and the development of a training manual to outline what is involved in the work. There is a clear need to review the job and person specifications to ensure that all staff know what is expected of them. In particular, peer workers believe that they should have career development opportunities including the ability to move up the pay scale and up-skill as other staff in their multidisciplinary team are able to. They would like opportunities to be involved in evaluating and improving the service and opportunities for career development. The themes highlighted throughout the results are common across the literature.

This research has contributed to the existing literature on peer work in mental health services. The recommendations which resulted from the quantitative and qualitative research outline the next steps for improving the current service. Future research should consider reviewing the progress on education and role clarity.

5. Recommendations

The following recommendations were developed based on the qualitative and quantitative data from the LEW, clinicians, managers, carers and consumers as well as the qualitative data from the LEW and supervisors' focus groups.

The recommendations are focused into four areas:

- Role clarity.
- Training and development.
- Resourcing.
- Supervision.

5. Recommendation 1: Role clarity

   5.1. Increase education at a local level via regular in-services and at a service level with all orientation and staff training to include sessions on the roles of peer specialists and carer consultants within mental health service delivery.

   5.2. Develop print based advertising on the LEW within each unit that is visible to consumers, carers and staff. This may include posters, fact sheets and handouts.

   5.3. Further develop the LEW role, the hours and days they work and how to access them within each service.

   5.4. Further develop LEW specific policies and procedures including but not limited to supervision and medical records. To be developed in conjunction with all stakeholders and distributed via service wide bulletins and accessible via the intranet.

6. Recommendation 2: Training and development for the LEW

   6.1. Review of ongoing training and development programs involving LEW staff to provide more effective training and development which better meets the needs of the LEW.

   6.2. Develop an orientation program specific to the LEW and deliver to all new lived experience staff, clinical staff and managers.

   6.3. Develop an orientation and training manual for LEW staff in partnership with the LEW, clinical staff and managers.

   6.4. Use evidence based training and ongoing evaluation of training to review the effectiveness in supporting role development.

7. Recommendation 3: Staff resourcing and job and person specifications

   7.1. Review the current 0.5 FTE (full time equivalent) positions for lived experience staff to determine if services are adequately resourced.

   7.2. Review the current job and person specifications to better describe the LEW roles with adaptation to individual services employed.

   7.3. Explore further career development opportunities for LEW staff.

   7.4. Fill LEW staff vacancies as soon as possible to provide an ongoing service to consumers and carers with minimal interruptions.

7.5. Involve supervisors and program coordinators to manage the selection process for new LEW staff.

7.6. Develop a casual pool of LEW staff to cover absences.

7.7. Involve lived experience staff in in-services and unit based development of policies, procedures and local work instructions.

8. Recommendation 4: Supervision and line management

8.1. Implement lived experience specific supervision and mentoring. Consider the use of a peer buddy system to help orientate new staff.

8.2. Utilise more experienced peer specialists and carer consultants to provide training and support to new staff.

8.3. Develop procedural guidelines for documentation and supervision, including a clearer definition of supervisors compared to direct line management.

8.4. Enhance support offered to LEW staff when required, within a defined support structure. Procedures to be developed in conjunction with all stakeholders.

8.5. Enhance program management support from the coordinators of the lived experience program and enhance partnerships with the supervisors/line managers of LEW staff.

8.6. Provide supervision training to supervisors of lived experience staff by program coordinators. Consider reviewing other areas that provide lived experience specific supervision training as a resource to develop evidence based training and practice.

6. Appendix

Appendix A - Lived experience worker survey

Government of South Australia
SA Health

The Lived Experience Staff Orientation Program adequately prepared you for your role within the acute and or/ rehabilitation unit settings.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

As part of my role I receive ongoing training and development; this enhances my skills, knowledge and abilities to carry out my role.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

I am well supported within role on the units and within the program.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

As lived experience staff I am valued as a member of the multidisciplinary team within the units where I work.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

As lived experience staff my role is understood by the clinical team, consumers and carers within the units where I work.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Appendix B - Consumer survey of peer specialists

Government of South Australia
SA Health

1. Do you remember working with a peer specialist? Yes No
   a. Were you aware of a peer specialist on ward? Yes No
   b. Were you offered services by a peer specialist? Yes No

2. How good was the peer specialist at ... (Please circle appropriate answer).
   a. Increasing your understanding of the symptoms you experience
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   b. Sharing their personal coping strategies
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   c. Helping you identify your own coping strategies
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   d. Increasing your sense of hope for recovery
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   e. Helping you feel supported
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   f. Encouraging you to manage your symptoms on a daily basis
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good
   g. Connecting you with community resources
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

3. Did you find anything different/special about working with a peer specialist in comparison to other staff?

4. What would make the peer specialist service even better?

_____

_____

_____

5. In addition to the peer specialist, were you aware of a carer consultant on the ward? Yes No

Appendix C - Carer survey of carer consultants

Government of South Australia
SA Health

1. Do you remember working with a carer consultant? Yes No
   a. Were you aware of a carer consultant on ward? Yes No
   b. Were you offered services by a carer consultant? Yes No

2. Did you receive an information package advising you of support options for your particular needs?
   Yes No

3. How good was the carer consultant at… (please circle the appropriate response)
   a. Assisting you to learn about the hospital system
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

   b. Explaining the Well Ways program
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

   c. Helping you feel supported
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

   d. increasing your sense of hope for your relative's or friend's recovery
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

   e. At reducing your distress by sharing their coping strategies
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

   f. Helping you identify and build upon your personal coping strengths in your caring role
      0 = very poor 1 = poor 2 = acceptable 3 = good 4 = very good

4. Did you find anything different/special about working with a carer consultant in comparison to other staff?

_____

_____

_____

5. What would make the carer consultant service even better?

_____

_____

_____

6. In addition to the carer consultant, were you aware of a peer specialist on the ward? Yes No

Appendix D - Survey about peer specialists for clinicians and managers

Government of South Australia
SA Health

I see the benefit of peer specialists working with the acute/rehabilitation units.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

I understand the role peer specialists have in promoting consumer recovery.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Peer specialists model personal recovery and positive coping strategies.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Peer specialists enhance a consumer's connection to community resources and the clinical team.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Peer specialists working within acute/rehabilitation mental health units benefit other unit staff.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

A peer specialist sharing positive coping strategies reduces consumer distress.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Peer specialists help consumers navigate mental health services.

Strongly disagree 1_____2_____3_____ 4_____5 Strongly agree

Questions about lived experience staff for clinicians and managers

Have any benefits resulted from having a peer specialist and/or carer consultant working within the acute and rehabilitation mental health units?

Have any difficulties arisen from having a peer specialist and/or carer consultant as part of the multidisciplinary team within the acute and rehabilitation mental health units?

If difficulties have arisen, how do you perceive these difficulties could/ or have been resolved?

Please provide any additional comments, suggestions and experiences with regards to peer specialists and/ or carer consultants.

Appendix E - Focus group questions: Lived experience workforce

Focus group

Lived experience workforce

The focus group was conducted with peer specialists and carer consultants to further explore the areas identified below. Supervisors were asked to answer the following questions in three themes; what's working well, what's not working as well as it should and what is missing that would make a positive difference.

1. Did the Lived Experience Workforce Staff Orientation Program (2010) adequately prepare you for your role within the acute and/or rehabilitation unit settings?
2. Does the ongoing development and training program (one day x eight weeks) enhance your skills, knowledge and abilities to carry out your role?
3. Do you feel well supported within your role on the units and within the program?
4. As a lived experience staff member do you feel valued as a member of the multidisciplinary team within the unit(s) you work?
5. Do you feel your roles are clearly defined?
6. As a lived experience staff member do you feel your role is understood by the clinical team, consumers and carers within the unit(s) you work?
7. How can the MHD better support the lived experience workforce?

Appendix F - Focus group questions: Supervisors and line managers of the lived experience workforce

Focus group

Supervisors of lived experience workforce

The focus group was conducted with peer specialist supervisors (clinical service coordinators) and carer consultant supervisors (senior social workers) to further explore the areas identified below. Supervisors were asked to answer the following questions in three themes; what's working well, what's not working as well as it should and what is missing that would make a positive difference.

1. Do you think lived experience workforce staff members are valued as members of the multidisciplinary team?
2. Do you think lived experience workforce roles are understood by the clinical team, consumers and carers within the unit(s) you work?
3. Are you satisfied that the supervision and accountability framework for the lived experience workforce adequately prepares you in your role as supervisor for either the peer specialists (CSCs) or carer consultants (senior social workers)?
4. In the context of your role as supervisor for either a peer specialist or a carer consultant, what's working well, what's not working as well as it should and what is missing that would make a positive difference what is not working as well as it should.
5. Do you feel the roles of peer specialist and carer consultant are clearly defined?
6. How can the MHD better support the lived experience workforce?

7. References

1 Repper, J. & Carter, T. (2011) A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392-411.

2 Davidson, L., Bellamy, C., Guy, K., Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World*, *11*(2), 123-128.

3 Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*, *10*(2), 29-37.

4 Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia bulletin*, *32*(3), 443-450.

5 Orwin, D. (2008) Thematic review of peer support: literature review and leader interviews. Mental Health Commission, Wellington, New Zealand.

6 Lawn, S., Smith, A., Hunter, K. (2008) Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health, 17*(5), 498-508.

7 Nestor, P., & Galletly, C. (2008). The employment of consumers in mental health services: politically correct tokenism or genuinely useful?. *Australasian Psychiatry*, *16*(5), 344-347.

8 Slade, M. (2009) Personal Recovery and Mental Illness. A Guide for Mental Health Professionals, Cambridge University Press, United Kingdom.

9 Kling, L.W., Dawes, F.J., Nestor, P. (2008). Peer specialists and carer consultants working in acute mental health units: An initial evaluation of consumers, carers and staff perspectives. *International Journal of Psychosocial Rehabilitation*, *12*(2), 81-89.

10 Rivera JJ, Sullivan AM, Valenti SS. Adding consumer-providers to intensive case management: does it improve outcome? Psychiatric Services 2007; 58: 802-809.

11 Yanos PT, Primavera LH, Knight EL. Consumer-run service participation, recovery of social functioning, and the mediating role of psychological factors. Psychiatric Services 2001; 52: 493-500.

12 Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. Psychiatric Rehabilitation Journal 2004; 27: 392-401.

13 Nelson, G., Ochocka, J., Janzen, R., Trainor, J., Goering, P, Lomorey, J. (2007) A Longitudinal Study of Mental Health Consumer/Survivor initiatives: Part V- Outcomes at 3-year follow-up. Journal of Community Psychology. *35*(5), 655-665.

14 Min, S., Whitecraft, J., Rothband, A. B., Salzer, M. S. (2007). Peer Support for Persons with Co-Occuring Disorders and Community Tenure: A Survival Analysis. Psychiatric Rehabilitation Journal. Vol 30, 3, 207-213.

15 Hodges JQ, Hardiman ER. (2006) Promoting healthy organizational partnerships and collaboration between consumer-run and community mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 267-278.

16 Peters, J. (2010)Walk the Walk and Talk the Talk: A summary of some peer support activities in IIMHL countries. The National Centre for Mental Health Research, Information and Workforce Development, New Zealand.

17 Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, *23*(4), 333-341.

18 Glover, H (2005). Recovery based service delivery: are we ready to transform the words into a paradigm shift? *Australian e-Journal for the Advancement of Mental Health, 4*(3).

19 Marsh, D. T. (1992). *Families and mental illness: New directions in professional practice*. New York: Praeger.

20 Hatfield, A. B., & Lefley, H. P. (Eds.). (1987). *Families of the mentally ill: Coping and adaptation*. Guilford Press.

21 Senate Select Committee on Mental Health. *A national approach to mental health: from crisis to community.* First report, March 2006. Commonwealth of Australia 2006.

22 Australian Government. (2010). National Standards for Mental Health Services. Commonwealth of Australia, 2010.

23 Parker, R., Leggatt, M., Crowe, J. (2010) Public interest and private concern: the role of family carers for people suffering mental illness in the twenty first century**.** *Australasian Psychiatry, 18*(2), 163-166.

24 National Mental Health Peer Workforce Forum: Identifying and prioritizing peer workforce development needs. (February, 2011) Sydney, NSW.

25 Department of Education, Employment and Workplace Relations. Report: CHCPW601A Establish and maintain mental health peer work. Approved May, 2012. Commonwealth of Australia.

26 Roberts, G. & Wolfson, P. (2004).The rediscovery of recovery: open to all. Advances in Psychiatric Treatment 10, 37–49.

27 McDonald, J. (2010) Consumer Workers' Forum Project Literature Review on the Mental Health Consumer Workforce. The New South Wales Consumer Advisory Group, New South Wales, Australia.

28 Miyamoto, Y.Y., Sono, T.T. (2012). Lessons from peer support among individuals with mental health difficulties: a review of the literature. Clinical Practical Epidemiology of Mental Health.

29 Lakeman, R. (2008)Practice standards to improve the quality of family and carer participation in adult mental health care: An overview and evaluation International Journal of Mental Health Nursing (2008) 17, 44–56.