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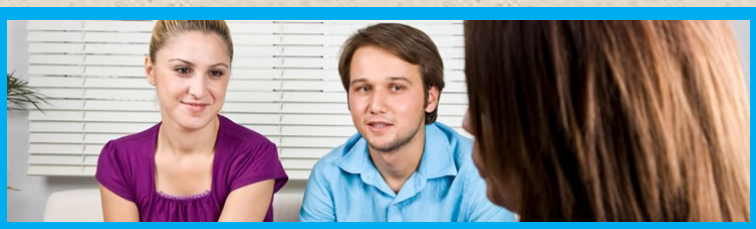

Establishing an effective peer workforce
A literature review

Prepared for the Frankston Mornington Peninsula Mental Health Alliance

by the Mind Australia Research, Development & Advocacy Unit

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PSS road to recovery Peninsula Support Services

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Glossary of terms

Carer
For the purposes of this literature review a carer is a person who "provides practical and emotional support to someone with a mental health issue including relatives, friends or neighbours. A carer may or may not live with the person they support; nor do they have to be identified by the individual with a mental illness as their 'carer'" (Clements, 1996 in Bartolo & Sanders, 2008).

Consumer
A person who has used or is currently using public or private mental health services, also known as service user, service recipient, or user/survivor.

Consumer/carer consultant
Consumer or carer consultants are individuals with a lived experience employed by mental health services in Victoria to promote inclusion of consumer perspectives in service delivery, and apply a systemic advocacy approach to improve service quality and responsiveness.

Lived experience
In the mental health context and for the purposes of this paper, 'lived experience' refers to an individual who has direct experience of mental health challenges, as either a consumer or carer/family.

Mutual support
"A process by which persons voluntarily come together to help each other address common problems or shared concerns" (Davidson et al., 1999).

Peer support
Peer support in mental health is a form of support provided by individuals with a personal lived experience as a consumer or carer, who are trained to use their experiences to support others to recover (Slade et al., 2014).

Peer support is one type of peer work. It is based on the premise that connecting with others that have had "the same or similar experiences can lead to a sense of genuine empathy and shared understanding, to reassurance and hope" (Basset, Faulkner, Repper & Stamou, 2010).

Peer worker, peer workforce
Peer workers are defined as people who are employed in roles that require them to identify as being, or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness and recovery is an essential criterion of job descriptions, although job titles and related tasks may vary (Mental Health Coordinating Council, 2011 in HWA, 2013b).

For the purposes of this paper, broad reference to peer workers or the peer workforce includes peer support (direct support work) positions, as well as systemic advocacy roles such as consumer or carer consultants.

1. Introduction

> *"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships."* (Mead, Hilton & Curtis, 2001)

> *"There are three major rationale that support the development of the service user workforce in the mental health sector. Philosophically it is the ethical thing to do. On a pragmatic level it is the sensible thing to do. On a policy level it is the expected thing to do."* (Mental Health Commission, 2005).

Recent years have seen significant, high level recognition for peer support as an important element of holistic mental health care; however, there has not necessarily been a concurrent rise in understanding around the core values of peer support, the range of services available, and what they can achieve. Despite growing evidence of the benefits associated with peer work, Australia's peer services have not developed to the extent they have elsewhere (Health Workforce Australia, 2013a).

As with any paradigm shift, introducing peer workers into a mental health service is a complex undertaking – one that requires staff at all levels to be willing to challenge long-held beliefs and practices regarding the nature of mental health expertise. In a sense, this is as it should be. Peer support services offer something new to the mental health sector, and indeed if they did not, why develop them? Peer support fundamentally challenges existing modes of service delivery and their underlying assumptions, in the interest of better outcomes for service users. This means that any provider seeking to develop peer services must be willing to recognise that it is not an "overnight" process (Repper, 2013).

There is now a growing body of literature that identifies best practice for integrating peer support work into existing mental health services as smoothly as possible. International experience has identified the typical challenges and barriers to this process, as well as strategies for minimising them. Key to the process is ensuring high levels of executive support; this is absolutely critical to driving the significant organisational change that is inherent in the implementation of a robust peer workforce. The recommendations are consistent across the literature, and provide a set of clear 'non-negotiables' for creating a sustainable and effective peer workforce.

This literature review will explore these themes in the context of the Frankston Mornington Peninsula catchment area, and provide a framework for progressing options in the best practice development of the Frankston Mornington Peninsula Mental Health Alliance (FMPMHA)'s peer workforce.

1.1 Project purpose

The purpose of this literature review is to provide a review of the evidence base for developing an effective, sustainable peer workforce for the Frankston Mornington Peninsula Mental Health Alliance. This review will assist FMPMHA to plan for the development of a peer workforce, in line with FMPMHA's work plan for the *Development of a Peer Support Workforce* project (see Appendix A). In so doing, the following areas will be addressed:

- Frameworks for peer work drawn from world leading practice
- Types of peer roles, including education, advocacy, direct support and others
- Role definition and competencies for peer workers
- Career structures and advancement for peer workers
- Good practice in training, supervision and management of peer workers
- Models of peer work/practice, and examples of peer practice across clinical and community settings

1.2 FMPMHA context & service settings

In discussion between the authors and members of the working group for FMPMHA's Development of a Peer Support Workforce Project, the following characteristics of mental health service delivery across the Frankston Mornington Peninsula have been identified as central to workforce development for this catchment area.

FMPMHA

- Frankston Mornington Peninsula comprises a significant geographic area across the two Local Government Areas of Frankston, and Mornington Peninsula Shire
- The Frankston Mornington Peninsula Medicare Local (FMPML) works with General Practice, Allied Health and community health care providers to drive improvements in primary health, to ensure that services are best tailored to meet the needs of Mornington Peninsula communities (FMPML website, retrieved 21 February 2014)
- FMPMHA is comprised of the following services operating within the FMPML catchment:
    - Peninsula Health Mental Health Service
    - Peninsula Drug and Alcohol Program (PenDAP)
    - Mental Illness Fellowship Victoria
    - Mind Australia
    - Peninsula Support Services Inc
    - Impact Support Services
    - Headspace
- A key strength of FMPMHA is the collaborative relationships that function effectively across clinical and community service staff in the region

Peer workforce

- Staff that currently comprise the FMPMHA peer workforce generally work in isolated roles (i.e. not in close proximity to support of other peer workers)
- Many peer roles are part-time, thus increasing the impact of geographic constraints, for example in travelling long distances to attend meetings with colleagues, or peer training opportunities that are currently based in Melbourne etc.
- There are currently no peer workers operating in FMPMHA clinical settings, with a goal to establish same as part of the Peer Support Workforce Project

To address the challenges of working across a regional and remote service area, FMPMHA have identified the need for an FMP-based peer network. Ideally, this network will be able to sustain enhanced support between peer staff, localised peer training delivery, supervision structures and robust workforce development. FMPMHA recognise that supporting significant cultural changes within the region's mental health services is a key element of local peer workforce development. This includes building a better understanding of peer support work as a model of care, for all staff and particularly managers working in the region.

The above listed considerations and objectives of the FMPMHA peer workforce will thus form a central focus of this literature review and subsequent implementation strategies.

2. Methodology

The Critical Appraisal Skills Programme (CASP) appraisal tool was used to select a range of high quality articles, spanning published papers and grey literature (e.g. papers and reports that do not appear in academic journals and service evaluations). Recent (2005 – 2014) and local evidence was prioritised, as was evidence from health service delivery systems similar to that of FMPMHA. Examples of peer-led services have been included where relevant, e.g. as examples of effective models for service delivery.

This literature was then summarised to present an evidence-based framework for the development of the FMPMHA peer workforce. Key models, values and skills required for peer work are presented, followed by a discussion of issues faced by this workforce. Based on the literature and professional experience of the authors and their networks, recommendations are presented throughout the document for FMPMHA to consider as effective strategies for integration of a sustainable and robust suite of peer programs.

3. Service map: Frankston Mornington Peninsula

Appendix (B) to be attached – FMPMHA contribution

4. Literature Review

4.1 Evidence base for peer work

"…Given appropriate training, support, supervision, and development opportunities, peer workers will be their own best advocates" (Repper, 2013).

There is a growing evidence base to support the continued implementation and development of peer support services across the FMPMHA catchment area. Broadly, accessing peer support services has consistently been found to be at least equally as effective as traditional professional support services alone; in a number of studies peer support has been found to enhance service user outcomes in various indicators/measures of recovery when used as an adjunct to traditional care (Repper & Carter, 2011).

Research shows that accessing peer support services leads to a reduction in hospital admissions for consumers (Lawn, Smith & Hunter, 2008; Sledge et al., 2011), increased self-esteem, self-efficacy and greater social networks, and lessens the impact of stigma on both consumers and carers (Ochaka et al., 2006 in Repper & Carter, 2011) .

In an Australian study, Lawn, Smith & Hunter (2008) undertook an evaluation of the first three months' operation of a peer support service that aimed to provide hospital avoidance and early discharge for adult consumers. It was found that 300 bed days were saved over the 49 service packages provided, equivalent to a saving of over $90,000 for the health system. In addition, feedback from all key stakeholders – consumers, family/carers, mental health staff and the peer support workers – was identified as being "overwhelmingly positive" (Lawn, Smith & Hunter, 2008).

Similarly, Sledge and colleagues conducted a study investigating the impact of peer mentors on reducing readmissions for consumers with multiple hospitalisations (2011). In a randomised control study, participants (consumers who had had three or more psychiatric hospitalisations in the preceding eighteen months) were assigned to either usual care alone, or usual care with the addition of peer mentor support. It was found that those assigned peer mentors had significantly less rehospitalisations than the control group at nine-month follow-up (Sledge et al., 2011).

In reviewing the evidence base, it is important to consider what is unique about peer support – what interventions and outcomes can only be achieved, or be achieved more effectively, by people with a lived experience? In attempting to answer these questions, Davidson, Bellamy, Guy and Miller (2012) found three areas unique or particularly suited to, peer support work:

- Providing hope through positive self-disclosure
- Role modelling self-care and skills for negotiating daily life (e.g. living on a low income; unstable housing; making sense of trauma; negotiating service systems)
- The peer support relationship, including worker's ability to empathise directly and immediately (Davidson, Bellamy, Guy & Miller, 2012)

This is consistent with findings from Repper and Carter's broad review of the peer support research (2011), that identified a particular strength of peer support staff as being more effective and efficient in building trusting relationships with service users, when compared to professional health staff (Repper & Carter, 2011).

Outcomes identified for service users, families/carers, health systems and staff (peer workers and other mental health staff) in these and similar studies have potential implications for the development of the FMPMHA peer workforce. See the *'Models of peer work'* and *'Peer work roles'* sections of this review for further information about the range of peer support interventions to consider.

4.2 Benefits for peer support workers

In addition to benefits for service users, families/carers and mental health services, it has also been found that peer support services directly benefit the peer support workers themselves. Moran and colleagues (2012) undertook research to explore such benefits, and identified several areas of personal benefit as reported by peer workers in the study. Benefits to peer workers may thus include:

- Increased understanding and awareness of one's own mental health issues
- Enhanced knowledge of self-care and practice of self-care behaviour
- Improved self-image and self-acceptance
- Development of identity as a peer worker
- Feeling respected as a professional
- Empowerment
- Personal growth
- Reduced hospitalisations and need for mental health services
- Improved relationships and social networks

Importantly, peer support workers also reported that employment in their profession had assisted them to make meaning of their experiences, and positively re-author their personal narratives (Moran et al., 2012).

However, it is important to note that such benefits are unlikely to occur in instances where peer staff are not provided adequate training and support, or if they are employed within organisations that have failed to carefully consider the implementation process for integration of new peer support services. Based on their findings and consistent with other literature, Moran et al conclude by exploring implications for services in terms of workforce development and support; see *'Service integration'* and *'Common challenges'* sections for how such implications apply to FMPMHA.

4.3 Values base

The rationale for clearly articulating a values base for peer support work points to several key factors:

- To retain the integrity of peer support and ensure roles remain true to a peer support ethos;
- To assist with clarifying the role and identity of peer workers;

- To create a foundation for the ongoing development of peer support roles and services;
- To assist in building a better understanding of peer work (Scottish Recovery Network, 2012)

At an organisational level, it is important to ensure clearly articulated values for peer support programs that align with the organisation's broader vision, mission and values (Mutual Support and Self-Help Network, 2011). While a national framework is yet to be developed in Australia (HWA, 2013a), a number of peer organisations and theorists have identified a set of core values that are common across the literature (International Association of Peer Supporters, 2013; MacNeil & Mead, 2003; O'Hagan, 2009, & Scottish Recovery Network, 2012).

Fundamental to peer support work is recognition that there is value in the lessons that can arise from experiences of mental distress. As such, peer values are likely to emphasise the existing wisdom, expertise, and strengths of clients. Core values of peer support work include:

- Equality and empowerment
- Mutuality and reciprocity
- Self-determination
- Strengths-based
- Respect
- Hope
- Honesty and transparency
- Learning over helping
- Empathy
- Compassion
- Flexibility
- Responsibility
- Authenticity

O'Hagan (2009) argues that it is essential for organisations employing peer workers to be familiar and aligned with these values in order for peer work to flourish and sustain itself. If not, peer workers risk compromising their own professional values in order to 'fit in' with colleagues and the broader work environment (O'Hagan, 2009).

4.4 Consumer and carer peer workforce

Formal peer support services have been provided by grassroots community organisations and groups in Victoria for more than 30 years. Over the last 10 years, however, the sharing of lived experience has been increasingly recognised as an integral, complementary part of the recovery journey in mental health (CEPS website, retrieved 6 February 2014).

A key driver of this growth was the introduction of the Personal Helpers and Mentors (PHaMs) program across Australia commencing in 2006 (Australian Government Department of Social Services website, retrieved 7 February 2014), creating an exponential rise in opportunities for, and

recognition of, peer support work nationally. More information about the PHaMs model is presented in the following section, '*Models of peer work*'.

Formal recognition has led to increasing numbers of paid peer support roles and a diverse range of terminology, services, activities, practices, protocols, research and resources. These have been developed by individuals, community and special interest groups, health professionals, government departments and support agencies, all aiming to harness the power of peer support for consumers of mental health services and their families/carers.

This 'ad hoc' development of the peer workforce in Australia has resulted in significant differences between states as to the number of peer workers employed, and the range of services available (Anglicare Tasmania, 2009), and at times a significant degree of confusion in regard to specific roles (Watson, 2013); Health Workforce Australia has identified over 30 different job titles alone, currently in use for peer work nationally (2013b).

A number of recent literature reviews and reports (Anglicare Tasmania, 2009; Bennetts, 2009; CS&HISC, 2010; HWA, 2013b; Paton & Sanders, 2011) are available to provide a more in-depth overview of current roles and functions of Australia's peer workforce.

4.5 Models of peer work

The term 'model' refers to how a peer support service is delivered, and may include theoretical and structural components. Each model or variation has merit and can be appropriate for different individuals, and at different stages of the recovery process. Paton and Sanders posit that models of peer work can "defy easy categorisation and views on the best models are divided" (2011). This section presents examples of some key models for peer work:

- Community based models
- Group based mutual support
- Peer education
- Coaching
- Telephone support
- Ward-based support
- Peer-led organisations

Community based models

A leading employer of peer support workers in Australia is the Personal Helpers and Mentors (PHaMs) program. PHaMs is a federal government initiative launched in 2006 that provides funding for paid peer support workers (1 full time equivalent) to work in teams of 5FTE total, alongside general mental health caseworkers (4FTE including a team leader). PHaMs programs operate within established organisations in every Australian state and territory, including mental health and employment services.

PHaMs utilises a strengths-based, recovery-focussed approach to provide support to people aged 16 years and over who are living in the community and experience mental ill-health. PHaMs workers

provide practical assistance to help service recipients achieve personal goals, develop better relationships with family and friends, and manage everyday tasks (Australian Government Department of Social Services website, 2013). Recipients are assisted to access services and participate in their community to increase opportunities for recovery. PHaMs peer support workers may work with service users on an individual and/or group basis depending upon the specifications of their position.

The introduction of PHaMs services has undoubtedly increased awareness and recognition of mental health peer support in the Australian context. However, anecdotally, minimal service/funding guidelines around the PHaMs peer support role led to many services implementing peer work positions without the support of peer work best practice frameworks, such as clear position descriptions and adequate training and supervision. Such structural issues facing the peer workforce are discussed in greater detail under *'Common challenges'*.

Internationally, there are numerous examples of community based peer support models with a focus on one-to-one supportive relationships. Some of these have been explicitly developed as models for other providers to draw upon. A notable example is Intentional Peer Support (IPS), a model developed in the U.S. by Shery Mead, drawing on her experiences as a service user. IPS emphasises the need for a purposeful relationship between the peer worker and the person they are working with, focusing on what the person wants to achieve (Mead, 2005). This model is used in multiple countries by a range of providers, including Brook RED in Australia; refer to *'Peer led organisations'* below.

Group based mutual support

A prominent example of group based peer support is GROW, a community mental health and mutual aid organisation founded in Sydney in 1957 and now operating worldwide (Shannon & Morrison, 1990 in Moran et al., 2012). GROW offers a recovery-focused, strengths-based 12-Step Program delivered through weekly structured meetings, developed and facilitated by peers. In a study that examined how GROW impacts on wellbeing, observational data and participant interviews indicated GROW supports:

- An increased sense of personal value
- Increased confidence
- A sense of belonging and a new purpose in life
- Communication and social skills development
- Increased motivation and sense of hope (Finn, Bishop & Sparrow, 2009)

Approximately 50 GROW groups are currently operating across Victoria, including in prisons and Alcohol and Other Drug centres (Centre of Excellence in Peer Support website, retrieved 18 February 2014). The 'GROW – better together' program provides a similar model of mutual support for families and carers of people who experience mental ill-health.

Peer education

While some group based mutual support models do provide an educational component to support, new initiatives in the area of peer-led recovery education models present new ways of thinking about mental health service provision broadly. 'Recovery colleges' are an educational approach to

supporting recovery first introduced in the US and now operating internationally (NHS Confederation Mental Health Network, 2012, in Slade et al., 2014).

There are two major differences between recovery colleges and other mental health education initiatives. Firstly, recovery colleges are designed and run according to an education model, instead of a therapeutic one. People enrol in a college as students, rather than being referred to the program as consumers – a substantial shift in identity from being "just a mental patient" to being "just the same as everyone else" (Perkins, Repper, Rinaldi & Brown, 2012).

Secondly, recovery college courses are designed and delivered by people with personal experience of mental distress. Central to recovery colleges is the notion that people can not only learn from their mental health challenges, but can also pass that learning onto others. In partnership with college staff, students take an active role in all aspects of the college, including curriculum choices, course design and delivery. As such, recovery colleges actively challenge the traditional dichotomy of service provider and service user.

The website of the Nottingham Recovery College, UK, describes the college model as follows:

> *"The college brings together two sets of expertise – professional and experience – in a non-stigmatising college environment with the same systems as other educational establishments. All of the courses provided at the college are designed to contribute towards wellbeing and recovery. People who share experiences of mental health or physical health challenges teach on the courses with the intention of inspiring hope and embodying principles of recovery.*
>
> *The courses are designed to put people back in control of their life, helping each person to identify goals and ambitions whilst giving the confidence, skills and support to access opportunities."* (Nottinghamshire Healthcare website, retrieved 18 February 2014)

As an education service, a recovery college does not privilege any one model of mental health, but rather presents a range of ways of thinking about the subject. Courses are available for consumers, families/carers and mental health staff. Australia's first Recovery College model is currently in establishment phase at Mind Australia.

Coaching

It is widely recognised that people living with mental health issues are at increased risk of living with chronic medical conditions that further impact on their quality of life and result in premature mortality (Swarbrick, Murphy, Zechner, Spagnolo & Gill, 2011). Rates of numerous physical health conditions are higher in mental health service user populations including obesity, heart disease, diabetes, and smoking-related illnesses (National Mental Health Commission, 2012). Models that utilise health coaching frameworks to provide peer support have been identified as an effective strategy to address this issue (Swarbrick et al., 2011).

In Australia, the pilot phase of a Peer Health Coaching program developed as part of Sane Australia's Mind and Body Project is currently underway, in partnership with Neami National. Following completion of the pilot evaluation, a physical health peer support model will be developed and made available for delivery across the broader mental health sector.

Telephone support

Peer-run 'warm lines' typically operate after business hours, when general public health services are not available to provide support. In one qualitative study spanning four years, callers to a warm line in the United States reported a reduction in use of crisis services and in feelings of isolation, and positive impacts in terms of wellbeing, personal empowerment and use of coping strategies (Dalgin, Maline, & Driscoll, 2011).

The warm line used for the above study was operated by 2-4 peer support workers, seven nights per week, between 5pm and 8am. Warm line peer workers were provided with introductory training, weekly group and individual supervision, and access to an on-call supervisor during all shifts (Dalgin, Maline & Driscoll, 2011).

To expand the range of peer support service options available to consumers living in the Frankston Mornington peninsula catchment area, FMPMHA may consider linking service users to existing warm lines in Australia. Local peer-run phone lines include:

- Phone Connections, CAN Mental Health

National peer support line based on the Warm Lines models from the United States and New Zealand. Phone Connections currently operates 4 nights per week, between 6pm and midnight (CAN Mental Health website, retrieved 19 February 2014).

- Community Phone Line, Brook RED

Operates from 5pm – 10pm Monday to Friday. More information about Brook RED can be found in the *'Peer-led'* section below.

- MI Helpline, Mental Illness Fellowship Victoria

Peer-led service staffed by trained volunteers with a personal experience of mental ill-health, as service users or families and carers. MI Helpline operates 9am – 5pm Monday to Friday, and a call back service is available for all callers.

- The Mind Arafemi Carer Helpline

Staffed by trained volunteers (carer peer volunteers and non-peer), provides information, support and referral for family, carers and friends of people living with a mental illness. The Helpline is open 9am – 5pm Monday to Friday, with a coordinator employed to provide volunteer training, supervision and support.

Ward-based support

Carers Offering Peers Early Support (COPES) is a ward-based, replicable peer mentoring support service for carers of people with a mental illness (Arafemi Victoria, 2010). Currently in operation at a number of clinical sites across Victoria, the model also has capacity for extending to consumer-provided peer support.

The carer peer support worker is based within an adult clinical mental health setting, providing one to one peer support that is connected to and compliments formal clinical, health and support services. Carers and family members referred are initially contacted via telephone by the COPES

worker, to explore further needs and invite attendance at a one to one meeting. Carers may receive one-off support, or ongoing short term support; where counselling and advocacy needs are identified, the COPES worker will assist with referral (Arafemi Victoria, 2013).

COPES provides individual peer support on-site, at a time when families/carers have reported high support and information needs. As a partnership model between a clinical and community mental health service provider, additional support is provided in the community to allow access beyond the acute environment (Arafemi Victoria, 2013).

In establishing the COPES model, a full literature review of peer to peer programs and mentoring was conducted, and a theoretical framework was developed for consideration of peer support in the context of clinical and psycho-social support (Bartolo & Sanders, 2008). In line with best practice, this model also provides a range of supervision and support structures for peer workers including training, individual and peer group supervision, and establishment of clinical staff champions to support and promote the peer support service in the clinical environment.

Peer-led organisations

One of Australia's largest peer-led and operated organisations is the Brook Recovery, Empowerment and Development (RED) Centre, based in Brisbane, Queensland. Brook RED provides a range of peer support services and activities and is funded by both State and Federal government departments (conference presentation, 2012). Brook RED services:

- 24 hour peer supported respite program
- Out-of-hours community support phone line
- Centre-based programs across two sites including: activities e.g. music, health and fitness, men's and women's groups; excursions; shared meals
- Group-based and individual peer support (Brook RED website, retrieved 18 February 2014)

Brook RED operates within the Intentional Peer Support (IPS) framework for peer working. IPS is centred on the core principles of mutuality in co-learning; connection; exploring worldview, and moving towards what a person wants rather than away from what they wish to avoid (Mead, Hilton & Curtis, 2001). Peer support at Brook RED is underpinned by the life experience of the peer support staff team, creating common ground from which authentic trust-based relationships are formed.

Both Centres are open five days a week, and also deliver IPS training for peer support workers. All of the membership and most of the Board identify as having a lived experience of mental ill-health and recovery (Anglicare Tasmania, 2009).

4.6 Peer work roles

Currently, peer workers undertake a range of different positions, duties and responsibilities across both clinical and community settings in the mental health sector (Bennetts, 2009 & HWA, 2013b).

This section outlines some of the key tasks commonly carried out within different types of peer work roles.

- Direct peer support/mentoring
  - Emotional support
  - Role modelling
  - Practical support e.g. filling out forms, transport, access to brokerage funds

- Education
  - Skills development e.g. communication, problem-solving, assertiveness, crisis management, self-care
  - Recovery education
  - Daily living skills: cooking, cleaning, budgeting
  - Providing training to other mental health staff or community services e.g. police, schools

- Individual advocacy
  - Attending meetings
  - Facilitating effective/improved communication with treatment teams or services
  - Attending review hearings
  - Advocating with other services or systems e.g. Centrelink, State Trustees, justice system

- Systemic advocacy
  - Participating in Consumer or Carer Reference Groups (CRGs) or other service committees
  - Providing consultation or feedback to staff, services, projects, governments
  - Input into policy, service development, strategic planning, research or evaluation

- Information and referral, e.g. warm lines
  - Provision of information on health services and system navigation
  - Assistance to understand supports and options
  - Rights as a service user e.g. confidentiality, accessing records

(Paton & Sanders, 2011)

What any given role looks like in practice will be dependent upon the model of peer work used, and the broader service setting within which the role operates.

4.7 Skills required

The identification of core skills and competencies for the mental health peer workforce in Australia was a vital step in progressing peer support as a reputable model of care.

The Community Services and Health Industry Skills Council (CS&HISC) conducted rigorous consultation and review processes to develop a set of core competencies for the Certificate IV in

Mental Health Peer Work (CS&HISC, 2010), with the qualification structure endorsed as a training package in 2012. Curriculum and learning resources for the Certificate IV are currently being developed by the Mental Health Coordinating Council (MHCC) in partnership with the National Mental Health Commission and Community Mental Health Australia (MHCC website, retrieved 17 February 2014).

Refer to '*Appendix C: Qualification structure CHC42912 Certificate IV in Mental Health Peer Work'* for further information. As an indication of the broad skill set required for peer work, core units for the Certificate IV include:

- Apply lived experience in mental health peer work
- Work effectively in trauma informed care
- Promote and facilitate self-advocacy
- Contribute to continuous improvement of mental health services (CS&HISC, 2012)

More specifically, an Australian project that developed a three-step process (prepare, train, support) to assist organisations in employing peer workers identified the following skill requirements for peer staff (Franke, Paton & Gassner, 2010):

- Deal with stigma and discrimination
- Promote recovery and social inclusion
- Research and information sharing
- Work and participate in teams/groups
- Active listening and communication
- Set boundaries and adhere to ethical guidelines
- Share one's own experiences safely and professionally
- Assist service users to identify needs, set goals
- Self-management and apply strategies for maintaining wellness
- Set goals for professional self-development

Furthermore, O'Hagan (2009) identifies additional requisite competencies specific to peer work positions:

- Familiarity with consumer movement knowledge and values; critiques of mental health treatments/services/rights; trauma and consequences of compulsory treatment
- Empathy for other service users and respect for the autonomy of peers
- Ability to encourage others to use their personal strengths and resources
- Ability to be non-judgemental about other people's realities and stories (O'Hagan, 2009)

It is worth noting that requisite skills incorporate a set of 'non-negotiables' for both peer work and work in the mental health sector generally. An additional suite of skills is to be determined on an individual basis, taking into account peer worker needs and interests, and the service delivery environment. Additional training options based on peer workers' existing skills and attributes may cover:

- Intentional Peer Support
- Group facilitation
- Education/public speaking

Consideration should also be given to applicability of core training requirements for all staff working across FMPMHA and the mental health sector broadly, such as:

- Applied Suicide Intervention Skills Training (ASIST)
- Strength-based practice
- Staff self-care and resilience
- Motivational Interviewing
- Trauma-informed practice
- Dual Diagnosis

4.8 Service integration

Carefully considered service integration is a key component of best practice peer workforce development (CEPS, 2013). Developing any new role or model of service delivery is a complex undertaking; when such roles may by necessity instigate significant shifts in organisational culture, thoughtful implementation will be fundamental to success.

> *"Since the hiring of peer staff both stimulates and requires significant changes in the culture of traditional mental health settings, as much, if not more, has been written about challenges involved in implementation, and strategies for overcoming these challenges, as about research on outcomes"* (Davidson, Bellamy, Guy & Miller, 2012)

This section provides an overview of the practice guidelines developed in a number of countries that aim to strengthen development of the peer workforce (Baptist Care SA & MIFSA, 2009; CEPS, 2013; Repper, 2013; Smith & Bradstreet, 2011); the authors encourage further reading of such guidelines in order to build a thorough understanding of the essential elements of peer support service integration.

Engaging stakeholders

Service integration begins in the planning stage: engaging other staff, current service users and the organisation's executive in planning and development will not only optimise the final program's responsiveness and functionality, but will also greatly assist in creating a sense of ownership and thus, commitment to the new program (CEPS, 2013). One Australian study found that "strong organisational leadership and commitment to peer work was seen as the most fundamental determinant for the successful integration of peer workers", while in organisations where the leadership support for peer roles was weaker, "peer workers felt more of a personal burden in demonstrating their value" (Franke et al., 2010).

Strategies to engage existing staff to support the implementation of peer work roles are as follows:

- Provision of training about peer support's history, values and evidence base for non-peer staff (see *'Training for colleagues'*, below)
- Ensuring executive support from the outset to promote peer work from the top down
- Identifying senior staff positions to actively champion peer support

- Creating mechanisms for staff to discuss any concerns they may have about peer work, safely and without judgement
- Distributing updates on program milestones, personal stories etc.
- Embedding feedback and response structures for all staff (CEPS, 2013; Smith & Bradstreet, 2011)

"It is fundamental to include a wide range of opinions and views in the development of roles…creating a planning group that includes people with experience of using services is not only expected practice in any new service development but also in keeping with the underlying values of peer working and recovery" (Smith & Bradstreet, 2011).

Training for colleagues

The format and content of training for existing, non-peer staff is dependent upon the status of the peer support program and its workers. Prior to launching a new peer service, for example, training may provide a general introduction to the core principles and functions of peer work. An overview of the evidence including outcomes for service users and teams, as well as an open discussion of findings from research in relation to common challenges, could also be beneficial at this stage.

In addition, Davidson and colleagues (2012) recommend that training for non-peer staff address:

- Relevant disability and discrimination legislation, including the provision of reasonable adjustments
- Use of person-first language, and a respectful attitude towards all co-workers
- Strategies for resolving conflict in the workplace, including how to talk openly about issues of power and hierarchy, and
- Peer work success stories that inspire hope and persistence in all stakeholders (Davidson, Bellamy, Guy and Miller, 2012)

For organisations with an existing peer workforce seeking to educate colleagues, the abovementioned content may be covered as required. Training will be strengthened by input from current peer staff and where possible – that is, where peer support workers feel safe and able to do so – it is recommended that peer workers either lead or co-produce design and delivery of training. Discussion between peers and other mental health workers may incorporate more operationally-focused content, such as approaches to collaborating with peer staff; when and how peers can enhance support to clients/other staff, and presentation of case studies.

Finally, Repper points out that where peers are working in broader mental health support teams, staff training and education is an ongoing process (2013): "At the heart of these discussions should be an acknowledgement that all staff bring a different balance of contributions from three essential sets of skills and abilities:

- Their personal experience of life outside the mental health arena (skills, interests, culture, values, education etc.)
- Their personal experience of trauma, distress and mental health difficulties
- Professional/mental health training and experience." (Repper, 2013)

Stages of integration

Peer service integration guidelines tend to adopt project management frameworks, thus breaking down the process into four main phases (CEPS 2013; Repper, 2013; Smith & Bradstreet, 2011). Listed below is an overview of incumbent considerations for each of the four stages, as identified consistently across the literature:

- Planning
    - Identifying the model
    - Defining new roles including clear position descriptions, line management and supervision structures
    - Preparing the organisation: ensure commitment, understanding of peer work, alignment with core values
    - Identifying requisite skills and training
    - Anticipating and addressing staff concerns

- Establishment
    - Policies & procedures
    - Recruitment, taking into consideration that some applicants may not have been actively employed for a length of time
    - Occupational health
    - Core training

- Commencing operations
    - Promotion
    - Orientation of new staff
    - Negotiation of flexible working arrangements as needed
    - Supporting wellness
    - Implementing strategies to maintain integrity of peer support services
    - Linking to internal and external peer networks

- Sustaining peer services
    - Evaluation and review
    - Ongoing training and development
    - Expansion of peer leadership, career pathways
    - Broader system change

(Baptist Care SA & MIFSA, 2009; CEPS 2013; Repper, 2013; Smith & Bradstreet 2011)

The following section will explore some of these considerations in further detail.

5. Common Challenges

The following section outlines common challenges associated with creating peer services, in Australia and elsewhere. Challenges identified are drawn from academic and grey literature where available, as well as from the significant professional experience of the authors and their networks across Australia and New Zealand; as peer support is a relatively new area of development, there remains important experiential knowledge yet to be widely available as published material. The authors have drawn on this collective body of practice knowledge in the belief that it provides valuable information for the development of peer services within FMPMHA.

The challenges presented here are remarkably consistent across the literature, and it is essential that FMPMHA consider and implement ways to address them in order to build a sustainable, robust peer workforce. These challenges are presented in order of the likely sequence in which mental health service providers will need to address them.

5.1 Role clarity

Numerous studies emphasise the importance of developing clear position descriptions for peer roles (Repper et al, 2013; Watson, 2013; Panther, 2013). While duties may evolve over time as a service develops, it is essential to ensure from the outset that peer workers, their managers and other colleagues have a shared understanding of what the peer support role is, and what it is not (CEPS, 2013).

At the most recent Victorian Peer Conference, Sandy Watson argued that a lack of role clarity was the single biggest issue for peer work in Australia:

> *"In what other industry would someone apply for a job having no idea what the job is that they are applying for, and employers recruit people to these jobs, also having no idea what they are recruiting for? And six months down the track neither the employee nor the employer are any the wiser about what the work actually is, and how it is practised."* (Watson, 2013).

In the Australian context, Watson also calls for a clearer distinction between peer support roles and consumer leadership and advocacy roles. In Australia perhaps more so than elsewhere, peer workers have often been required to do the systemic advocacy work of consumer consultants, and vice versa (Watson, 2013). Watson points out that the two streams of work require two different skill sets, and as such need to be treated as two separate disciplines (Watson, 2013).

Lack of role clarity can be a particular issue when peer workers operate within clinical teams. It is vital to ensure that both peer workers and clinical staff are aware of the boundaries of the peer role, in order to minimise the occurrence of any expectation that peers are to act simply as 'mini-clinicians' (Panther, 2013). Effectively outlining the key functions and responsibilities of a position will in turn guide development of effective recruitment strategies, training, policies and procedures.

5.2 Recruitment

First-time recruitment of peer workers can pose a significant challenge to service providers. Both clinical and community mental health services in general face difficulties in finding staff with adequate experience for their roles (HWA, 2013b). With regard to peer roles, the question becomes how to find interested people with the necessary life experience, as well as the values, skills, and potential that fit the roles being recruited for. Effective recruitment may require organisations to explore different recruitment practices than they would normally use.

A well-considered strategy for advertising the role can help expand the pool of applicants (Baptist Care SA & MIFSA, 2009; Repper, 2013). A wider than usual range of advertisement options may be required, for example:

- Notifying the organisation's existing service users
- Advertising via extended professional networks
- Visiting local service user groups
- Targeting students undertaking peer support training courses (Repper, 2013)

Given that peer roles are relatively new, there may be value in including the job description in the advertisement (Repper, 2013), and being very clear about the fact that the role requires personal experience of mental distress or 'mental illness' (Baptist Care & MIFSA, 2009) and recovery. Best practice frameworks for peer recruitment also advocate designing an application process that addresses likelihood of some applicants having been out of employment for some time (Repper, 2013; Smith & Bradstreet, 2011). Potentially, excellent peer workers may consequently lack the confidence or skills to apply, such as those needed for writing a resume or IT skills for online application processes.

While feeling nervous before an interview may be considered a common experience in general, for some potential peer workers this can be exacerbated by the length of time since their last employment, in addition to understandable anxiety about discussing stigmatised experiences with a prospective employer (Baptist Care SA & MIFSA, 2009). It may thus be beneficial to both the organisation and applicants, if avenues to make the interview atmosphere as relaxed as possible are explored and implemented (Smith & Bradstreet, 2011). For example:

- Provide applicants the option of arriving early to read through the interview questions
- Allow applicants to meet with an existing peer worker beforehand to discuss the role
- Include people with lived experience of mental distress on the recruitment panel
- Prepare ways to comfortably discuss applicants' lived experience, such as arranging for peers on the panel to disclose some aspect of their own lived experience initially

(Baptist Care SA & MIFSA, 2009; Repper, 2013; Smith & Bradstreet, 2011)

In terms of assessing work readiness, it is worthwhile to note that recovery is not a linear process for most people. As such, employers and peer workers alike cannot guarantee that mental health issues will not affect the work at some stage; however, "most people who use mental health services are capable of working most of the time" (Slade et al., 2014). In exploring work readiness as part of the recruitment process, some discussion points to consider are as follows:

- Applicant's personal views of recovery
- What they have learned from their experiences of mental ill-health

- Supportive strategies for them in an employment setting
- Personal concepts of healthy work practices in general
- Ways in which it is envisaged the job may impact on their wellbeing

It is important to point out that experiences of mental distress can provide people a great resource to call upon in dealing with other life stressors, including work challenges. Many peer workers have also reported finding value in periods of mental ill-health during the term of their employment, as it provides an opportunity to discuss the ongoing nature of recovery with the people they support (Moran et al, 2012).

5.3 Training for peers

Training for peer workers can be divided into two broad categories: training tailored specifically for peer workers, and training for broader audiences which peer workers may also undertake. Broadly, common challenges of peer training lie in the inconsistency of peer-specific training in terms of quality and availability, and in the appropriate application of generalist mental health training for peer workers (Repper, 2013; Watson, 2013).

In Australia and elsewhere, a number of agencies have developed training packages designed specifically for peer workers. Training is often designed and delivered by people with their own personal experience of mental distress, and often by people who have worked as peer workers themselves (for instance, Mind Australia's five-day Mental Health Peer Work course, or Mind and Body's Certificate in Peer Support (Mental Health, Level 4) in New Zealand. This 'ad hoc' development of courses has resulted in a somewhat inconsistent spread of training options, in terms of both quality and availability, across Australian states and territories.

However, Repper (2013) notes a "high degree of consistency" internationally in content and style of delivery in training for peer workers. Common topics include:

- Peer support ethics, values, and boundaries
- Communication skills
- Goal setting
- Self-care
- Cultural competency
- Effective self-disclosure

There is far less consistency, however, regarding the length of training and consequently, depth of content, with courses ranging from less than a week to a full month (Repper, 2013). In the Australian context, steps are being taken to address this inconsistency by the introduction of the Certificate IV in Mental Health Peer Work (HWA, 2013a; MHCC website, retrieved 17 February 2014). For more information about the Certificate IV, refer to *Appendix C* and the *'Skills required'* sections of this review.

Peer support providers may also supplement peer-specific training with other mental health training. Regardless of the model being used, there is likely to be some overlap between the skills

required for peer support and for other forms of mental health work, thus it is common for peer workers to make use of training options that are already available.

In doing so, Watson (2013) emphasises the need to assess whether or not mainstream mental health training fits the model of practice being employed by peer workers. For example, Watson describes a peer worker being required to complete a course in take-down and restraint procedures, as part of mandatory training for all mental health staff in one service setting; not surprisingly, the training elicited distressing memories of the peer worker's own experience of being restrained (2013). Perhaps even more importantly, Watson points out that it is difficult to see how such training fits with any known model of peer support practice. Service providers thus need to consider whether it is appropriate that peer workers undertake all training, even when it is mandatory for other workers in the service (Watson, 2013).

Lastly, training for the broader staff team, including managers of peer support workers, helps build understanding around the purpose and value of peer roles (Repper, 2013). Several studies have shown that peer support workers are less effective when working with colleagues that are not working in a recovery oriented way, or do not understand the core values and approaches of peer working (McLean et al, 2009; Repper & Carter, 2011).

5.4 Supervision & support

For many mental health workers, professional supervision provides an important adjunct to training, helping ensure effective practice. Professional supervision in this context is distinct from line management. It is an additional form of ongoing professional development that explores and reflects upon current practice (Panther, 2013). Resourcing professional supervision for consumer roles has not typically been a priority in mental health (Bennetts, 2009; NSW CAG, 2010). However, there is a growing evidence base that indicates regular, high quality, structured supervision improves peer work practice (Repper, 2013), and also helps to prevent burnout and stress in peer workers (Basset, Faulkner, Repper & Stamou, 2010).

Supervision may also help mitigate the negative effects of role isolation, a serious issue that can have significant impact on the effectiveness and job satisfaction of people working in consumer roles. Isolation occurs at two levels, with consumer workers in Australia reporting a feeling of isolation either from "working as the sole consumer worker within a mental health service, or working in a rural remote setting" (Watson, 2007, cited in NSWCAG, 2010). Watson (2007) emphasises the importance of support structures that allow people to network with others working in consumer roles, across service boundaries. This is of particular importance in the FMPMHA context, given the significant geographic barriers for all mental health staff in the region.

To effectively combat role isolation, consideration needs to be given to how many peer workers are employed by FMPMHA within each service or worksite. At a minimum, it is recommended that three peer workers be employed in any given program to ensure adequate collegial support is available; this incorporates opportunities for day-to-day reflective practice. Schedules for more formal group supervision across the broader FMPMHA peer networks should be embedded within policy, and factored in to allocation of work hours.

It is strongly discouraged for a single peer worker to be employed to work within a service comprised of existing/traditional health professional roles (Davidson, Bellamy, Guy & Miller, 2012). Having more than one peer worker "can counter difficulties with isolation" (Anglicare Tasmania, 2009), and is also seen to increase the probability of peer workers successfully shifting the culture of services they work within (Franke, Paton & Gassner, 2010).

Professional supervision for peers can be provided individually, or in groups. In the authors' professional experience, the benefits of supervision are increased when the supervisor has experience in peer support delivery, because this often provides insight into the unique challenges of peer work. For mainstream services seeking to develop peer support, Repper (2013) suggests actively partnering with peer-run organisations to develop or provide both training and supervision.

5.5 Career pathways & leadership

Career progression for peer workers can be thought of in two ways: progression into more senior peer roles, and progression into non-peer roles in mental health. In either case, peer workers may wish to develop skills to work in a range of roles not necessarily linked to direct support work. Repper (2013) points the development of pathways to roles not explicitly identified as peer roles, noting that:

> *"Whilst there may be specialist peer worker positions in peer supervision, peer management, peer training, or peer research, these are unlikely to reach high bandings. Once peers are working as a team leader or a project manager, then their primary identity and role is likely to be developing beyond their lived experience, and whilst their personal experience of mental health problems will always have an influence on their work, it will not be their primary qualification"* (Repper, 2013).

O'Hagan and others have highlighted the need for greater development of consumer leadership at all levels of the sector, for the sake of better sector outcomes (O'Hagan, 2009). For example, Edwards suggests that the significant shift toward recovery oriented systems over the last 10-15 years in New Zealand is partially a result of the appointment of people with lived experience as service users in sector leadership roles, with varying degrees of the two essential features of 'power' - decision making and budgetary control (Edwards, 2012).

Peer work may be a starting point for many future mental health leaders. Mental health agencies can help support this process by actively recruiting for lived experience in senior roles. Given that 1 in 4 Australians experience mental health issues (Australian Bureau of Statistics, 2007), it is likely that there already are people with lived experience in many roles throughout the sector, but the career path from peer worker to senior mental health roles will not be seen as viable until the visibility of lived experience at all levels is encouraged and welcomed.

In turn, this approach may also help reinforce effective integration of peer support staff into the mental health workforce. Hiring people with lived experience of mental distress for management roles not only provides an immediate career pathway for peer workers, but helps address the issues of isolation, support and supervision outlined above. It is thus strongly encouraged by the authors that FMPMHA develop genuine opportunities for peer leadership across the alliance.

6. Conclusion

Peer support is a contemporary, rapidly expanding area of the mental health workforce that activates the personal strengths and resources of each individual. As an integral component of recovery, peer support provides a flexible, responsive framework that values the lived experience of consumers and carers.

Based on the strengths of the region's professional networks and their aims for the local peer workforce, the Frankston Mornington Peninsula Mental Health Alliance has a legitimate opportunity to create a leading example of best practice peer workforce development in Australia. Progressing this work will require identification and implementation of development strategies in line with the evidence presented in this report. In so doing, FMPMHA services will build an integrated, robust and effective peer workforce across the region, ultimately creating more options and better outcomes for service users.

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Appendix

A: FMP Mental Health Alliance *Development of a Peer Support Workforce* 2013-2014 work plan

B: FMPMHA Service Map

C: CHC42912 Certificate IV Mental Health Peer Work qualification structure (Release 2)

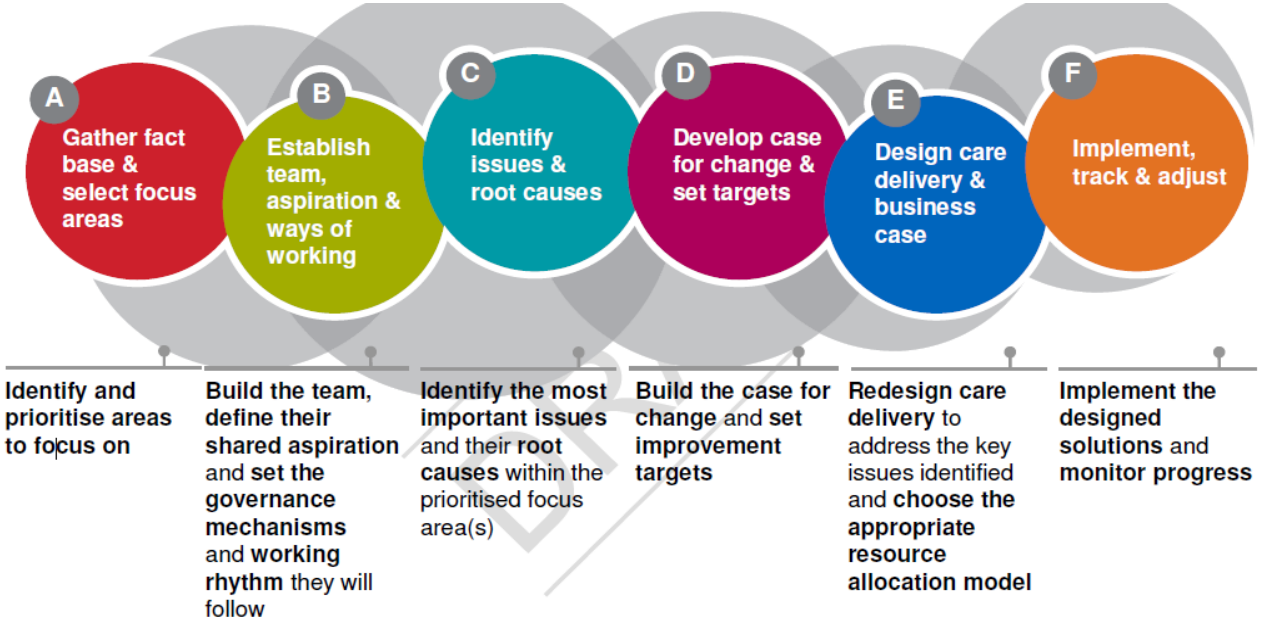
Mental Health Alliance

Development of Peer Support Workforce

2013 – 2014 Workplan – DRAFT 1

Working group members: Bronwyn Lawman PH (Chair), Fiona Reed PH, Sean Hegarty MIF, Cindy Keys PSS, Michael Matthews MIF, Denis Hovic MIND, Sharon Collins FMPML

Meetings to date:



Progress of the *Development of Peer Support Workforce:*

The Development of Peer Support Workforce is currently at stage C of the Medicare Local Collaborative Framework (McKinsey Collaborative Framework for Service Development).

Problem Definition (identification of priority issue and need/data analysis):	• **Currently there is no "shared vision" of a Peer Workforce across services within the FMP catchment** • **We do not currently have a sustainable support network for current and future Peer Workers** • **There is no forum for learning from each other as Services and we lack a collaborative approach to sharing information.**
Solution generation (identification of evidence based strategies):	• **Literature Review** • **Mapping of current Peer Workforce within the Frankston Mornington Peninsula catchment to determine baseline for pre and post evaluation.**
Workplan	
Aim:	**To develop a shared Peer Workforce Framework across Clinical and Mental Health Community Support Services within the Frankston Mornington Peninsula Catchment.**
Outcome indicators (how will you know the aim has been achieved):	• **Increased employment opportunities for Peer Workers within Clinical and Community Mental Health Services** • **Development of career pathways for Peer Workers** • **Introduction of base level of qualifications/education for Peer Workers** • **A Support Framework for all Peer Workers across the catchment that allows for peer supervision and support** • **An organisational change to culture and how peer workers are perceived and an improved recovery focus.**
Objectives:	1. To gain an understanding of the evidence base for best practice for Peer Workers through a literature review and service mapping process. 3. Develop the framework for a Peer Workforce across Mental Health Services within the FMP catchment, specific to the needs of individual services. 3. Implementation of the framework with "buy in" from all organisations and participation in the delivery of a shared Peer Workforce framework.
Target population group/s:	Peer Support Workers and Mental Health Services
Key Stakeholders:	*Mental Health Clinical and Community Based Services, Peer Support Workers, Consumers*
Resources required:	*Funding to support the Lit review and Mapping process*

Objective 1 **To gain an understanding of the evidence base for best practice for Peer Workers through a literature review and service mapping process.**	**Strategies**	**Impact indicators (how will you know the objectives have been achieved)**	**Timelines and responsibilities**
	Literature Review	A comprehensive Report on current best practice in the area of Peer Support	February, 2014
	Mapping of current Peer Support Workers within the FMP catchment.	Documented map of the current status of Peer Support Work within the Catchment.	February, 2014
Objective 2 **Analyse the data so as to scope the work required to develop a Framework for a Peer Workforce.**	**Strategies**	**Impact indicators**	**Timelines and responsibilities**
	Analyse data		March, 2014
	Develop Program Logic Map		March, 2014
Objective 2 **Develop the Framework for a Peer Workforce within Mental Health Services within the FMP catchment.**	**Strategies**	**Impact indicators**	**Timelines and responsibilities**
	Consult with individual organisations so as to understand the needs specific to their service when considering a Peer Workforce.		April 2014
	Develop a Resource ie guidelines, training needs, specific to the requirements of Peer Workers.		June 2014

Program Logic					
Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term

Risk Management Analysis							
Risk Description	**Potential Impact**	**Likelihood** • almost certain • likely • possible • unlikely • rare	**Consequence** • severe • major • moderate • minor • negligible	**Risk Score** • Low • Medium • High • Very high	**Proposed Actions to Control Risk**	**Cost**	**Responsibility**

Australian Government

CHC42912 Certificate IV in Mental Health Peer Work

Release 2

INDUSTRY SKILLS COUNCILS
Creating Australia's Future

CHC42912 Certificate IV in Mental Health Peer Work

Modification History

CHC08 Version 4.0	CHC08 Version 4.2	Comments
CHC42912 Certificate IV in Mental Health Peer Work	CHC42912 Certificate IV in Mental Health Peer Work	Correction of errors. No change to qualification outcome.

Description

This qualification covers consumer workers and carer workers who are employed within the mental health sector in government, public, private or community managed services.
This qualification is specific to workers who have lived experience of mental health problems as either a consumer or carer and who work in mental health services in roles that support consumer peers or carer peers.
Occupational titles may include:

- Consumer consultant
- Consumer representative
- Peer support worker
- Peer Mentor
- Youth Peer Worker
- Carer consultant
- Carer representative
- Aboriginal Peer Worker
- Participation Coordinator
- Family Advocate

Pathways Information

Not applicable.

Licensing/Regulatory Information

Not applicable.

Entry Requirements

Not applicable.

Employability Skills Summary

Not applicable.

Packaging Rules

PACKAGING RULES

15 units must be selected for award of this qualification including:

- 6 core units
- 9 elective units

A wide range of elective units is available, including:

- Group A Cultural Sensitivity units of which one unit must be selected for this qualification
- Group B Consumer Peer Worker units of which two units must be selected for Consumer Peer Work Stream; or
- Group C Carer Peer Worker units of which two units must be selected for Carer Peer Work Stream
- The remaining 6 electives may be selected as set out below:
- Units of competency to address workplace requirements and packaged at the level of this qualification or higher in Health and/or Community Services Training Packages
- Where appropriate, to address workplace requirements, up to 2 units of competency packaged at this level or higher in other relevant Training Packages or accredited courses where the details of those courses are available on the TGA or other public listing

Core units

CHCPW401A Apply peer work practices in the mental health sector
CHCPW402A Contribute to the continuous improvement of mental health services for consumers and carers
CHCPW403A Apply lived experience in mental health peer work
CHCPW404A Work effectively in trauma informed care
CHCPW405A Promote and facilitate self-advocacy
HLTWHS300A Contribute to WHS processes

Group A electives – at least one unit must be selected

One of the following units **must** be selected for this qualification.
HLTHIR403C Work effectively with culturally diverse clients and co-workers
HLTHIR404D Work effectively with Aboriginal and/or Torres Strait Islander people
Where work involves a specific focus on Aboriginal and/or Torres Strait Islander and culturally diverse clients or communities, candidates are recommended to select both units.

Electives required for Mental Health Peer Work specialisation

Group B Electives - Consumer Peer Workers [2 UNITS]

CHCPW406A Work effectively in consumer mental health peer work
CHCPW407A Support self-directed physical health and wellbeing

Group C Electives - Carer Peer Workers [2 UNITS]

CHCPW408A Work effectively in carer mental health peer work
CHCICS304B Work effectively with carers

Other Relevant Electives

Electives are to be selected in line with specified Packaging Rules. The following grouping of relevant electives is provided to facilitate selection and does not necessarily reflect workplace requirements. Electives may be selected from one or more groups. Employers may specify that certain electives are required to address specific workplace needs.

Administration

BSBWOR204A Use business technology
CHCINF303B Contribute to information requirements in the community sector

Advocacy and representation

CHCAD401D Advocate for clients
CHCAD402D Support the interest, rights and needs of peers within duty of care requirements
CHCAD603B Provide systems advocacy services

Alcohol and Other Drugs

CHCAOD402A Work effectively in alcohol and other drugs sector
CHCNET404B Facilitate links with other services

Community development and participation

CHCCD402B Develop and provide community education programs
CHCCD401E Support community participation
CHCCD508D Support community action

Community work

CHCCD307D Support community resources
CHCCD401E Support community participation
CHCCD404E Develop and implement community programs
CHCCD413E Work within specific communities
CHCCD420B Work to empower Aboriginal and/or Torres Strait Islander communities

Disability Work

CHCDIS302A Maintain an environment to empower people with disabilities
CHCDIS410A Facilitate community participation and inclusion
CHCICS406B Support client self-management
CHCICS407B Support positive lifestyle

Education and facilitation

TAEDEL401A Plan, organise and deliver group based learning,
TAEDEL402A Plan, organise and facilitate learning in the workplace,
TAEDES401A Design and develop learning programs
BSBCMM401A Make a presentation

Family Work

CHCFAM417B Identify and use strengths based practice
CHCFAM421B Work with parents of very young children
CHCICS410A Support relationships with carers and families

Group Work

CHCGROUP403D Plan and conduct group activities

CHCGROUP410B Deliver a structured program
CHCGROUP302D Support group activity
CHCICS405D Facilitate groups for individual outcomes

Health and Wellbeing
Where work involves participation in care coordination or case work the following unit of competency is recommended
CHCICS406B Support client self-management

Other units related to health and wellbeing work include:
CHCFAM417B Identify and use strengths based practice
CHCICS407B Support positive lifestyle
CHCICS408B Provide support to people with chronic disease
CHCCS426B Provide support and care relating to loss and grief

Homelessness
CHCCH410B Manage and maintain tenancy agreements and services
CHCCH427B Work effectively with people experiencing or at risk of homelessness
CHCCH428B Work effectively within the Australian housing system
CHCCH522B Undertake outreach work

Networking
CHCNET301A Participate in networks
CHCNET402B Establish and maintain effective networks
CHCNET404B Facilitate links with other services

Policy and Research
CHCPOL402C Contribute to policy development
CHCPOL403C Undertake research activities
CHCPOL404A Undertake policy review

Support work
CHCLD514B Analyse impacts of sociological factors on clients in community work and services
CHCCS514B Recognise and respond to individuals at risk
CHCCS521B Assess and Respond to individual's at risk
CHCCS426B Provide support and care relating to loss and grief
CHCFAM504B Respond to and contain critical incidents

Settlement Work
CHCSW401A Work effectively with forced migrants
CHCSW402B Undertake bicultural work with forced migrants in Australia

Working with young people
CHCYTH301D Work effectively with young people
CHCYTH404E Support young people in crisis
CHCYTH403B Support young people to create opportunities in their lives
CHCYTH511B Work effectively with young people and their families

Working with older people
CHCLD315A Recognise stages of lifespan development
CHCAC317A Support older people to maintain their independence
CHCAC318A Work effectively with older persons
CHCAC319A Provide support to people living with dementia
CHCCS426B Provide support and care relating to grief and loss

Custom Content Section

Not applicable.

Supporting mental health recovery

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