Submission to the Productivity Commission on their Draft Report into Mental health.

Peer Work in PC Commission – Tim Heffernan

Preamble

This submission is in two parts

1. **Responses to sections and recommendations in the draft report pertaining to Peer Work. Responses are in bold and italicised.**
2. **A paper – originally written in 2018, with additional current comments bolded and italicised**

Improving the ED experience and providing alternatives

Complementing this, State and Territory Governments should aim to provide more and better alternatives to EDs for people with mental health problems, including peer and clinician led after-hours services and mobile crisis services. This may include providing separate spaces in or near EDs for mental health patients, or otherwise creating a more de-escalating environment. The 'Safe Haven' spaces created in Melbourne and more recently in Queensland provide an effective model for this. When Emergency Departments are built or renovated, the design should take account of the needs of people with mental health problems. P24

- *"Another important theme is the need for new community-based crisis services, hospital diversion and step-down supports" in Alternatives to Coercion in Mental Health Settings: A Literature Review* *https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf*

- *"Here, through peer support and talking to someone with a shared experience, people can learn to self-manage their stress without bouncing back to ED all the time."* *https://www.qmhc.qld.gov.au/media-events/news/ed-alternative-trial-underway*

- *"The Safe Haven Café model offers an innovative, community-based model of MH support with quantifiable and qualitative benefits for its visitors and the local hospital service." Economic impact of the Safe Haven Café Melbourne https://www.thecentrehki.com.au/wp-content/uploads/2019/06/Safe-Haven-Cafe-Cost-Benefit-Analysis._FINAL.pdf*

A health workforce that can deliver the changes needed

There are many health professionals who can help people to improve their mental health and address any physical comorbidities they may have. Only some of these professionals —psychiatrists, psychologists, mental health nurses and mental health peer workers — specialise in mental health. P27

Totally disproportionate numbers. Peer workers numbers have remained small for decades in contrast to USA for example – look at Recovery Innovations, Arizona

Benefits in recovery innovations
One year after the peer support staff have began working in the two hospital facilities, there was, according to hospital administration, a:
- *36% reduction in the use of seclusion*

- ***48% reduction in the use of restraint***
- ***56% reduction in hospital re-admission rates***
- ***www.recoveryinnovations.org***

http://www.promise.global/psw.html

Mental health specialists

Among those providers who work specifically in mental health in Australia, we see scope for a greater role for mental health nurses and mental health peer workers, although there are notable gaps in some other specialities that should be addressed to improve consumer outcomes. We found no evidence of a need for more psychologists (indeed, Australia has one of the largest workforces, per population, of psychologists in the world).

Peer workers — people employed on the basis of their lived experience of mental illness — are well placed to support people with mental illness during their recovery. The nature of the experience and training required to allow peer workers to be most effective and the circumstances in which they can best be utilised, is the subject of ongoing work in the sector. A barrier to more widespread use of peer workers is the acceptance of their role by clinicians. A program to build support among clinicians for role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies. P29

- ***A barrier is the lack of investment in developing the peer workforce.***

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

In the short term (in the next 2 years)

- State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.

- ***Including peer run respite accommodation places and investment in peer run services.***

- State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.

- Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.

In the long term (over 5 – 10 years)

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

Complementing this, State and Territory Governments should aim to provide more and better alternatives to EDs for people with mental health problems, including peer and clinician led after-hours services and mobile crisis services. This may include providing separate spaces in or near EDs for mental health patients, or otherwise creating a more de-escalating environment. The 'Safe

Haven' spaces created in Melbourne and more recently in Queensland provide an effective model for this. When Emergency Departments are built or renovated, the design should take account of the needs of people with mental health problems. P65

- ***Need a whole of system adoption of Safe Havens etc***

Peer workers with lived experience, and in particular bilingual and bicultural peer workers, can enable the mental health system to better meet the needs of these consumers (Mental Health Australia, Federation of Ethnic Communities' Councils of Australia (FECCA) and National Ethnic Disability Alliance (NECA), sub. 524). Peer workers can provide a shared perspective in the provision of treatment. If those peer workers are from the same community or group, they may be more culturally capable in meeting the needs of these consumers. For example, the Western Australian Department of Local Government, Sport and Cultural Industries (DLGSC) called for the:

… adoption of customised multilingual communication strategies and give the end user a voice, particularly the lived experience voice, through employment of peer workers, consumer and carer representatives including people from diverse population groups. (sub. 78, p. 2) p195

Agreed

Putting the pieces together – planning, coordination and workforce development

The availability of a well trained mental health workforce is the cornerstone of implementing many of the Commission's recommendations. There are substantial challenges in developing a workforce to address the needs of consumers. The workforce available today comprises thousands of committed and capable doctors, nurses, allied health professionals, non clinical staff and many others; but there are still substantial shortages in clinical professions, especially mental health nurses and psychiatrists, as well non clinical roles, such as peer workers. P200

- ***This is critical – need more we peer workers. And need to invest in building the capacity of the peer workforce.***

The Commission has made a range of recommendations intended to boost the number of mental health nurses, for example by creating additional pathways for training and promoting the profession to existing nurses and nursing students. Similarly, the Commission has made recommendations to support an increase in the numbers of psychiatrists and peer workers, and expand the mental health workforce in rural and remote areas, by reducing professional isolation and increasing opportunities for professional development (chapter 11). P200

- ***Critical to get peer work numbers up to comparable level as MH nurses***

5.2   Matching consumers with the right level of care

Under stepped care (chapter 4), a consumer presenting to the health system should be matched to the level of care that most suits their treatment needs (DoH 2019k). However, currently consumers do not have easy access to low intensity mental health services. Many are being referred for individual psychological therapy when they would have their needs better met through more accessible, lower cost and lower intensity services.

The least intensive level of care is self management, in which consumers are able to manage their own mental health distress or symptoms. They can be supported in this by automated digital therapies (chapter 6), or by information and education about mental health, often found online or provided by a GP. Other self management tools include online peer support forums, and in person support groups in the vein of Alcoholics Anonymous. P208

- ***Need to fund a peer run organisation to coordinate voluntary peer support groups***

Box 6.1   What is e-mental health?

E-mental health refers to the use of the internet and other digital technologies to facilitate engagement in, and the delivery of, mental health information and services, including suicide prevention, primarily to consumers but also carers and the broader public. It includes services delivered via phone, web chat, video, websites (including social media), applications and software, wearable devices, sensors and robots. They may be self-guided or involve real time or delayed interaction with a person, including peer support. Consequently, e-mental health covers a wide assortment of information and services delivered in a multitude of forms.

E-mental health, and the internet more broadly, also plays an important role for people living with mental ill-health and their family and friends to search for information (chapter 10), encourage help-seeking behaviour (chapters 17 & 18), engage in online support groups and seek crisis help. These are valuable tools that can help people living with mental ill-health as they receive treatment.

- ***Increased awareness of consumer-run social media sites and activities that are independent of services. Facebook sites like Consumer and Peer Supporters (CAPS) and Psych ward support.***
- ***Creation of local online support groups and forums to compliment National services like those offered by SANE and LifeLine***

7.1   Consumers must be matched with the right care

Under the stepped care model (chapter 4), a person presenting to the health system should be matched to the level of care that most suits their treatment needs (DoH 2019k, p. 9). The Australian Government Department of Health has published guidance that outlines which factors should be considered in deciding which type of treatment suits a person's current needs (while recognising that consumers should have a say in any referral decision) (DoH 2019k). The appropriate service depends especially on the severity of their symptoms and distress, their risk of harm to themselves and others, and the effect of their mental illness on their functioning (as well as other factors) (DoH 2019k, pp. 36–43).

- ***Consider using language differently – "suits a person's current needs" is better expressed as "suits person's current needs and choices", or just "suits person's current choices"***

Consumers needing specialised clinical services almost always need services from multiple providers. People with less complex or severe illnesses might need services from two or three individual providers (such as a GP, a psychiatrist and/or a psychologist), while those with the most complex or severe illnesses might need additional services (such as mental health nurses, social workers, peer workers and employment and housing support workers). With numerous service providers delivering treatment, support and interacting with the consumer, coordination between service providers becomes increasingly important.

- *Consider role of peer workers in long term support. Regular contact to reduce loneliness.*
- *Support consumer-run peer work services across all services, including NDIS. Stronfg evaluated service in Australa – Brook Red in Brisbane*

Specialist community mental health services can vary in how well they facilitate multiple providers working together as a team. Private outpatient psychiatric care — subsidised under the Medicare fee for service model (box 7.2) — is not structured to facilitate coordination between more than a few providers:

In relation to people with more complex or severe problems, mental healthcare is optimally organised through a multidisciplinary team, comprising, for example, a psychiatrist, a psychologist, a GP, a mental health nurse, a social worker, a peer worker, an employment support worker, a housing officer and others. This fact, and together with the inability of fee for service to generate this kind of teamwork, has already been acknowledged by the Department of Health. (Rosenberg and Hickie 2019a) p279

Agreed. Need to be able to refer directly to peer workers. Not possible at this time. Require Medicare item for peer work. Peer work is available under Medicaid in many states in the USA.

Emergency and acute inpatient services

Emergency and acute inpatient services matter because …	• Emergency departments (EDs) are not working for people with mental illness — they are high stimulus environments, and people with mental illness must often wait many hours before they receive treatment.
	• Many of these people would be better served outside the hospital environment, although few alternatives are available.
	• Restricted access to acute inpatient mental health beds has led to problems such as long waiting times to be admitted through an ED, and pressure on hospitals to discharge people early to free up beds.
	• Some jurisdictions do not have the dedicated child and adolescent mental health beds required to provide safe and high-quality acute treatment.

- Eds - We need radical change – like Arizona   *https://crisisnow.com/wp-content/uploads/2018/10/Be-the-Change.pdf*
- Hospital alternatives - Non-clinical alternatives especially. We need peer run respites *https://www.westernmassrlc.org/afiya*

Successful intervention requires …	As a priority, action should be taken to ensure: • More and improved alternatives to EDs for people with mental illness, including peer- and clinician-led after-hours services and mobile crisis services. • Paramedics are provided with access to mental health resources when undertaking medical assessments in the field. • Acute mental health beds are provided on an ongoing basis at the levels determined by regional service planning to be necessary to meet specific needs of each region. • All State and Territory Governments provide child and adolescent mental health beds which are separate to adults.

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- Peer workers need to be available in ED's and in non-clinical alternatives to ED. Consumer Peer Workers to be with consumers. Carer peer workers to assist carers navigating ED and services,

Offering improved alternatives to EDs

In addition to increasing the availability of the community mental health services, State and Territory Governments should aim expand the range of alternatives to EDs for people experiencing mental illness. Such alternative models — including after hours services and mobile crisis services — can significantly improve the experience of people with mental illness.

After hours services

Half of all mental health attendances at EDs are after hours (Doggett 2018). Some of these people do not need acute hospital care and could instead be treated in alternative after hours services if they were available.

- ***These alternatives must include consumer-run services that include trained peer workers. Many won't need 'treatment'- they will need connection – hence peer run respites, warm lines and real time and online support groups***

One option is more after hours GP clinics. For example, the Australian Government announced $28 million funding in June 2019 for four new 'urgent care' clinics (employing GPs and nurses) in Perth to provide timely alternative care pathways for unscheduled care, with extended opening hours (Hunt 2019d). The effectiveness of such clinics in assisting people with a history of mental illness depends on having after hours access to patient records, such as through My Health Record, because the treating clinician may not have seen the patient previously.

- ***Any such clinics must include an appropriate peer worker presence***

Another option is for more headspace centres to open after hours, although this would only focus on younger people and so would not be a universal solution. Currently, headspace centres are typically

closed on weekends and only open from 9am to 5pm during the week, although some stay open later on selected weeknights.

After hours services can also be staffed by peer workers, rather than clinical staff. For example, the Safe Haven Cafe operates near the ED in St Vincent's Hospital, Melbourne. The cafe offers respite in a warm, caring and respectful environment to people needing mental health support, as well as social connection, but not necessarily acute care. It is based on a model successfully trialled in the United Kingdom, which was developed by and for consumers (St Vincent's Melbourne 2018). In June 2019, the Queensland Government announced that it was allocating almost $11 million over the following 4 years to fund safe haven cafes in some of its hospitals (Miles 2019).

- ***There is a role for team based acute care, including peer workers***

An evaluation of the cafe in St Vincent's Hospital found that it reduced mental health related ED presentations, with almost 40% of those attending the cafe saying they would have gone to the ED if the cafe did not exist (PWC 2018a). It was also found to improve patient experiences and social connections in the local community. However, the café is currently only open for a limited number of hours (Beyond Blue 2018b; St Vincent's Melbourne 2018). It is not open late on Friday and Saturday nights, which are peak times for mental health crises. P307

- ***Obviously, a need for Safe Spaces to be available 24/7, and also in settings outside of hospitals***

Mobile crisis services

In 2017 18, almost half of all mental health ED attendances arrived by ambulance, which was nearly twice the rate for all patients (AIHW 2019aa). Greater mental health expertise among first responders, and improved access to ED alternatives, could help some people with mental illness to avoid EDs.

For example, in 2015 the NSW Ambulance Service implemented the Mental Health Acute Assessment Team program, which involves specially trained paramedics and mental health nurses providing medical assessment at the scene before a decision is made on the best course of care. This could be to contact a GP, follow up with a community mental health team, or admit the patient to a mental health facility. Between 2015 and 2017, about 50% of mental health related callouts resulted in patients bypassing EDs in favour of more appropriate care (WSLHD 2017). Ambulance Victoria is also trialling mental health nurses in its ambulances to help ambulance officers deal with mental health emergencies, and has seen a reduction in the number of people coming into EDs (ACEM 2018a).

Crisis assessment and treatment (CAT) services can also divert people from unnecessary attendance at EDs. They are staffed by people with backgrounds in medicine, nursing, social work and psychology. Clinicians may also be accompanied by a peer worker. CAT teams provide mobile assessment and treatment, including in people's homes. They are skilled at de escalation, and can often keep someone having a mental health crisis from needing the ED. P308

Agreed

Improving the experience for people who attend EDs

While more alternatives are required, some people with mental illness will continue to need emergency clinical care in an ED. For these patients, the ED experience should be improved.

The RANZCP argued that the design of EDs need to be significantly changed.

… emergency departments require significant structural redesign of specific spaces for mental health, to ensure that individuals with mental illness can seek help in a calm, safe and private environment. (sub. 385, p. 10)

This could involve a dedicated space in EDs for people experiencing mental illness, which:

•   provides a calmer environment for the person

•   allows for longer periods of observation and assessment

•   reduces the need for restraint because there is perimeter security

•   creates a safer and calmer environment for other patients elsewhere in the ED.

Separate mental health units within EDs have recently been trialled with some success in hospitals in Western Australia. Similarly, in May 2018, the Victorian Government announced that it would invest $100 million to create six units in hospitals across the state, to be termed crisis hubs (Andrews 2018). Not only does the creation of separate units require substantial funding (albeit potentially outweighed by the benefits), hospitals may not be able to add a new mental health unit within their existing building footprint.

A lower cost alternative is to make existing EDs more suitable to the needs of people with mental illness. For example, there is evidence to support:

•   sensory modification techniques, which could be as simple as giving the patient bubble wrap or a stress ball to play with

•   having peer workers in EDs to support mental health patients

This is critical – if pools of peer workers were available they could be called in as needed 24/7, or they could be rostered on each shift. Need for primarily consumer peer workers, but also carer peer workers to help carers navigate ED

•   employing nursing assistants with basic training in dealing with people with mental illness as an alternative to security guards

•   increasing natural light, surfaces and colours. (ACEM, sub. 516) p309

Co location or community hubs

One option to improve integration of services is to have services 'co located', for example at community hubs, bringing together more than one service in the one physical location (Bonciani et al. 2018). This can include clinical and non clinical services, such as co locating physical health, mental health, drug and alcohol and vocational support services. There are many examples of successful co location of mental healthcare and other services (box 10.7).

In recent years, there has been increasing interest and investment in co located services. For example, the Australian Government announced in the 2019 20 Budget that it would be dedicating $114.5 million over five years (from 2020 21 to 2024 25) to fund a trial of eight walk in community

mental health centres (DoH 2019o). Mental Health Victoria (sub. 479) has commissioned KPMG to examine the options for Adult Community Mental Health Hubs with multidisciplinary teams including clinical and non clinical workers drawing on stepped care approaches to provide a range of services including peer support, counselling, alcohol and drug programs, housing and employment p361

- ***These eight community MH services must have a strong peer worker presence***

11   Mental health workforce

An effective health workforce matters because …	• There is a lack of needed skills, most evident in shortages of psychiatrists in some areas and mental health nurses, and under-utilisation of peer workers.
	Absolute need to provide training – Cert IV or IPS to build local workforces. Needs to be coordinated by PHN's/RCA's
	• There is an inefficient allocation of skills, evidenced by psychologists providing very low-intensity interventions.
	• Health workers are disproportionately concentrated in major urban areas.
	Grow you own programs needed – could be part of stigma reduction
	• Negative workplace cultures in some health services exposes workers to stigma, stress and burnout and leads to high staff turnover.
Successful intervention requires …	• Increasing the number of locally-trained mental health nurses by introducing an undergraduate degree in mental health nursing, and recognising specialist mental health qualifications as part of nurse registration.
	• Training more psychiatrists in Australia by raising the number of training placements and availability of supervisors for trainees.
	• Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent

- ***Absolutely! A National Peer Work Professional Association is essential.***

- ***PHNs or RCAs need to fund and support the development of regional peer worker networks who meet regularly to provide regional planning, support, co-reflection and professional development. See attached paper (Heffernan 2018)***

- ***Research into alternatives to medication needs to be prioritised***

- ***Mobilising both local paid and local voluntary peer workers through incentives built into DSP, New Start, and NDIS.***

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11.1 Why reform the health workforce?

The structure and composition of the current health workforce reflects the deficiencies in mental health services identified in other chapters of this report, such as large gaps in the availability of many types of services and an over emphasis on acute care.

This is evident in a lack of individuals with the needed skills across the workforce as a whole, which can be partly attributed to a failure to train and employ sufficient people in clinical professions, especially mental health nurses and psychiatrists (detailed later in this chapter). It is also due to a failure to broaden the mix of skills to include non clinical roles, such as the support that peer workers can provide to people experiencing a mental illness (discussed further below), and the navigation services and care coordination that consumers may need (chapter 10). p370

- *It is like climate change – we need to move from fossil fuelled workforces to ones that are renewable resources, like peer workers*.

- *We need workforces who are not blindly following the biomedical 'model' of mental health*.

- *We need workforces that can assist in reconnection of people with selves, family, community, work, and study*. *Peer workers have experienced these reconnections in their recovery. That is why they are so essential.*

11.2   Improving the quantity, mix and allocation of skills across the health workforce

In chapters 5 to 9, the Commission has proposed a redesigned mental health system based on a stepped model of care. To deliver this redesigned model, the health workforce will need to have a:

•   greater quantity and wider mix of skills — such as in providing peer support, navigation services, care coordination, and low intensity psychological treatment

•   more efficient allocation of skills to specific services — such as a greater reliance on low intensity therapy coaches (and e mental health) to provide psychological interventions and support for mild mental disorders. P373

- *There is an important role for lived experience leadership on this low intensity coaching.*

Governments have committed to various initiatives to improve their workforce planning, given the issues identified in section 11.1 above, such as skill shortages, lack of emphasis on peer support and difficulties in accessing services in regional and remote areas. P375

Peer workers

A professional workforce of peers who provide support and advocacy for people with mental ill health and their carers is a relatively new and still developing concept. It is supported by growing evidence that peer workers can facilitate better outcomes because having lived experience gives them a unique ability to develop trusting relationships with clients and provide them with hope (for example, Cherrington et al. 2018; Davidson et al. 2012; HWA 2014c; Lawn, Smith and Hunter 2008; Trachtenberg et al. 2013) (Australian Red Cross Society, sub. 490; Mission Australia, sub. 487; NMHCCF, sub 476; Wellways Australia, sub. 396).

There are already numerous examples of peer workers working in Australia (box 11.6). They are most often employed in admitted settings, public community mental health services, community managed organisations and disability services. Their different experiences will lend them to assisting in different fields, for example suicide prevention, perinatal mental health and the issues faced by military veterans.

- *Need to articulate the variety of peer worker roles*

Box 11.6   Australian examples of peer workers

Connect Beyond Blue provides a low intensity service for adults in the Greater Dandenong region with, or at risk of, mild to moderate depression and/or anxiety. The peer workers, or mentors, in the program speak a range of languages (Beyond Blue, sub. 275).

Flourish Australia operates a community based mental health support model with workers and volunteers, all of who have lived experience of mental ill health. The service was launched in 2011 in Hervey Bay, Queensland (Flourish Australia, sub. 330).

Mind Australia (sub. 380) has 65 people in designated peer roles. They are employed at all levels of the organisation, and include consumer and carer peers.

The NSW Government's Peer Supported Transfer of Care initiative gives people discharged from mental health services up to 6 weeks of support by an experienced and qualified peer worker to help them successfully transition back into the community. The peer workers are based in community mental health teams (NSW Government, sub. 551).

The Peer Support Worker program provides peer support services to people in inpatient wards in Bloomfield hospital in Orange. This involves 7 full time peer workers who work across a range of specialist mental health wards. An additional peer worker is based in the emergency department (Mission Aust, sub 487).

Roses in the Ocean is building a lived experience workforce to contribute to suicide prevention. Its peer support program contributes to a better understanding of the perspectives of people with mental health conditions (Rosie in the Ocean 2019).

St Vincent's Hospital in Melbourne has a peer worker employed in its emergency department and a nearby safe haven cafe (ACEM, sub. 516).

The Western Sydney Recovery College provides education to assist people in their recovery and increase knowledge, skills and awareness of mental health within the community. The courses are delivered by peer facilitators with lived experience of mental illness, and are co designed with clinicians (Wentwest sub. 445).

There are many more examples that should be named.

- ***Peer workers have worked in NSW public mental health since 1993, as Peer Advocates, Representatives, Consultants and Support Workers.***
- ***Suicide Aftercare – Next Steps in SE NSW***
- ***Flourish 'Resolve' program – Independent Community Living***
- ***Peer worker as sole trader in NDIS***

The total number of peer workers employed in Australia is not known because historically there has not been a comprehensive data collection. What is known is the number working in state and territory specialised mental health services. In 2016 17, there were 125 consumer peer workers and 42 carer peer workers (in full term equivalents) in these settings (AIHW 2019ab). The Commission understands that there are many more peer workers employed by non government service providers. For example, Flourish Australia (sub. 330) employ about 200 peer workers across their services.

Inquiry participants highlighted a number of problems that have hindered the development of a peer workforce and its effectiveness.

•	Role confusion — the role of peers workers is not always clearly defined, leading to confusion about their scope of practice, responsibilities and how other health professions are expected to work with them.

• Low support for value of the role — peer workers are often under valued, marginalised, discredited and sometimes bullied by the people they work with because of scepticism about the abilities of people with lived experience of mental illness, their professionalism and validity of their qualifications.

• Re traumatisation — by advocating for the people they support, peer workers can be repeatedly exposing themselves to the risk of re traumatisation if the professions they work with do not value and understand the role of peers.

• Few opportunities for career development and advancement — there is rarely a career path for peer workers to have the basis for a long term vocation in mental health services.

• Underdeveloped system of qualifications and professional development — there is currently only one specialised qualification (a Certificate IV in Mental Health Peer Work offered through the TAFE/VET sector).

- ***Lack of significant investment in the workforce. The workforce has developed in an ad hoc, uncoordinated fashion, often without dedicated funding.***
- ***Predominance of part-time short term contract work, making careers tenuous.***

In 2014, the National Mental Health Commission recommended that some of these issues be addressed by developing national guidelines on peer workers (NMHC 2014f). The NMHC recently commenced work on preparing such guidelines as part of its contribution to the National Mental Health and Suicide Prevention Plan.

This project will support the peer workforce through the development of formalised guidance for multiple audiences, including governments, employers and the peer workforce about support structures and other steps that are required to sustain and grow the workforce. In the development of the guidelines, the project is seeking to explore a range of topics, including role delineation, key roles and functions, guiding principles for peer workers, minimum training, career progression pathways, peer supervision and mentoring, and principles for employment (such as reasonable adjustment, remuneration and safe workplaces). (NMHC 2018c, p.3)

A steering committee of stakeholders has been established to oversee the project and had its first face to face meeting in July 2019, with the aim of having a set of guidelines ready for endorsement by the Mental Health Principal Committee by mid 2020.

Various peer workforce frameworks have already been produced in recent years, or are in development, at a service provider, regional and state level (NMHC 2018c). The NMHC aims to build on these to ensure greater national consistency and move towards professionalisation of the peer workforce.

The remainder of this section considers what further reforms are needed to address the barriers to developing an effective peer workforce.

Build support for the value of peer workers

Addressing the low support for the role of peer workers will require a combination of leadership to foster improved workplace cultures, educating health professionals about how peer workers can improve outcomes for their patients, and further demonstration on the ground that such benefits are real (such as through more trials and pilots).

Governments have an important role in this regard, given that they are major funders and providers of mental health services. But non government service providers will also need to drive improvements in their workplaces. And professional bodies, including the medical colleges, should play a role in changing attitudes in their professions. Governments should take a leadership role in supporting and coordinating the efforts of all the parties.

- *And funding*

Greater acceptance of the role of peer workers would also be facilitated by this inquiry's proposed reforms to reduce the stigmatisation of people with a mental illness (chapter 20).

- *Peer workers should be involved in co-designing and delivering any anti-stigma initiatives.*

More developed system of qualifications and professional development

The underdeveloped system of qualifications and professional development for peer workers needs to be addressed to facilitate a more professional workforce, career pathways, and greater acceptance among other professions of the value of peer workers. It should foster even better outcomes for people who are supported by peer workers. This will require expanding training options to more than just the existing Certificate IV qualification. Consideration should be given to a graduate training program, including more on the job traineeships and recognition of prior learning in granting peer work qualifications.

The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to recommend a comprehensive system of qualifications and professional development for peer workers. This should include consideration of how peer worker qualifications would be recognised as prior learning to enter (or credit towards) training for other health professions.

There may also be a role for governments and other service providers to provide scholarships to facilitate people with lived experience of mental illness to participate in peer worker training (WA MHC, sub. 259). The National Rural Health alliance (sub. 353) stated that a lack of affordable training can be a barrier to becoming a peer worker.

- *Agreed*

Implement improvements at the 'coal face'

In addition to the NMHC's work to set national guidelines, service providers will need to clearly define the role of peer workers, their scope of practice and their career pathway.

While implementation is largely a role for service providers at a local level, there could be a case for governments to set national competencies or standards to guide what service providers do. This is a matter that will become clearer as the NMHC develops its national guidelines on peer workers. Therefore, the NMHC should, when submitting its finalised guidelines to governments for approval in mid 2020, also recommend how the guidelines should be supported by national standards in particular areas.

- *Agreed*

Occupational representation for peer workers

To ensure there is consideration of the perspectives of peer workers in developing policy changes, there needs to be a professional group to represent peer workers. This may have to be funded by governments initially, but over time the peer workforce could contribute financially and by participation in advocacy for their profession.

The NMHC recently funded the Private Mental Health Consumer Carer Network to produce a feasibility study on a national peer workforce organisation. The NMHC received the report in January 2019 and is currently considering its next steps (Kaine 2018; NMHC 2019b). It should provide a recommendation to the Australian Government by the end of 2019 on how to facilitate a national peer workforce organisation, including possibly the amount of needed seed funding to establish the organisation.

DRAFT RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCE

Governments should strengthen the peer workforce.

In the short term (in the next 2 years)

- The National Mental Health Commission should, when submitting its finalised national guidelines on peer workers to governments for approval in mid-2020, recommend how the guidelines should be supported by work standards for particular areas of practice.

- The National Mental Health Commission should, by the end of 2019, submit a recommendation to the Australian Government on how to establish of a professional organisation to represent peer workers. This should include advice on how governments should, if at all, make a financial contribution, such as by providing seed funding to establish the professional organisation.

In the medium term (over 2 – 5 years)

- The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. The program will need leadership to improve workplace cultures.

- The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. This should consider of how peer worker qualifications would be recognised as prior learning for health professional qualifications.

- *Funding for peer workforce, perhaps to meet a certain ratio in services.*
- *Funding for consumer run peer work services, like Brook Red and Peachtree in Brisbane.*
- *Research projects around trials that are co-designed by peer workers.*
- *Establish regional networks of peer workers, allowing peer workers across all services to come together for support, co-reflection and professionaldeelopment.*
- *Support cooperatives/ collaboratives of NDIS sole trading peer workers.*

There are differences in the practising requirements of several allied health practitioners. For example, while OTs and social workers need a degree or postgraduate qualification, only OTs must

be registered. Counsellors must also be registered and hold a bachelor level qualification to be fully qualified, but can obtain entry level roles in the industry with just a Diploma of Counselling. Peer workers on the other hand require only the relevant lived experience as a consumer or carer. Additional qualifications are available, such as a Certificate IV in Mental Health Peer Work, but are not mandatory.

Though these differences exist, they are not necessarily problematic and may simply reflect differing expectations of the roles performed by each worker.

Who provides psychosocial supports?

Psychosocial support workers were primarily non clinical — owing to the non clinical nature of psychosocial supports — and predominantly female (72%). Most were also skilled workers — 43% of respondents had a bachelor degree or higher tertiary qualification and 34% of workers had a vocational qualification, with the majority of these being at the Certificate IV and Diploma levels (NHWPRC 2011). Results from more recent surveys of the sector found that in Victoria, 90% of paid staff have a diploma or above (CMHA 2017; VCOSS, sub. 478, p. 22), and that in 2014 15, there were 47 NGOs delivering psychosocial supports across Western Australia with an average of 3.92 (paid) full time equivalent staff (WA MHC 2016). There are also a significant number of volunteers and peer workers in the sector (peer workers are discussed further in chapter 13). P421

13.3   Social services for carers

The discussion on social services focusses on carer support services, which aid carers in their role, and employment support services.

Carer support services

Services for carers are provided by government mental health services, non government organisations (NGOs) and for profit providers. Some NGOs are carer specific service providers and others are providers of psychosocial supports in general. Services are mostly government funded, but some are also funded via private donations and consumer charges (MHCN, sub. 245). Funding for carer support services has long been provided by both the Australian Government and State and Territory Governments.

Services provided vary widely between regions but typically include:

•   Information and education — this includes practical information to help with service navigation as well as 'psychoeducation', the term given to interventions that aim to increase knowledge about the consumer's illness and treatments, provide carers with tools to be more effective in their role or improve family functioning (Lyman et al. 2014)

•   Counselling and peer support — to meet the emotional and practical needs of carers. Counselling may be provided in person or via carer phone helplines. Peer support includes carer peer support groups and individual support from a carer peer worker. Carers with complex needs may receive case management. P482

•   a review of what works for mental health nurses in supporting carers of people with schizophrenia found that supportive family education reduced carer burden and that there was some evidence that peer support groups reduced burden and improved coping (Macleod, Elliot and Brown 2011). P482

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Some carers and ex carers may be interested in becoming a volunteer or paid carer peer worker. McClure, Aird and Sinclair (2015) recommended volunteering as one way job seekers can prepare for paid employment. Chapter 11 discusses peer workers, including ways to reduce barriers to becoming a peer worker. P491

13.4   Family focused and carer inclusive practice

Supporting families affected by mental illness

In addition, children may benefit from age appropriate information about their family member's mental illness and referral to support services, such peer support groups and group recreational activities that provide respite.

> **Box 13.2**   **Examples of efforts to improve family-focused practice**
>
> The Victorian Government commenced the Families where A Parent has a Mental Illness (FAPMI) strategy in 2007 to reduce the effects of parental mental illness on all family members, particularly dependent children. The strategy includes employing local FAPMI coordinators in each catchment area. FAPMI coordinator tasks include 'building capacity of the mental health workforce and partner agencies through education and training, referral pathways and procedure development to improve identification and support for parents and their children' (Falkov et al. 2016).
>
> The Victorian FAPMI strategy also includes peer support services for young people with a parent or sibling with mental illness (Victorian Government, sub. 483). An evaluation of one of these programs called CHAMPS found that the intervention resulted in significant improvements in self-esteem, coping and connections within the family, and reductions in relationship problems (Goodyear et al. 2009).
>
> The New South Wales Children of Parents with a Mental Illness Framework sets directions for its mental health services, such as the provision of services for families, strengthening the capacity of interagency partners and supporting the workforce to provide family-focused practice (NSW Health 2010). It provides detailed instructions on ways to achieve the directions, including the use of COPMI coordinators.
>
> The Queensland Government has also produced a guideline for working with parents with mental illness and the ACT Government has a Children of Parents with a Mental Illness policy (ACT Health, 2013; QLD Health 2010).

Mental healthcare in correctional facilities

Participants to this inquiry, both government agencies and peak bodies, highlighted that access to mental healthcare is difficult for prisoners:

Despite a high rate of mental health issues, it was indicated that access to a psychiatrist in prison was "virtually zero" unless the person was under a forensic psychiatrist — "ten minutes with a psychiatrist every six months does not help". Greater access to social workers and potentially to peer workers is likely to be beneficial, but resource are limited and provision of in reach services was difficult due to lack of resource for supervision. (South Australian Mental Health Commission, sub. 477, p. 21). 619

- ***Forensic Peer workers are needed in jails, forensic hospitals and especially in the community – similar to 'hospital to home peer workers. Researched pilots needed soon.***