Implementing mental health peer support: a South Australian experience

Carmen C. D. Franke\textsuperscript{A,C}, Barbara C. Paton\textsuperscript{B} and Lee-Anne J. Gassner\textsuperscript{B}

\textsuperscript{A}Peer Work Project, Baptist Care (SA) Inc., PO Box 39, Glen Osmond, SA 5064, Australia.
\textsuperscript{B}Research and Business Development Unit, Baptist Care (SA) Inc., 157 Beulah Road, Norwood, SA 5067, Australia.
\textsuperscript{C}Corresponding author. Email: cfranke@sabaptist.asn.au

Abstract. Mental illness is among the greatest causes of disability, diminished quality of life and reduced productivity. Mental health policy aims to reform services to meet consumers' needs and one of the strategies is to increase the number of consumers working in the mental health service system. In South Australia, the Peer Work Project was established to provide a program for the training of consumers to work alongside mental health services. The project developed a flexible training pathway that consisted of an information session, the Introduction to Peer Work (IPW) course and further training pathways for peer workers. External evaluation indicated that the IPW course was a good preparation for peer workers, but a crucial factor in the implementation process of employing peer workers was commitment and leadership within the organisation in both preparing the organisation and supporting peers workers in their role. To assist organisations wanting to employ peer workers, a three step model was developed: prepare, train and support. The project has been successful in establishing employment outcomes for IPW graduates. The outcomes increased with time after graduation and there was a shift from voluntary to paid employment.

Additional keywords: mental health consumers, peer specialists, workplace mentoring.

Introduction
Mental illnesses are universal, affecting people of all countries and societies, individuals of all ages, women and men, the rich and the poor, and people from urban and rural environments. Globally, mental and behavioural disorders affect more than 25% of people at some time in their lives (World Health Organization 2001). At any one time, the incidence is considered to be one in five. One in four families is likely to have at least one member with a behavioural or mental disorder (World Health Organization 2001). Australian research has produced a similar picture and mental health problems are identified as the greatest cause of disability, diminished quality of life and reduced productivity (Australian Health Ministers 2003). People who live with mental illness confront issues of homelessness, poverty, isolation, ill health, unemployment and stigmatisation. Of the participants in an Australian survey of people living with psychotic illness, 77.0% of men and 64.7% of women had no regular occupation, 72% had no formal employment and 85% were reliant on welfare benefits (Jablensky \textit{et al.} 1999). Unemployment does not imply that the person does not want to work, but may represent discouraged job seeking or loss of vocational hope (Waghorn and Lloyd 2005). Barriers to employment are numerous. Although some are directly caused by mental illness and the side effects of medication, others are systemic, resulting from community and workplace stigma and the way health and vocational services are organised in Australia (Waghorn and Lloyd 2005).

The National Mental Health Plan 2003–2008 aimed to reform services to address consumers' needs and one of the strategies was strengthening the role of consumers working in the mental health service system. Based on this strategy, the South Australian Government established the Peer Work Project under the Mental Health Care Improvement Initiative. The project's directive was to provide a program for the 'training of peer support workers to work alongside mental health services in providing peer specialist activities'. Two not-for-profit agencies, Baptist Community Services SA Inc. (now Baptist Care (SA) Inc.) and the Mental Illness Fellowship of South Australia (MIFSA), worked in partnership to develop the Peer Work Project. The project achieved the Margaret Tobin Award in 2007 in recognition of its contribution to excellence in leadership in and commitment to mental health reform.

The following paper presents the context of the development of peer support in South Australia and a description of the Peer Work Project. The aim of the project is
to support both peer workers and the employing mental health organisation. The paper presents the findings regarding training and support for peer workers as well as critical factors within employing organisations to make peer support a successful strategy to reform mental health services and increase the participation of people with mental illness in the workforce.

**Context of the development of peer support in South Australia**

**Social and historical context of peer support**

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and understanding another’s situation empathically through the shared experience of emotional and psychological pain (Mead et al. 2001). The benefits of peer support can be explained by the underlying psychosocial processes including social support, experiential knowledge and the personal benefits derived from effectively helping others. Peer support has been more widely applied in the mental health arena in recent decades and the benefits are far reaching. There are improved gains in some aspects of quality of life for consumers, improved quality of life, personal and professional growth for peer workers (peer providers), potential cost savings for mental health services through reduction in hospitalisations, and decreased societal stigma of persons with severe mental illness when peers are successfully functioning in productive social roles (Solomon 2004).

Davidson et al. (2006) have credited the modern growth in consumer involvement in mental health care to the political advocacy provided by the mid 1970s consumer movement in the United States and to the established tradition for self-help and mutual support groups in American culture. The consumer movement seeks social justice in terms of human and social rights and social change regarding the perception of mental illness and wellness. A pivotal change in mental health, and a facilitator of peer support, has been the recognition that mental health patients can recover and regain control over their life and have a meaningful role in society, despite experiencing mental illness, including its negative and sometimes disabling consequences (Anthony 2000; Fisher and Chamberlin 2004). Within this framework, people who have a mental illness use health management strategies to maintain their well being. Peer workers provide positive role models for other consumers and can apply the expertise they have derived from living with their own mental illness to support others dealing with similar issues. By necessity, to operate as a peer also requires openness about one’s own mental health issues.

Peer support programs generally share common empowering functions as well as caring functions (Campbell 2005), but the models used can vary considerably in terms of role definition, organisational structure and their relationship with mainstream mental health services. Just as consumer involvement in planning, research and evaluation of service delivery has grown, so have the types of peer support and peer support services that are available for consumers. The most basic form of peer support is the informal mutual support provided by individuals on a one-to-one basis. An inherent feature of mutual support is that there is a two-way flow of help between participants. Organised peer support may also be provided through networks or self-help organisations (Davidson et al. 1999; Corrigan et al. 2002). Consumer-run services, where the administration and support are controlled or organised by consumers, were established as an alternative to mainstream facilities (Davidson et al. 1999). More recently, the consumer partnership model was developed and involves a consumer-provided service working in partnership with a traditional mental health service (Solomon and Drainé 2001).

The ‘peer specialist model’ usually refers to consumers who are trained and employed to provide support to consumers in mainstream mental health services (Fisher and Chamberlin 2004). This form of peer support is seen as more asymmetrical because the peer provider is employed within mainstream mental health services, which can undermine mutuality and equality. Concerns have been raised that the more peer support is professionalised, the more it can resemble the structure of established mental health services and thus it can dilute its emancipatory and normalising value (Davidson et al. 1999; Campbell and Leaver 2003). Resnick et al. (2004) have argued that peer specialists employed within a mental health service may be influenced by professional attitudes, thereby detracting from their ability to act as peers. And the peer workers who operate within the often exclusionary environment of clinical and professional support services can face considerable discrimination from professional staff and exposure to stress (Mowbray et al. 1996, 1998; Davidson et al. 1999). Mowbray et al. (1998) also noted that a lack of support from supervisors was an added barrier. A lack of role models and tensions or confusion over issues of confidentiality, boundaries and friendships may be further impediments to peer support (Mowbray et al. 1996, 1998; Davidson et al. 2006). Carlson et al. (2001) identified dual relationships, role conflict and confidentiality as the major challenges. Boundaries can become blurred as many consumers have dual relationships. It can cause challenges when a peer specialist’s professional colleague is also their own service provider or they know the consumers with whom they are working. Effective management is critical (Chinnan et al. 2006) and Davidson et al. (1999) have suggested that peers may benefit from working in a more structured and supportive environment, with provision of training and supervision included among possible supportive strategies.

**South Australian context**

In Australia, consistent with overseas experience, peer work is best understood within the broader changes in mental health care. The National Mental Health Strategy and the National Mental Health Plan 2003–2008 emphasise...
Improving consumer and carer participation in decision making, advocacy and service and community development (Australian Health Ministers 1992, 2003). This national directive to increase consumer involvement has been translated into policy at the state level (Government of South Australia Department of Health 2005; South Australian Social Inclusion Board 2007) and the South Australian Department of Health launched the Mental Health Care Improvement Initiative in 2005. Funding was allocated to non-government organisations (NGO) to improve the access to and effectiveness of existing services for consumers, to support the satisfaction of the workforce and focus on developing future models or frameworks of care. The strategies involved health promotion and prevention, psychosocial rehabilitation services, respite, day programs, support for carers and Baptist Care (SA) Inc. and MIFSA received funding to develop a project to increase the employment of mental health consumers as peer workers within the mental health services.

Baptist Care (SA) Inc. and MIFSA were chosen because of their involvement in two earlier pilot peer work projects: the Consumer Collaborative Pilot (a collaboration between the Noarlunga Health Service, the Noarlunga Consumer Advisory Group, the Onkaparinga Council and Baptist Community Services) and the Peer Specialist Pilot (a joint initiative of the North Western Adelaide Mental Health Service and the Schizophrenia Fellowship of South Australia (now part of MIFSA) and funded by Health Promotion SA). These two pilot projects highlighted the importance of consumer involvement in the South Australian mental health sector and the value of using the ‘lived experience’ in the planning, implementation, delivery and evaluation of services.

**Peer Work Project**

**Project objectives and set up**

Training and mentoring for (those who want to become) peer workers and support for mental health services that want to employ peer workers are the key objectives of the Peer Work Project. Figure 1 shows the relationships between the various project components. On the consumer side this includes: training for (consumers who want to be) peer workers, support for graduates of the Introduction to Peer Work (IPW) course to find a position as a peer worker, and workplace mentoring. On the employer side, organisations who (want to) employ peer workers are supported through consultancies and provision of information to: prepare their organisation, develop peer work roles and establish an effective support structure for peer workers (Fig. 1). The Employer Toolkit and Peer Network provide additional supports for employing organisations and peer workers, respectively, along with the website (http://www.peerwork.org.au, verified April 2010), and facilitate sustainable employment for peer workers (Fig. 1).

The project developed a training pathway for peer workers, as there was no training available for peer workers in South Australia. The training pathway consisted of three steps: an information session about the nature of peer work, the IPW course and a Certificate III in Community Services Mental Health – non-clinical. Information sessions were organised to provide information about available training and to help consumers decide whether they were interested.
in the course and wanted to pursue peer work. After attending the information session, consumers could apply to do the 6 day IPW course. The course was based on the experience and knowledge of existing peer workers and the course topics included peer work roles, boundaries, sharing your story, self management and job opportunities. In partnership with the Australian Nursing Federation and Central Northern Adelaide Health Service, a Certificate III course was adapted to cater for peer workers.

To achieve sustainable employment outcomes for peer workers, the project developed a mentoring model that aimed to support employed peer workers. To support peer workers in the workplace, both group and individual mentoring support was established. The aim was to help peer workers gain skills, find alternatives to overcome work related issues and become familiar with reflective practice as well as giving and receiving feedback about work practices. Recurring themes for the mentoring sessions were: safely share their story, avoiding retraumatisation, working within boundaries, dealing with stigma, and working with other professionals in a team.

Employers were supported in the development of an effective support structure for peer workers within their organisations through the establishment of effective supervision and management. The project supported organisations to develop clear role descriptions for the peer workers and in the process of informing and involving staff about the new peer worker roles.

Project evaluation

Since its inception, the Peer Work Project has evolved in response to evaluation outcomes and feedback from consumers, employing organisations, and the Stakeholders Reference Group, which had been instigated to provide advice, feedback and direction for the project. In addition, the South Australian Community Health Research Unit (SACHRU) was engaged as an external evaluator and to provide recommendations on future directions.

The first SACHRU evaluation focussed on training (March 2007). Data were collected from written surveys completed by participants of the IPW course, telephone interviews and a focus group with peer workers undertaking the Certificate III course and telephone interviews with members of the Stakeholder Reference Group.

The SACHRU final report (January 2008) focussed on the introduction of new peer worker positions in mental health service settings across South Australia. A broad range of factors that contributed to or inhibited the implementation process were identified. The evaluation was based on a thematic analysis of 25 interviews with peer workers, their managers and colleagues of government and non-government organisations in various settings.

Results and interpretation of survey data

Training consumers

The 2007 SACHRU report evaluated the training pathway. The majority of the trainees valued the IPW course and the Certificate III course. Survey results of participants of the IPW course (n=50) indicated that the majority (>90%) of participants found the topics fairly useful or very useful (5 point scale). Having completed the course, 88% were definitely interested in pursuing a peer worker role and the remaining 12% indicated that they might be interested in such a role. Interviews with stakeholders (n=14) also indicated that the IPW course offered many benefits to those who attended; it was a good preparation for peer worker positions and it raised awareness around competencies (South Australian Community Health Research Unit 2007).

Although the evaluation findings were generally very positive, some improvements were suggested. With regard to the IPW course it was suggested that it was important to prepare peer workers for dealing with issues around workplace culture in the hospital setting and how to communicate with staff and clients (South Australian Community Health Research Unit 2007). In response to this feedback and another meeting with stakeholders, the course was reviewed in 2007. Required knowledge and skills regarding the social justice and recovery framework, mental health, mental health services, working within an organisation, the peer work role and personal and professional development were identified in consultation with organisations that employ peer workers (Table 1). The

<table>
<thead>
<tr>
<th>Topic</th>
<th>Knowledge requirements</th>
<th>Skill requirements</th>
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<tbody>
<tr>
<td>Social justice and recovery framework</td>
<td>Human rights, discrimination and stigma</td>
<td>Dealing with stigma and discrimination</td>
</tr>
<tr>
<td>Mental health and mental health services</td>
<td>Principles of recovery and social inclusion</td>
<td>Promoting recovery and social inclusion</td>
</tr>
<tr>
<td>Working within an organisation</td>
<td>Mental illnesses other than their own</td>
<td>Research and sharing information</td>
</tr>
<tr>
<td>Peer work role</td>
<td>Mental health services, resources and terminology</td>
<td>Using resources for the benefit of consumers</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>Workplace culture and communication</td>
<td>Working and participating in a team or group</td>
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<td></td>
<td>Issues of confidentiality</td>
<td>Setting boundaries and adhering to ethical guidelines</td>
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<td></td>
<td>Importance and variety of peer work roles</td>
<td>Sharing own experience safely and professionally</td>
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<td></td>
<td>Recovery-based principles</td>
<td>Assisting consumers to identify needs and set goals</td>
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<tr>
<td></td>
<td>Issues and barriers in the communication process</td>
<td>Active listening and communication</td>
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<tr>
<td></td>
<td>Recognising own triggers, warning signs and symptoms</td>
<td>Self-management and strategies for maintaining wellness</td>
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<tr>
<td></td>
<td>Personal and career opportunities</td>
<td>Setting goals for professional self development</td>
</tr>
</tbody>
</table>
revised course content now covers principles of recovery, dealing with stigma, mental health (services, acronyms, jargon and resources), workplace communication and culture, working with small groups, sharing your experience in a professional manner, workplace mentoring and debriefing. Another concern raised by participants and stakeholders was that the certificate training should have been at Certificate IV level (South Australian Community Health Research Unit 2007); some peer workers found the Certificate III course not sufficiently challenging and stakeholders argued that the industry generally expected qualifications at Certificate IV level (South Australian Community Health Research Unit 2007). In response to this feedback and based on the various individual needs, the Peer Work Project decided to establish relationships with training organisations and support participants with the development of individualised training pathways.

Introduction of peer workers in organisations

To provide more insight into the factors that were critical for the introduction of peer work in South Australia, SACHRU conducted qualitative interviews (n=24) with peer workers, their managers and colleagues. Interviewees represented different settings such as acute care and supported residential facilities (45%) and community settings (55%), with almost equal representation from government and non-government organisations. Themes identified from the interviews related to the relationship between peer workers and consumers, leadership, preparation for the introduction of the new role(s), the importance of a support structure and recognition of the benefits of peer work.

The strength of the relationship between peer workers and consumers is seen to be the most compelling reason for the integration of peer work.

What peer workers provide to clients couldn’t be provided by anyone in the medical profession. (Colleague)

They tell him (the peer worker) different things that are actually vital to their treatment. It brings a new understanding to our team. (Manager)

The relationship is seen to be beneficial to the recovery of consumers due to the more trusting and empathic relationship and because it provides hope.

Some organisations felt that peer work naturally complemented their ethos. The consumer-peer worker relationship is seen to be empowering, honest, humanising, relevant, and a valid addition to already existing clinical teams. The introduction of peer workers caused a significant cultural shift in other organisations.

It changes the atmosphere. (Colleague)

He’s changed the way we do things...staff views have moved...he’s like another check and balance. (Manager)

Most agreed that there should be more peer workers to meet the needs of consumers as peer workers enhance recovery (South Australian Community Health Research Unit 2008).

Strong organisational leadership and commitment to peer work was seen as the most fundamental determinant for the successful integration of peer workers.

Leadership was crucial in making it work. (Peer Worker)

In other organisations where there was not such strong leadership support for peer work, peer workers felt more of a personal burden in demonstrating their value (South Australian Community Health Research Unit 2008).

The culture needs to support peer work and then other staff would follow. As a single peer worker you’re not going to be able to change the culture. (Peer Worker)

Managers have an important role in leading by example to create a culture that is accepting of peer work and they play a role in managing incidents.

Leadership is so important in setting up the process as well as management of issues. (Manager)

Most organisations indicated that it took a significant amount of time to develop and establish peer worker roles.

They could offer more direction. We floundered a bit at times, especially at the start. (Peer Worker)

Those who were best prepared to take on peer workers had the least problems in establishing the roles (South Australian Community Health Research Unit 2008). But most interviewees recognised that even under good circumstances, the integration of peer work into the workplace takes time and a period of adjustment.

Integration into the team is taking time. (Peer Worker)

Organisational commitment is needed in setting up the process. It’s about process and policy development. (Manager)

Some peer workers felt instantly welcomed while others experienced strong barriers to being accepted as part of their team. Some peer workers had to work hard to change the attitudes of other staff, which has implications for the well being of the peer worker (South Australian Community Health Research Unit 2008). Supervision and support mechanisms for peer workers differ across workplaces; however, it is clear that both managers and peer workers value strong support mechanisms. In relation to maintaining employment as a peer worker, mentoring by the Peer Work Project and support by the employing organisation were seen as critically important, especially where the roles were new (South Australian Community Health Research Unit 2007, 2008).

BCS [Baptist Community Services] mentoring is very effective for us. I had a fantastic relationship with a peer worker, but he needed to discuss other things
with the mentor, e.g. issues of disclosure. This stopped his mental illness dominating our relationship. We often meet with all three of us so it’s collaborative. (Manager)

Peer workers agreed that taking on their roles had in fact been a factor in validating their self worth and sense of purpose, and many felt that becoming a peer worker had improved their own recovery. Managers and peer workers agreed that there were particular requirements around balancing the well being of peer workers with work commitments (South Australian Community Health Research Unit 2008).

It feels like my experiences were for a reason...it hasn’t all been a waste. It’s really a reason to keep going sometimes. Helping others get through it and witnessing their success is inspiring. (Peer Worker)

**Employment outcomes**

The main objective of the project was employment of peer workers in mental health services. In the 2007 SACHRU evaluation, the main concern for stakeholders was the small number of available paid positions for peer workers. There were concerns about the ethics of training people when there were limited job opportunities, as this may have a negative impact on participants. The report also identified that the culture within the mental health services needed to change. In response to these concerns, the project limited the number of graduates, promoted peer work more actively to increase positions and facilitated the matching of jobs and peer worker graduates more actively.

The project limited the number of IPW courses that were run. This increased the numbers on the waiting list and the project started to assess candidates; work readiness, communication skills, willingness to share their story and motivation to become a peer worker were the criteria for assessment. Most applicants for the IPW course strive to obtain meaningful roles, but need to rebuild the confidence that they are capable of working (South Australian Community Health Research Unit 2007). This is an important aspect of the IPW course and the mentoring support. Employment barriers can result from the symptoms of the illness, from side effects of medications, and from subsequent impairments to social skills, sense of self, personal confidence, and self-efficacy. In addition, negative experiences of stigma and unfair discrimination can disrupt formal education and training, impede school-to-work transitions and damage the formation of work values and core work skills (Waghour and Lloyd 2005).

To match job seekers and organisations, a Peer Network for both graduates of the IPW course and employed workers was established to actively provide information about job opportunities, training and support. Members of the Peer Network choose to engage with the project and are contacted to monitor the needs of the members as well as employment outcomes. Employment outcomes for members of the Peer Network have been growing. In December 2007, 132 graduates of the IPW course were interviewed. Of these, 59% (n = 78) had paid or volunteer work; 60% of this group (n = 46) had a paid position and 40% (n = 32) volunteer work. A year later, in December 2008, 140 members of the Peer Network were contacted and 73.5% (n = 103) had paid or volunteer employment; 71% of this group (n = 73) had paid employment and 29% (n = 30) had a volunteer position. In March 2009, 140 Peer Network members were surveyed and the members with employment outcomes had risen to 78.6% (n = 110); 72% of this group (n = 79) had paid employment, 28% (n = 31) had a volunteer position.

The chance of gaining employment increased with the time after graduation (Table 2). Of the members that graduated in 2005-06, 79.2% found paid employment, compared with 35-40% for the more recent graduates. Graduates often start working in a volunteer capacity for a few hours per week. Then, as time progresses, the number of hours worked per week increases and there is a shift towards paid work.

Of the members with voluntary work (March 2009), 9.7% had casual employment, 38.7% worked less than 5 h per week and 51.6% worked 5-15 h per week. Of those with paid work (March 2009), 5% had casual employment, 8.9% worked less than 5 h per week, 25.3% worked 5-15 h per week and 60.8% worked more than 15 h per week.

An analysis of the type of employment undertaken in March 2009 indicates that of the 32 members with paid employment, 40.5% worked as a peer worker, 13.9% worked as a mental health support worker, 16.5% worked in a non-mental health support worker role (e.g. disability care), 11.4% worked in mental health but not in a support worker type of role and 17.7% worked in a role unrelated to peer work. The majority of the paid workers (82.3%) and volunteers (87.1%) worked in a peer work role or related area, where they could use the knowledge and skills learned in the IPW course.

Of the 32 paid peer worker positions, 23 were within government, eight were with a NGO, and one was across both sectors. By contrast, of the 24 mental health support workers, all but two worked for an NGO. Most of the identified peer worker roles were within government. By contrast, within some NGO there are no identified peer worker roles but the lived experience is valued and workers are encouraged to utilise their life experiences. These organisations choose not to differentiate between peer work

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1A peer worker role was defined as a position where it was required to use the lived experience of mental illness.

2Some organisations do not differentiate between peer worker roles and support work and in some organisations the individual can choose whether or not to disclose their lived experience.
Table 2. Employment outcomes (volunteer and paid) for peer network members in relation to the year they graduated from the metropolitan Introduction to Peer Work (IPW) course, as at December 2008

<table>
<thead>
<tr>
<th>Graduation year from IPW course</th>
<th>n</th>
<th>In a volunteer position n</th>
<th>%</th>
<th>In a paid position n</th>
<th>%</th>
<th>With an employment outcome n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>2005-06</td>
<td>24</td>
<td>2</td>
<td>8.3</td>
<td>19</td>
<td>79.2</td>
<td>21</td>
<td>87.5</td>
</tr>
<tr>
<td>2006-07</td>
<td>47</td>
<td>12</td>
<td>25.5</td>
<td>26</td>
<td>55.3</td>
<td>38</td>
<td>80.8</td>
</tr>
<tr>
<td>2007-08</td>
<td>35</td>
<td>7</td>
<td>20.0</td>
<td>14</td>
<td>40.0</td>
<td>21</td>
<td>60.0</td>
</tr>
<tr>
<td>2008-09</td>
<td>20</td>
<td>5</td>
<td>25.0</td>
<td>7</td>
<td>35.0</td>
<td>12</td>
<td>60.0</td>
</tr>
<tr>
<td>Other*</td>
<td>14</td>
<td>4</td>
<td>28.5</td>
<td>7</td>
<td>50.0</td>
<td>11</td>
<td>78.5</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>30</td>
<td>21.4</td>
<td>73</td>
<td>52.1</td>
<td>103</td>
<td>73.5</td>
</tr>
</tbody>
</table>

*Members that had (1) graduated from a regional IPW course, (2) graduated from an Aboriginal-specific IPW course, or (3) not graduated from an IPW course but had experience in peer work roles.

Conflicts of interest
None declared.

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References

Implementing mental health peer support

Conclusions
The South Australian Government established a Peer Work Project to provide a program for the training and employment of peer specialists in mental health services (Government of South Australia Department of Health 2005). Through the project, Baptist Care (SA) and MIFSA developed a successful training and mentoring program for peer workers and consultancy and support for employing mental health organisations. The IPW training developed is a good basis for employment and further study. Consistent with overseas experience (Mowbray et al. 1996, 1998; Davidson et al. 1999; Carlson et al. 2001; Campbell 2005; Chinnman et al. 2006), we found that peer specialists face exposure to stress. Support through leadership is crucial for peer workers to reduce and manage the challenges of introducing the new roles. The three step model for employers (prepare, train and support) has provided organisations with the tools to successfully introduce peer workers. For many peer workers the ongoing support for both the peer worker and the employing organisation provided through the Peer Work Project has decreased adverse outcomes. Outcomes from the Peer Work Project also indicate that provision of long-term support improves good employment outcomes for people with mental illness within mental health services. Since the inception of the Peer Work Project there has been considerable growth in workforce participation by Peer Work Project graduates. In addition, graduates showed significantly higher workforce participation rates than previously reported for people with a severe mental illness (Jablensky et al. 1999). Peer workers are successful social role models for mental health consumers, carers, staff and the broader community. They provide hope for recovery and show that it is possible to work despite a mental illness, which is important both in the battle against stigma and for social inclusion.


South Australian Community Health Research Unit (2007) Midpoint report. External evaluation of the Baptist Community Services Peer Support Project. [Copy available from the corresponding author on request]


