Independent Advisory Council:
National Disability Insurance Agency (NDIA)

Discussion Paper: Peer work in the National Disability Insurance Scheme

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Introduction

This discussion paper has been prepared for the Independent Advisory Council (Council) to the National Disability IInsurance Agency. The Council since its inception has advocated the importance of respecting and empowering the lived experience of people with disabilities. Council has considered on a number of occasions the model of peer worker that has been developed in the mental health sector. It has recognised that this model has a number of possible applications in the broader disability sector. This paper has been produced and released by the Council as a resource document for consumer and service provider organisations and to assist policy makers in framing strategies that support more and more effective peer work in Australia.

The objective of this document is to clarify the concept of the peer worker role in relation to the disability field. In order to do this, we will provide background context, considerations and philosophical/ethical principles relating to the concept of peer work. We will also indicate how such work could be implemented into NDIS service paradigms, give a guide to subsequent practices and explain potential activities and values of peer roles.

This paper will provide the necessary information for the National Disability Insurance Agency (NDIA) to:

1. create and implement a specific strategic goal/policy statement regarding the employment of those with lived experience
2. create, adapt and implement a peer workforce strategy based on the suggestions, ethics and principles outlined here.

A **specific strategic goal/policy statement direction** would enable the employment of people living with particular disabilities (provided they were appropriately skilled) to offer expertise, support and leadership to participants in the NDIS with similar life or participation challenges. It is envisaged that these people, whom we shall refer to as ‘peer workers’ (see Definitions, pages 4), would act as support facilitators or providers and/or mentors. They would, by their professionalism, intent and status as lived-experience experts, model spects of how to challenge oneself, offer encouragement and raise participants’ awareness of their personal potential. The expertise that such people offer is vital, even though, as Galbally (2011) pointed out, the grass-roots peer work/support model “has been underutilised and undervalued in the past yet it has played an important role in the support of individuals who have been impacted by events, incidents or issues that have disrupted their lives and wellbeing”. Our assertion is that in NDIS services and support agencies the time has come to combine the best of what peer support work has to offer and learn from the health and social sector’s knowledge and expertise to support the very best of what we can bring to participants.

The **peer workforce strategy** that we suggest in this paper will, if implemented, lead in time to new disability support workforce directions, further policy developments and the ability of NDIS providers to employ adequate support personnel as demands grow with full NDIS roll-out. A by-product of this activity will be the enhancement of employment opportunities for those people who have gained insights and considerable knowledge through their personal lived experience of disability.

Agreement on the philosophy, ethics and principles that underpin the employment of those with lived experience in the support workforce is pivotal as a starting point. Such considerations will provide guiding principles for the development of additional policies and protocols around the employment of people with lived experience in agencies offering services to participants under the NDIS.

This paper will also, in particular**:**

- enable key stakeholders to understand and appreciate the value and power of peer work as a cost-effective part of the disability support system and as a means of preventing the escalation of personal, support or inclusion issues and of promoting adjustment and inclusion by improvement in emotional, physical and spiritual wellbeing
- emphasise the value and power of lived experience, placing it in its proper context as a specialist knowledge base – an expertise. Having it valued and utilised alongside other types of expertise will enhance the provision of relevant supports to individuals, increasing their opportunities and participation goals
- highlight the validity and value of peer work as an integral and valued method of service delivery
- promote personal involvement, participation and empowerment.

The NDIA will champion the inclusion of those with lived experience by an overt and direct policy commitment to employing them. This paper articulates guiding principles of our intent, values and purpose, and, although not prescriptive, it presents a commonsense way forward to fulfil our commitments and show leadership across the disability sector.

The peer worker role in relation to the disability field

Definitions

The definitions of 'peer workers' and related terms vary. The following are definitions used in this paper.

Peer

According to the Macquarie dictionary, a 'peer' is "an equal in any respect".

We each have many peer groups, based on age, work, hobbies and other facets of our identity; for example, in the mental health system, 'peer support' is offered by an individual who identifies as a peer through having lived experience of trauma, mental health issues, psychiatric diagnosis and/or emotional distress.

In the context of a peer work or peer support role, use of the term 'peer' indicates that the role requires the appointment of a person who brings an essential job criterion of having personal 'lived experience' (see page 7). In such positions, the peer is regarded as bringing a particular and valued expertise to their role through their personal experience, enabling them to become a specialist support provider with unique dimensions to bring to the required tasks. (Selection of such a person for a peer work role would depend on additional elements of qualification for the job. For example,

having specific personal experience but not an appropriate level of emotional intelligence or ability to process the personal learning of how to live and grow despite challenges, being bitter about the deal that life has dished out or being ‘self-absorbed’ and not outward looking would indicate that enabling positive growth in another as a peer worker might not be feasible.)

Peer work

“Peer work is a professional role that is distinguished from other forms of peer support by the intentionality, skills, knowledge and experience that peer workers bring to their role. They are employed as professional subject matter experts who can be a key conduit between a consumer, their other support people, and the services they use.” Department of Health 2016, *PHN, Mental Health and Suicide Prevention Implementation Guidelines*, Australian Government, Canberra.

Casey (2008) states that peer work is “providing support, encouragement and hope to another”. It aims to promote hope and to focus on strengths and supports rather than illness or disability. It is different from other types of support work in that the source of support is a person who identifies as having lived through similar related and relevant experiences to those of consumers. An example of peer work might be people with specific health conditions meeting others to share experiences and talk about what works for them. Such support may help people to manage their personal, physical, sensory, health, cognitive and emotional situations more successfully and to cope with choice and control as well as personal ‘melt-downs’ or the reoccurrence or worsening of symptoms. Formalised peer work is support provided by paid peer support workers who are people with personal experience of living with a disabling, traumatic health or living condition. Through their processing of this personal experience, they may be able to offer specific empathetic disability and personal support, empowerment and validation to other people with comparable experiences. (It is not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not consider, offer or even know about.)

In identifying the critical elements of peer work, Solomon (2004, p8) reminds us that “Consumer provided services need to remain true to themselves and not take on the characteristics of traditional … services”, while Campbell (2004, p32) also notes that “consumer operated programs should present an alternative world view”. Maintaining peer work’s non-clinical vantage point is crucial in helping people rebuild their sense of community when they have had a ‘disconnecting’ experience (Mead 2001). Identifying the skills and ingredients that enable services to stay true to themselves and programs to provide a different world view helps in determining what constitutes ‘good outcomes’ for peer work programs. It also helps peer workers to become more self-evaluative, and therefore continuously build on emerging knowledge, and to challenge assumptions (and the methods by which those assumptions were reached).

Peer work is **not** voluntary work. It is professional work for which specific training, development and peer supervision is desirable. In peer work roles there are productivity, accountability and performance expectations similar to those of other professional staff. It is regarded as essential that those with peer work responsibilities must have and maintain ethical and performance standards commensurate with sector expectations.

In understanding what peer work is, it is instructive to be aware of what peer work is **not**.

Peer work is not:

1. 'being kind' to a disadvantaged individual
2. giving an unemployable or disadvantaged individual a 'sort of a job', to make them feel better
3. a 'cheaper' way of staffing
4. employing someone with less experience in the field to save 'professional' staff from doing menial tasks
5. voluntary work.

Peer worker

The peer workforce consists of peer workers. For the purposes of this paper, peer workers are defined as: people who are employed in staff or support roles that require them to identify as having, or having had, personal lived experience of a disabling, traumatic or particular health or living condition. (This is based on a definition of the Mental Health Coordinating Council, 2011, and is, incidentally, a definition that forms an essential criterion of job descriptions, although job titles and related tasks may vary.)

Peer workers occupy a variety of functions that include (but are not limited to) participating in:

- vocational support
- personal support
- social integration
- preparing or implementing/coordinating plans
- educative programs or classes
- rehabilitation, habilitation and recovery facilitation
- community integration activity
- accommodation support
- transitional support from hospital/care to reintegration into the community.

Peer workers can look very different, depending on who they work for or the model of support they are using, as well as on their individual skills or attributes. The values and beliefs held about peer work by an organisation and its staff will also influence interpretations of what peer support is within different service contexts.

Experienced peer workers from the mental health sector suggest that the following five qualities are required in an effective peer worker:

1. having integrated their experiences of mental ill-health (or particular disability experience) into their lives so they see value in them and do not feel ashamed or disempowered
2. being able to think critically and reflect on what they do and why they do it, and be capable of making judgements based on reasonable possibilities
3. having values consistent with the peer values of the service for which they work
4. having a good understanding of marginalisation issues, exclusion and discrimination
5. being empathetic, emotionally mature and objective.

Again, it is instructive to consider what a peer worker is **not**.

A peer worker is not:

- a counsellor – peer workers may use some counselling skills, but it is important that they know that they are not counsellors
- an advocate – by definition, an advocate is someone who **pleads or speaks for another**, which is not part of a peer worker's role
- a friend – although some aspects of friendship may enter into the peer relationship, there are clear differences between friendship boundaries and peer work boundaries; for example, a friend can be contacted at home and at any reasonable time, whereas a peer worker would be available during agreed hours and would not be contactable in their private 'home time'
- a 'friendly ear' – although providing participants with non-judgemental listening is part of the peer worker role, the ability to empathise while remaining emotionally focused on the reason for their being present is a very important part of being a peer worker
- a sympathetic listener – peer workers express *empathy* with participants, not sympathy
- an advisor – peer workers may be called upon to give advice, but it is important to remember that they are not advisors. The focus should be sharing encouragement and experience rather than giving advice
- a 'role model' – peer workers may be seen as 'inclusion guides' by offering their life experiences and activities as exemplars, but will also point participants to a range of community identities for broader modelling.

Lived experience and peer work

Burge (2001) described lived experience as "the expertise that comes from firsthand experiences … that experience places the peer in the best position to provide hope and support and encourages [others] to participate and to voice their needs and concerns based on their individual … journey".

As Bennett and Meagher (2010) explained, peer work values lived experience as an asset: "A Peer Worker is an occupational title for a person [who has lived with a] problem, who is working to assist other people with a [similar issue]. Because of their life experience, such persons have expertise that professional training cannot replicate; they are important sources of information, a potential source of motivation, and may serve as mentors to others".

From the outset, we state categorically that having 'lived experience' alone is not an automatic qualifier for employment or appointment as a peer worker. Regardless of the position, each applicant must bring specific, relevant skills, experience and qualifications, together with their personal lived experience.

A peer work or peer support position uses the term 'peer' to indicate that it is one that requires the person appointed to the job to be one who brings an 'essential job criteria' of having personal lived experience. In these positions, the person is regarded as bringing a particular and valued expertise to their role through their personal experience, enabling them to become a specialist support provider with unique experiences to bring to the job.

People with lived experience working in traditional roles that do not require it are **not** peer workers. Peer-to-peer work is primarily about **how** people connect to, and interact with, one another in a mutual relationship. Peer-to-peer roles are different from traditional roles that happen to be filled by someone with a similar lived experience. A person working in a traditional role, such as a clinician or support worker, may have had similar experiences to those who are using their services (for example, a nurse may also be a cancer survivor). This does *not* make that person a 'peer' in the sense that we are discussing here. They may share their personal experience, but they are still operating within their primary role as a clinician or support worker. There remains a substantive difference between peer and non-peer roles, although both have value. The definition of the peer role within the context of the systems in which they exist is further clarified by the policies, values and actions that underpin the recruitment of peer workers.

In general, peer work has been defined by the fact that appropriately chosen people who have like experiences can better relate and consequently offer more authentic empathy, empowerment and validation. Maintaining peer work's non-clinical vantage point is crucial in helping people rebuild their sense of community when they've had a 'disconnecting' experience (Mead 2004).

Peer support

Peer support is one element of peer work. It is primarily about *how* people connect to, and interact with, one another, and it involves people drawing on shared personal experiences to provide knowledge, social interaction, emotional assistance and personal or practical help to each other in a way that is often mutually beneficial.

Peer support is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope and, perhaps, mentorship to others facing similar situations (Davidson et al. 2006), and has been defined as: "Any organised support provided by and for people with similar conditions, problems or experiences" (O'Hagan 2011). Orwin (2008) states that "it should be noted that peer support … is about understanding another's situation empathically through the shared experience of [disability, trauma or] emotional and psychological pain". Peer support roles differ from other roles because they are based on different philosophical assumptions. They carry no assumptions of deficit or historical baggage about the social support and maintenance of 'the disabled', and are the only roles to have emerged that are grounded intrinsically in recovery and reintegration.

Sherry Mead, in her comprehensive definition of peer work from 2003, defines peer support as:
"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 … 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 whom 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. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles".

O'Hagan (2011) defines peer support as: "Any organised support provided by and for people with similar conditions, problems or experiences. Peer support is sometimes known as self-help, mutual aid or mutual support".

Peters (2010) cites Bradstreet's 2006 delineation of three types of peer support:

1. informal/unintentional and naturally occurring peer support
2. participation in consumer or peer-run groups and programs
3. use of service users as paid providers of services – formal or intentional peer support.

This paper's focus is primarily on the *third* type of peer support described above, where 'service users' are those who identify as people who have personal lived experience of disability, trauma or a particular health or living condition.

The peer support approach promotes a coping, inclusion and wellness mindset. Fostering responsibility and critical self-awareness, it assists a person to find and develop their own personal interior resources, empowering them with the knowledge and belief that they can and do have control over their life. For some people, being ready and willing to take responsibility for their own journey towards participation, inclusion and wellbeing is a fundamental part of recovery.

There are three essential areas of focus for peer support:

1. mutuality: here, 'mutuality' refers to operating from as equal a playing field as possible, where connection is the focal point and neither person is the 'fixer'
2. being a change agent: based on wisdom gained from personal experience, people in peer roles advocate for growth and facilitate learning within the individual served, the service system and beyond
3. remaining 'in' but not 'of' the system: this refers to working in the service system while holding values that are specific to the peer role and not taking on responsibilities that dilute those values or widen their purpose.

There have been many recent studies exploring the 'critical ingredients' of peer support. Many of their findings are congruent with the Independent Living (IL) framework and offer both process and structural standards, as follows.

Structural standards are elements of peer initiatives that define basic rules of groups and, where relevant, how they are constructed. They include being **free from coercion**, being **consumer-run and directed** (both governmentally and programmatically) and having an **informal** setting, with flexibility and a non-hierarchical and non-clinical approach, for example, not diagnosing or doing 'rehabilitation' (Solomon 2004, Salzer 2002, Holter et al. 2004, Clay 2004, Campbell 2004, Hardiman 2004).

Process standards may be likened to beliefs, styles and values. They include:

- utilising the 'peer principle' – affiliating with someone who has similar life experiences and having an equal – that is 'peer' – relationship
- understanding that being helpful to someone else is also self-healing

- empowering – enabling people to find hope and develop a belief that independence and inclusion are possible
- taking personal responsibility to make change happen
- developing of self and system advocacy skills
- creating choice and decision-making opportunities
- developing personal skills and self-help
- allowing positive risk taking
- developing a sense of reciprocity and support
- becoming part of a community (based on Campbell 2004, Clay 2004).

The following table from the review *Peer Support: what it is and what it does* (The Evidence Centre 2015) provides a useful encapsulation of the components of peer support.

Table 1: The components of peer support

Factor	Components	Examples of types
WHO		
Who is involved?	Target group	• People at risk (eg smoking, alcohol, poor diet) • People with long-term physical conditions • People with mental health conditions • Carers of people with physical or mental health conditions • Parents, including breastfeeding mothers • Children and young people • Students • Older people • Employees • Groups with specific experiences (eg veterans, sex workers) • Health and care professionals
Who provides support?	Set up by	• Professional group such as statutory services • Voluntary or community group • Peers themselves
	Facilitators	• Peers alone • Peers working with professionals • Professionals facilitating peer group • Lay-people (but not necessarily 'peers')
	Training	• Peers are trained • Peers are not trained
	Payment	• Peers are paid • Peers are volunteers

The ethics and values of peer work

Historically speaking, many people who experience disability have been labelled as 'the disabled', 'a client' or 'consumer' or have a diagnosis that represents only what people see as their 'sick' or 'broken' parts (for example, 'an epileptic', 'a para', 'retarded', 'spastic' or 'a schizophrenic'). Although they are commonly and frequently approached for assessments and evaluations, few have been asked to discuss what experience has taught them and the personal talents or gifts it has given them, nor have they been helped to develop ways of finding meaning in their life experiences. Often, people have been taught that others are the experts, that there is a professional who has 'the answer' and knows what is best and that there are only limited, rigid versions of a way forward.

Additionally, problems encountered along people's life paths have typically been regarded as the result of their faulty bodies or malfunctioning brains, rather than (at least in some instances) due to

the ways they have been affected by a variety of bureaucratic, professional and environmental factors.

People around them have frequently operated from a sense of responsibility, lack of confidence and fear of liability that have driven decisions and limited tolerance of risk taking, which sometimes has eliminated choice entirely. All too often, people have been taught to have low expectations and focus on maintenance of the status quo rather than the prospect of a full life.

These experiences have driven the creation of the following values, which underpin the peer work ethos.

- Human potential and vision:

  We believe in the probability that all of us can and will be able to have a contributing and fulfilling life. Our focus is on the vision of a full and meaningful life for all, not just day-to-day functioning and survival.

- Prioritise self-determination and choice:

  We put a high value on the healing power of simply having choices and refuse any participation in force or coercion.

- Dignity of being a whole person:

  We, the people who have personal lived experience, are the experts on our own experience. We regard each person as whole, with many strengths and contributions to make.

- Easy-to-understand language:

  We value clear, human, non-clinical language that creates space for each person to explore and find their own meaning in life and their experiences.

- Mutuality:

  We are committed to reciprocity and being honest and real in our connections. We recognise the fluidity of human experience and our various roles, and the ability of each of us to learn from one another.

- Approach each other with genuine curiosity:

  We seek to understand each participant’s world view. We are dedicated to learning about people from themselves, and not from files or meetings where they are not present.

- Honesty, truth and transparency:

  We believe in people’s fundamental resiliency and are upfront with them about limitations, concerns and conflicts. We are never complicit in decisions about people in decisions being made about people without their knowledge and input.

- See challenges as growth and learning opportunities, not as a crises:

  We choose to regard our times of greatest frustration or distress as a potential sign of change to come and as an opportunity for growth. This is not intended to deny the deep pain that people may experience, but rather to value and have faith in what can emerge

from that experience.

- Recognise the need for transformation in support systems and the community:
  We believe that, for change to be sustainable and real, it must happen within our communities and systems. It is not solely the responsibility of each participant.

- Focus on moving forward:
  We seek the development of something better and healthier than the power structures and approaches that have harmed and limited many of us in the past. We will consciously avoid compromising our values or replicating past wrongs.

- Recognise our connectedness and our part in a movement:
  Our work is a part of a human rights movement. We strive to have our fundamental connectedness to a history of disempowerment and oppression and fight for inclusion and for disability rights to be recognised, implemented and understood.

- The importance of community involvement:
  We believe in the importance of human connection in healing and inclusion. A person in a peer role can support someone to find resources within and from the community to meet this need and make sustained change.

We suggest that a code of ethics for peer workers would include the following behavioural stipulations:

- enabling empowerment for participants
- never being judgemental of participants' choices
- having peer worker reporting and support expectations
- not imposing personal limits on others
- encouraging freedom of choice
- acknowledging that a peer worker is not 'all things to all people' – peer workers must know their personal and professional limitations and be honest about them
- exhibiting high standards of personal conduct with regard to
  - ensuring their own safety and wellbeing
  - maintaining emotional and personal control
  - maintaining integrity in 'professional' relationships
  - exhibiting respect
  - respecting and protecting participants' dignit and avoiding substance misuse
- protecting participants' privacy and confidentiality
- exhibiting personal integrity and honesty
- enhancing their own knowledge constantly.

The value and power of peer work

The value of self-help support groups, social and friendship groups, telephone support trees and consumers connecting individually with each other on an informal basis, whether in hospital or in the community, has been recognised for over 50 years. More recently, international research and

literature has provided the evidence base for peer work and peer support upholding and enhancing the quality of participants' lifestyles and personal choices.

Across a range of human service sectors it is acknowledged that good-quality peer work is a means of individualised interaction that is known to be successful in preventing the escalation of personal, support or inclusion issues and promoting adjustment and inclusion by enhancing the participant's emotional, physical and spiritual wellbeing.

Peer support work in particular is known to be an effective and positive intervention strategy for, for example, people who have lost children, people with alcohol and substance misuse problems and people with breast cancer. It has proven to be a tremendously important mechanism towards helping many people move through difficult personal situations (Reissman 1989, Roberts and Rappaport 1989), and in alcohol and other drug services and organisations it is offered as an intervention type that is seen as more practical and effective than generic or traditional methods of support.

Peer work seems to be unique because it provides alternative service delivery processes and courses of action to participants who seek help in ways other than traditional clinical, rehabilitation, social or intervention frameworks. It is intrinsic to inclusion and wellbeing because it provides affordable and accessible assistance that is not comparable with any other type of support, nor is it available in any other way. For people with chronic mental health issues, clinical health services and formal treatment services are essential but can present many challenges, not the least of which are accessibility, timeliness and cost. Peer workers offer an approach that can be either complementary to clinical services, or, in some situations, stand alone.

Peer work is shown to assist organisations in developing and maintaining a 'sensitive support service culture'. It is acknowledged that to promote peer support/work as a valued service type in its own right has validity because, as mentioned above, it is a proven means of preventing the escalation of isolation and emotional issues and promotes help seeking behaviours and improved wellbeing in the people it supports.

A consideration of what peer workers strive to include in their daily practice helps to clarify the value of peer work:

- actively advocating and supporting people to find and use their own voice
- sharing experiences, strengths and wisdom without giving unsolicited advice
- acknowledging those being supported as their primary responsibility
- avoiding discussion of diagnoses or the use of pathologising language – not referring to people using words like 'client', 'consumer' or other consumer systematised terms
- respecting the power of simply 'being with' people in their efforts
- supporting others in peer roles and those working in isolated environments
- staying connected to others and their work by participating in peer worker meetings, events and gatherings and acquiring knowledge and new ideas; this an essential responsibility
- treating each other with compassion (but not through regarding each other as being fragile) through a commitment to honesty, transparency and a willingness to work through issues or conflict

- acting as change agents, sharing new ideas and challenging existing ideas as required
- supporting a culture of questioning to understand and be well informed about how practices and beliefs are shaped
- being committed to being aware of, and transparent about, their own power and privilege in their roles
- understanding the obligations of 'working with' – not 'working for' – a participant.

Further insight into the value of peer work can be gained from the opportunities that peer workers aim to provide each participant with. These are opportunities to:

1. rediscover and activate their own personal, innate resources, enabling them to:
    - share their life challenges with those who understand
    - grow in confidence and be encouraged to share and explore their issues in increasing breadth and depth
    - believe that they can and do have control over their own life, inclusion and happiness
    - take on responsibility for their own journey towards participation and integration
    - gain and share knowledge of skills, activity pathways and tools that may be useful
    - be strengthened, and take that strength out into the community.

2. experience benefits from collective wisdom, providing:
    - access to accumulated knowledge from multiple perspectives
    - new insights, widening the basis of understanding of their particular issues and building meaning in their life
    - an unmatched source of support, inspiration and empowerment, reducing their perceived limitations
    - self-respect, knowing that their wisdom is valued
    - opportunities to understand their inclusion issues, enabling them to have the freedom to be themselves without fear of rejection, failure or humiliation and gain knowledge of their rights and an understanding that their lived experience is accepted and valued.

3. receive hope, inspiration and empowerment for inclusion or providing:
    - proof that inclusion and recovery are possible, gained from observation and learning from the stories of others
    - encouragement from others
    - an understanding that inclusion, observation, understanding, recovery and health are all part of a life-long journey.

4. develop a renewed sense of self-respect, understanding and belonging through being part of a caring community, gaining:
    - knowledge that they are not isolated and are not the first to be in their position
    - strength from the realisation that they are an important part of the community
    - opportunities to make authentic connections that increase wellbeing socially, mentally, physically and spiritually
    - opportunities to give help to others, as equal-to-equal, through:

- sharing what they have learnt
- encouraging listening, as well as being listened to
- potentially offering support to others from their lived experience
- experiencing the personal strength and healing that come from helping others and contributing to the greater good of their community
- self-respect and having knowledge of (and valuing) collective wisdom.

5. access a unique pathway to growth that is:
    - non-threatening
    - affordable
    - complementary to existing provider goals
    - either complementary to existing services or stand-alone
    - open to freedom of participation.

Giving peer support, like receiving it, results both in increased self-esteem and increased levels of hope (Razlaff, McDiarmid, Marty & Rapp 2006). Peer work has added value in that it can provide a meaningful career option for some people living with mental health difficulties. For many people, work provides structure and meaning, and Hutchison et al. (2006) suggest that, for peer workers, employment can provide an identity shift from patient/consumer/client to that of valued worker and contributing citizen. Moran, Russinova et al. (2012) report that peer providers discovered personal strengths that they were not aware of previously, and that their sense of themselves as capable human beings was augmented through their work. As a London manager of peer workers commented, "It's very powerful how it lifts people out of that sick role, to say, 'let us give them a job, here's some responsibility, I believe in you, you can do this'" (Gillard et al. 2013).

Peer work has also been shown to assist organisations in the development and maintenance of a 'sensitive support service culture'. Organisations emphasise that, through their peer workforce, they acknowledge the value and power of lived experience. They see this lived experience in the context of a specialist knowledge base, an expertise. Having that expertise valued and utilised alongside other types of expertise is an effective way to bring relevant supports to a range of participants, enhancing their opportunities and participation goals.

The evidence base for peer work

The following requirements underpin the imperative to employ peer workers in the *UN Convention on Rights of People with Disabilities* 2006:

Article 26.1: "Parties shall take effective and appropriate measures, including through **peer support**, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation."

Article 27.1e, 1f: "Promote employment opportunities and career advancement for persons with disabilities", "Promote the employment of persons with disabilities … through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures."

In Australia, there has been phenomenal growth in the mental health peer workforce in the past five years. In the community sector, for instance, there is evidence of growth of numbers of peer employees from single digits to triple digits in the space of three years. However, peer work is still a comparatively new approach to service delivery and evaluation has lagged behind implementation of peer workforce roles. However, it is important to consider the available evidence regarding the utility and value of a peer workforce. The available evidence is growing, and utilising it will assist agencies and organisations to apply best practice models and contribute to the further development and diversification of the workforce. (There are, however, many aspects of peer work to consider when looking at how service delivery can be improved, and not all elements will be relevant to all organisations or all workers.)

Research has focused more on some areas of peer work and service delivery than others; more studies have been undertaken on consumer peer workers than on carer peer workers, and research has often focused on peer support as a specific element of lived-experience peer work. Where research specifically concerns peer support, efforts have been made in literature reviews to ensure that this is clear; however, it should be noted that definitions in relation to aspects of peer work are often ambiguous. Research has also concentrated on peer work in the context of adult services; there are fewer studies on which to draw with regard to children, young people and older people. For particular age groups, the definition of 'peer' may also involve a person of a similar age or developmental stage, as well as personal disability or lived experience of mental ill-health (Daley et al. 2013). As the research base grows, knowledge of the utility of peer work for people across the lifespan, as well as for their families and carers, will be enhanced.

In the UK, the review *Peer Support: what it is and what it does* was undertaken by an independent organisation, The Evidence Centre, in 2015. The review process followed best practice for identifying and summarising trends in research. Two reviewers searched ten bibliographic databases independently to identify studies published between January 2000 and January 2015. Research of any type was eligible, as long as it was published in English and focused on peer support in Organization for Economic Cooperation and Development (OECD) countries (to allow some comparability with the UK). Research with people with long-term physical or mental health conditions or their carers was prioritised, but other studies were included to illustrate how widely peer support has been used.

More than 20,000 studies were screened, of which 1,023 were identified for inclusion. In total, 524 of these studies examined the outcomes of peer work and the others described processes. They came from the UK (23%), Europe (27%), North America (41%) and many other parts of the world (9%). There were 27 reviews compiling findings from multiple studies and 147 randomised trials (which are thought to provide high-quality evidence). The rest were lower-quality, non-experimental studies. All 1,023 studies were used to develop a simple 'typology' showing the variety of initiatives that are labelled 'peer support'. The researchers then looked at the results of the 524 outcome studies to identify which types of peer support/peer work were associated with improvements in people's experience (including knowledge and satisfaction), health behaviour and outcomes and service use and costs.

Systematic processes were used to identify and analyse the material, but the review was not exhaustive. It showed trends in the research evidence and sparked discussion rather than providing definitive answers about the most effective peer support/work model or the findings of every study.

Using the 1,023 studies to classify the types of peer support/work available, the reviewers found that peer support varies in terms of:

Who is involved

- target group
- who set up the support
- who provides support
- training and payment of facilitators.

What type of support is provided

- support activities
- support type.

Why support is provided

- rationale.

How support is provided

- mode of delivery
- number of people involved.

Where support is provided

- location.

When support is provided

- duration
- frequency.

Interpretations from these variations and analysis of the findings, together with other research and consultations in Australia, are instructive in terms of what a roll-out of peer workers and peer support in the NDIS would require. It would need to be underpinned by a clear set of principles and core values, employment and industrial standards and training and development expectations. Activity to address the firming up of these elements and the creation of relevant guidelines has already been undertaken by key stakeholders across the mental health sector. So, the work required to set up a disability peer workforce will be able to 'piggy-back' on that and adapt – rather than create – the required underpinnings of introducing a new element of our workforce.

Widespread acknowledgment of the usefulness of lived-experience roles exists throughout the literature, with better outcomes, increased quality of life for consumers and reduction of service costs frequently cited (Bennetts 2009, Commonwealth of Australia 2009, Disability Services Queensland 2009, Happell and Roper 2007, Hussain 2010, Mental Health Commission 2005, National

Advisory Council on Mental Health 2009, National Mental Health Consumer and Carer Forum 2010, World Health Organization 2010). However, major barriers to the development of the lived-experience workforce are also identified (Bennetts 2009, Craze Lateral Solutions 2010, Disability Services Queensland 2009, Happell and Roper 2009, National Mental Health Consumer and Carer Forum 2010).

On the subject of barriers, it was found by Goldman and Lefley in 1991 that the attitudes of mental health professionals towards mutual support services prevent their clients from accessing peer support services. Many are reluctant to refer clients and even perceive such services as being potentially detrimental to their overall functioning. Davidson (1999) stated that partnerships struck between professional and peer support services are necessary for the peer support role to have a substantial effect on the majority of mental health consumers. Another significant barrier is funding. Despite the potential gains of peer support, only a minority of consumers with severe mental health issues, that is, up to one-third of individuals, participate in activities offering mutual support. A significant contributor to this phenomenon includes a lack of funding for peer support services and the challenges this presents.

Several studies of peer work report raised empowerment scores by consumers (Repper and Carter 2011). One found that both providers and recipients of peer support reported an increased sense of independence and empowerment, which may have related to increased stability in work, education and training (Ochocka, Nelson, Janxen & Trainer 2006). Personal empowerment can be regarded as a positive process parallel to the negative processes associated with self-stigma. Repper and Carter (2012) note that peer workers embody the possibility of acceptance and success, so they can challenge the barriers created by self-stigmatisation. Engaging in peer support can alter attitudes to mental illness and break down stigma, as well as fostering hope (Mowbray, Moxley & Collins 1998).

Studies have found that consumers involved in peer support initiatives have higher levels of community integration (Repper and Carter 2011). Forchuk, Martin, Chan and Jensen (2005) found that consumers who received peer support demonstrated improved social support, enhanced social skills and improved social functioning. As a person involved in a peer support program run by Mental Illness Fellowship Victoria, put it: “I’ve done a complete turnaround in my life. Even just going to a restaurant or a shopping centre, I don’t feel that anxiety and stress any more. Yeah, I’m a citizen, whereas before, I didn’t feel as if I was” (quote undated).

Importantly, for the peer worker themselves there is evidence that peer work assists with “increased confidence, self-esteem, increased knowledge … increased levels of employment leading to better financial situations, increased volunteering, social support and networking and increased aspirations for life” (Peters 2010). (This aligns well with the community provider’s mission to support people who are affected and who have complex needs, and to resource their journey towards living a fulfilling life in the community. It illustrates a clear business case for embracing a peer work workforce strategy.)

Studies report that peers can be very effective at establishing connections with ‘hard to reach’ clients. Sells, Davison, Jewell, Falzer and Rowe (2006) reported that peer support workers were highly skilled and effective at engaging and communicating acceptance. They were able to increase

treatment participation among the more disengaged in case management for consumers with comorbid mental health and alcohol and other drug issues. Davidson, Bellamy, Guy and Miller (2012) note that peer staff can be especially effective in engaging people into care and acting as a bridge between clients and other staff. In this and other ways, peer support can be an important and useful complement to existing mental health services.

In terms of specific groups, in the mental health context researchers have reported that Māori, Pacific and Chinese participants say that peer support translates well across cultures but requires adaptation to the cultural needs or expectations of each group. Peer support for specific groups or populations should have sufficient operational independence to ensure that the unique and cultural aspects of the service are respected and preserved.

Overall, the evidence with regard to cost-effectiveness and peer workers is limited, largely due to the fact that not enough rigorous studies have been undertaken. A report by the Centre for Mental Health in the UK (Trachtenberg et al. 2013) specifically examined whether peer support workers can reduce psychiatric inpatient bed use and thus prove cost-effective. The study found that peer support workers bring about significant reductions in bed use among the patients they support, leading to financial savings that are well in excess of what it costs to employ the peer workers. The study concluded that the use of peer support workers is justified on value-for-money grounds.

Additionally, a cost-benefit analysis has shown that "peer support workers cost less than clinicians – suggesting they are cost effective" (Peters 2010). Generating cost-effectiveness while utilising an expert resource that is central to achieving a provider's mission makes sound business sense. Peer workers may be cost-effective in a range of ways. They may complement the non-peer workforce, allowing both peers and non-peers to focus on using their respective expertise. Supporting health practitioners to use their full scope of practice can improve satisfaction, retention and productivity (Boston University, Center for Psychiatric Rehabilitation 2010).

In terms of risk management, some studies have shown that peer work has no effect; however, there are no studies to date to show that it has any *adverse* effects (O'Hagan 2011).

A literature review undertaken by Canadian researchers (Leung et al. 2002) revealed that, although past research findings are limited due to the lack of rigour in their methodologies, participants of groups offering peer support have described the following significant gains:

- self-esteem
- better decision-making skills
- improved social functioning
- decreased psychiatric symptoms (resulting in decreased rates or lengths of hospitalisation)
- lower rates of isolation
- larger social networks
- increased support seeking
- greater pursuit of educational goals and employment.

(Davidson et al. 1999, Humphreys and Rappaport 1994, Froland et al. 2000).

Research undertaken by Health Workforce Australia included a small-scale survey of 305 people who identified as peer workers. Of this sample, 18% worked casually, 29% full-time and 53% part-time. About half of the sample worked for non-government organisations, while 17% worked in public hospitals, 11% in a Commonwealth-funded mental health service or program and 10% in a state- or territory-funded public mental health service or program (National Mental Health Commission 2013).

Although, as has been stated, many studies are qualitative, some randomised control trial findings are available. The quantitative and qualitative evidence suggests that the peer workforce can be as effective as the professional mental health workforce in some roles, and may offer particular benefits to consumers, peer workers, families, carers and service providers.

The history of peer work

Peer work has its origin in self-help and mutual support movements that were volunteer in nature (Davidson et al. 2006). People came together to help one another or to advocate for better services. As has been stated, peer work has recently evolved into more formalised approaches, and people are employed as peer workers in varying roles. Today, referring to 'peer work' is different in that we use this term to relate to 'professional' lived-experience peer workers who are in paid employment.

Australian efforts towards peer work

1980s: a push to incorporate peers into organisations and participation in policy formulation and service evaluation was not welcomed. People with lived experience were tolerated as volunteers and needed to show their worth. In time, most community organisations began to include lived-experience and carer volunteers in such positions as board member, but there were no formal involvement opportunities and no funded roles in staff, policy or support areas.

1990s: in 1992 a small committee of people who had personal lived experience of psychosocial disabilities met with Ms Jan Whalan, Manager of the large Sydney Rozelle Hospital, to discuss and develop the creation of roles that would utilise the value of those who have learnt from such experience. This meeting was followed by the historic employment of consumer peer advocates at the hospital, with appropriate employment conditions and salary rates. These peer worker roles are acknowledged as the earliest nominated roles for people with lived experience, and the people who performed them are recognised as the first paid peer workers in Australia. They were a cohort of part-time and casual consumer advocates (peer workers). Historically, this coincided with the publication of *The Report of the National Inquiry into Human Rights of People with Mental Illness*, the development of the first National Mental Health Strategy and the formation of The NSW Consumer Advisory Group. This period also saw an increase in the variety of consumer and peer engagements and opportunities. Victoria and a few other states followed, with various forms of paid roles for lived-experience consumers being created in services.

2000s: by 2008 it was clear that the diversity of roles and, in some places, the distortion and corruption of the integrity of such roles, had the potential to undermine the higher values that they represented. A peak lived-experience organisation (Australian Mental Health Consumer Network) created a working group to set out standards and ethics to underpin peer work in Australia.

However, they were unable to complete that work (it remains incomplete).

The founder of the USA's Georgia Peer Support Network, Larry Fricks, visited Australia in 2008, and again in 2011, to discuss peer work and establishing enhanced peer workforce training and employment opportunities. He spoke about 'certified' peer specialist training and the variety of peer roles, and said that, following US Federal legislation in 2007, such certified peer workers are able to bill Medicaid for certain services. The Georgia Peer Support Network's Certified Peer Worker Training course is the core training requirement for peer workers in 23 states. The takeaway message from Mr Fricks was: "I am an expert in lived experience; I am the evidence of recovery".

2010s: Professor Larry Davidson (of Yale University, USA) visited Australia several times, promoting peer work and the academic case for integrating it into service provision. He outlined both the academic research and the evidence base that backs up such concepts as the value of lived experience and, particularly, the efficacy of peer worker roles. His work reminds us that integrity and truthfulness, aligned to the core values of peer work, need to underpin everything we do.

In this decade, Mental Health Commissions (national and state) have shone a new spotlight onto the peer workforce and its potential, particularly its part in improving the 'contributing lives' of those who can benefit from peer work activity. The Mental Health Commissions reinforce that what is needed now is a greater commitment on the part of providers to expand on their peer workforce and establish career structures to enable those staff in specialist peer roles to continually improve and look to future career developments. The peer workforce is now the most rapidly growing workforce in the mental health sector in Australia, with many working in the non-government sector.

Australia's National Register of Vocational Education and Training has approved a course "**Certificate IV in Mental Health Peer Work**", and a range of accredited Registered Training Organisations and Technical and Further Education Colleges currently offer professional training and accreditation for people wanting to work as peer workers. Separate units of training are available for those with personal lived experience and for carer peer workers. This training has a suite of peer-developed open access training resources to support delivery of the course, thereby maintaining its quality and integrity. This paper proposes that work be undertaken to amend Cert. IV MH Peer Work training units to facilitate adaptation of the course for a broader scope, encompassing the elements and needs of the broader disability sector and creating from that work a training course for Disability Peer Work. This will not be a major task but one that is specialised and will require a consultative and expert team to draw the relevant elements together.

Overseas efforts towards peer work

USA: peer work/peer support "has gained an important and effective role in state systems of mental health care. While there are ongoing challenges, it is clear that participating states have been successful in integrating peer support in their workforces and overall systems of care" (Grant et al. 2012, p7).

UK: peer work/peer support has been identified as key facilitators across a range of UK health and social care policy agendas, including recovery, self-care and personalised health and social care. An

implementation program to support the UK mental health strategy has been established, with a specific remit to develop and demonstrate new peer worker roles. In September 2013, the Scottish Government published the Scottish Recovery Network's *Reviewing Peer Working: A New Way of Working in Mental Health*, which showed that peer working was becoming an increasingly important part of recovery focused services. The Care Quality Commission, the independent regulator of health and social care in England, has launched its 'Experts by Experience' program, in which people who have personal experience of using mental health and/or social care services (or who care for people who use them) take part in inspections of services and contribute to the consequent reports.

New Zealand: the participation of peer workers with experience of mental ill-health, distress or addiction is regarded as important in improving and developing responsive and effective mental health and addiction services in New Zealand. A number of policy documents emphasise the importance of the peer workforce and a culture of resilience and recovery (Ministry of Health 2005, 2012–17, Mental Health Commission 2007). Mental health and addiction peer workforce development has been identified as a priority in national mental health and addiction policies and plans. Service users are "an underutilised resource which could be strengthened to address current workforce shortages and contribute to building a more effective mental health and addiction workforce" (Te Pou 2010, p9).

Canada: In 2010 the National Mental Health Commission wrote the policy document *Making the Case for Peer Support*, which made a number of recommendations for strengthening the Canadian peer workforce.

Peer work in the NDIS context

Why should the NDIS be interested in peer workers?

The international human rights treaty, the *UN Convention on Rights of Persons with Disabilities 2006*, to which Australia is party, contains the following articles:

Article 26.1: "Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation".

Article 27.1e: "Promote employment opportunities and career advancement for persons with disabilities".
1f: "Promote the employment of persons with disabilities … through appropriate policies and measures, which may include affirmative action programs, incentives and other measures".

An NDIS peer workforce would provide meaningful, appropriately supported and recognised employment opportunities for persons who experience a disability. In supporting such a workforce, the NDIS would be exercising a level of social responsibility that acknowledges the expertise locked up in lived experience and would thus give individuals a chance to contribute, utilise their experience and enjoy opportunities that they may not otherwise get. Furthermore, by recognising the

contribution of lived-experience practitioners, the NDIS would be demonstrating its awareness that social responsibility is real, not tokenistic.

How to introduce peer work

In promoting the importance of peer work, the NDIA will provide information that will enable key stakeholders and providers to understand and appreciate its value and power. Peer work can legitimately be promoted as:

- an effective workforce mechanism that will alleviate predicted workforce shortages
- an efficient means of preventing the escalation of personal, support or inclusion issues
- a mechanism to promote adjustment and inclusion by improvement in participants' emotional, physical and spiritual wellbeing.

Providers will be given information that will help them to see and understand the benefits of establishing a peer workforce. We suggest that an NDIS Guideline be developed and supplied to providers who are introducing a peer workforce, covering the following elements to inform practice, as well as guide and support the recruitment and retention processes:

- the attitudes towards and understanding of peer work
- the evidence base and theory of peer work
- problems and barriers to peer work
- the NDIS's peer workforce role – issues and processes
- maintaining the integrity of peer work and peer workers
- training in peer work
- supervision of peer workers
- that not every person with lived experience is a potential peer
- that peers should organise for peers, not have others design their role and activities
- that professional peer work needs appropriate wage and career structure.

It should be made clear that 'reasonable adjustments' policies must be imbedded within organisations and negotiated with the individual employee. Care must be taken to ensure there is a balance in staffing practices to ensure the organisation can accommodate reasonable adjustments and support. Failure to do so will impact on the organisation, service users and the individual employee.

What is the intrinsic value of a disability peer worker?

In the NDIS provider context, the validity of the disability peer worker will be in acknowledging the value and power of lived experience in the context of a specialist knowledge base. Lived experience will be valued and utilised alongside other types of expertise, bringing 'specialised' and relevant supports to individuals that will enhance their opportunities and participation goals.

There is a strong ethical and economic case for the employment of disability peer workers. Potential disability peer workers are currently 'out there', are available and are keen to be trained and to find fulfilling employment opportunities.

We offer this option as a response to the reported 'crisis' in the disability workforce across parts of Australia, which is that there are not going to be enough workers to fulfill needs. In addition, this peer disability worker project offers an option for support provider organisations that are keen to assist the NDIS in fulfilling the disability employment goals that form part of its design.

Would ethics and values be different for a disability peer worker?

Historically, the disability peer worker would see their philosophical foundations and values set as deriving from the **Independent Living (IL) Movement**. In essence, those values and ethics would be similar, if not identical to, those that are accepted as the core elements of the mental health peer workforce's ethics and values. An overview of IL and its foundations will help in the understanding of the possible ethical and values 'fit' between a mental health peer and a disability peer.

Across the disability sector, the Independent Living Movement became a reaction to social, physical and treatment barriers primarily for people with physical disabilities. It arose at a time when other movements were gaining headway in establishing rights for oppressed groups of all kinds.

Through strategic advocacy, the Independent Living Movement focused on three general areas:
1. enforcing the **civil and benefit rights** for people with disabilities
2. developing a **way of thinking** created by people with disabilities
3. creating **alternative services and advocacy centres** (Deegan 1992, DeJong 1979).

As DeJong (1979, p443) explains: "According to the IL paradigm, the problem does not reside in the individual but often in the solution offered by the rehabilitation paradigm- the locus of the problem is not the individual but the environment that includes not only rehabilitation process but also the physical environment and the social control mechanism in society at large."

In identifying the critical elements of peer work, Solomon (2004, p8) reminds us: "Consumer provided services need to remain true to themselves and not take on the characteristics of traditional … services", while Campbell (2004, p32) also notes that "consumer operated programs should present an alternative worldview" So what does it mean for such services to stay true to themselves and provide a different worldview?

There have been many recent studies exploring the 'critical ingredients' of peer work in the mental health sector. Most findings are congruent with the IL framework and offer both structural and process standards.

Structural standards are elements of peer initiatives that define the basic rules and how related groups are constructed. They include being **free from coercion**, that is, being voluntary, **consumer-run and directed** (both governmentally and programmatically) and taking place in an **informal** setting, with a flexible, non-hierarchical and non-clinical approach – for example, not diagnosing, doing 'rehabilitation' and so on (Solomon 2004, Salzer 2002, Holter et al. 2004, Clay 2004, Campbell 2004, Hardiman 2004).

Process standards are best seen as beliefs, styles and values. They include:

- the ‘**peer principle**’ – affiliating with someone who has similar life experiences and having an equal, that is, ‘peer’ relationship
- the ‘**helper principle**’ – the knowledge that being helpful to someone else is also self-healing
- **empowerment** – finding hope and believing that independence and inclusion are possible
- taking **personal responsibility** for making things happen
- **advocacy** (self and system advocacy skills)
- **choice and decision-making** opportunities
- **skill development**, **positive risk taking**, **reciprocity**, **support**, **sense of community, self-help**, and **developing awareness** (Campbell 2004, Clay 2004).

Roles of peer workers in the NDIS

Disability peer workers will work alongside traditional support and personal care workers. At times their tasks will appear identical; the differentiating factor will be the mutually shared aspects of their life experiences, and, because of that mutuality, an enhanced empathy will exist. There will be increased motivation and willingness for participants to challenge their ‘status quo’ and attempt to achieve more in their lives. There are no limits to the type of support role a peer can undertake, except for those prescribed by the person’s own aptitude for the tasks, together with their natural physical, sensory or intellectual limitations.

There are many aspects of life that are commonly found between and across disabilities that a peer worker can assist a participant to reverse, and it could be said that there are aspects that only someone with a similar life experience can hope to reverse so that, for example, vulnerability becomes strength and isolation becomes mutuality.

There would be several types of peer worker in disability settings. These would include:

- **Peer-to-peer worker** – would work solely with those who have a similar type of life experience/disability. For example, a peer worker living well with spinal cord injury could be incredibly useful as a supporter of a participant with a similar injury.
- **Cross disability peer** – would work in a ‘cross disability’ environment where their knowledge and lived experience would be relevant to the requirements of the participant. For example, a mental health peer worker could possibly be a significant support to a person with emotional support needs who is physically or intellectually disabled.

Insurance Principles and peer work

There are three principles underpinning the philosophy and practices of the NDIA. These are termed ‘Insurance Principles’, and all activity, support and funding is aimed at realising them in the lives of people with disabilities in Australia.

The Insurance Principles of the NDIS are that each participant will have enhanced:

1. choice and control
2. independence
3. self-management.

It is envisaged that, by the use of peer workers, the NDIA will more readily implement these principles and entrench them both into the NDIS and into the lives of those who participate in it.

Peer workers: plans, support and LAC

It is envisaged that the tasks allocated to disability peer workers would be similar to those that other support and personal care staff would undertake. However, the way they would be undertaken and the extent of personal contact and development of a working relationship would vary slightly. These peer workers would be eminently suited to supporting the participant to develop and implement their plan. They would assist in its coordination and perhaps advise on the types of most effective supports. They would involve the LAC as necessary in the best interests of the participant and would be effective advisors at that level.

Human resources considerations

We suggest that, in making a commitment to a diverse, peer-inclusive workforce, the provider organisation should**:**

- determine a staffing mix that will meet the needs of participants by encompassing the Insurance Principles of choice, hope and inclusion
- ensure that practices are in place that build the capacity of all staff in all areas of practice, including the support and recognition of the value of workplace diversity through peer workers and peer support
- ensure that ongoing personnel support and resources are available to provide for ongoing development, reasonable adjustment and workplace support for the peer workforce.

There are six aspects of successful peer work providers that relate to human resources. These are that they offer:

1. a clear philosophy and guiding principles to ensure focus and differentiation from traditional support roles, ease of supervision, key performance indicators for peer workers and determination of outcomes
2. integrity – peer work is most effective when it is operationally independent, led by those with lived experience, not tokenistic or viewed as just another contract, supported by other providers, well supervised, based on understanding relationships with funders and has outcomes consistent with the role. It may be more difficult for peer support to maintain integrity when integrated within traditional providers or clinically focused organisations
3. effective recruitment processes
4. training consistent with the role – it is of concern if people working as peer workers receive no training
5. an effective peer supervision structure
6. a fully developed organisational structure – organisations providing peer workers must be credible and able to support the provision of effective peer support. The disability sector has a responsibility to build capacity and capability among disability service organisations.

An important human resources consideration when creating or maintaining a peer workforce is to bear in mind what its members should **not** do. Within an organisation there is an inherent risk of 'colonisation' of a peer worker. This may occur if there is a strong requirement or inducement

towards conformity in performance or lack of peer supervision/peer-led training and development. It means that the peer worker no longer holds to the 'mutuality' and 'collaboration' that is intrinsic to their relationship with the supported peer, but rather takes on the role of 'doing to' or 'doing for' them.

In peer work, 'collaboration' is not always recommended where that type of relationship may result in loss of identity, where philosophical incompatibility precludes compromise or where there is an inherent power imbalance in the service provision. It is not consistent with peer worker values to participate in activities that run the risk of further increasing power imbalances.

These activities include (but are not limited to):

- involvement in medication administration
- acting in the role of substitute decision maker for the participant
- routinely talking about people without them being present in individual, team or plan related meetings.
- participating in routine non-support documentation (for example, clinical notes)
- reading assessments or other non-related system documents
- any actions that make peer workers complicit in force or coercion (Western Massachusetts Peer Network).

Providers should be warned against setting up peer workforce recruitment, only to have the peer workers performing the 'lowest' types of work. In these situations peer work becomes a 'bottom-of-the-heap', degrading job. The provider's motive for establishing peer work may, in fact, be incompatible with the values that underpin the use of peer workers, and the peer workforce may even be a token presence to enable providers to fulfil their service user participation goals or contractual or PR requirements.

Human resources departments have a responsibility to maintain the integrity of peer work. This can be undermined by what some call 'systems erosion', whereby peer support is subjected to system requirements that were developed with a different underlying philosophy and value base. Without a clear understanding of its role, peer work will have difficulty relating to other roles and boundaries will be unclear. Similarly, peer work can lose integrity if it is not clearly differentiated from other support roles. Peer work must be understood to be radically different from other support roles, and how and why this is so should be made clear.

The following table, which has been slightly adapted from Orwin (2008), outlines some strategies to maintain the integrity of peer work.

Table 2: Strategies to maintain the integrity of peer work

Factors affecting the integrity of peer work	**Strategies to maintain integrity of peer work**
Avoiding tokenism	• peer support team leader should be a peer • peer support team leader should be a member of the senior

	management team • peer support ought to be operationally independent • funders should ensure there is peer leadership • funders should ensure the service is credible.
Leadership	• have explicit support for peer support from all levels of leadership • train all managers, from CEO to line managers, in understanding peer work.
Systems	• should be a clear understanding of the role of peer work • peer support work should be clearly differentiated from other support roles • policies and procedures should be adapted to support development of peer workers/peer workforce.
Supervision	• skilled, knowledgeable supervisors should help peer workers to 'stay peer' • external supervision should be provided • there should be active development of peer supervision capacity.
Funders and outcomes	• it should be understood that peer support is different from other forms of support • mutual understanding between peer work service and funder should be built • outcomes consistent with the philosophy of the service should be ensured • clinical/rehabilitation outcomes should never be demanded but functional expectations should be consistent • it should be accepted that outcomes from peer work are evolving • qualitative measures that can capture the impact on lives should be sought • outcomes that are broader participation and inclusion outcomes should be sought • functional expectations should be consistent with the role.

The 'Avoiding tokenism' section of the table recommends that peer support team leaders should be part of the senior management team. This may prevent the peer support service becoming tucked underneath other services and being little more than a tacked-on service. In cases where peer work is an add-on service or one component within a suite of services but with little to distinguish it, participants often cannot tell the difference between a peer worker and other types of support worker. This is indicative of poor support and training of peer workers.

Some participants argue that funders should see proof that there is peer leadership of peer support, that the service is credible and not just a contract. If a peer support team is integrated within a larger organisation it should, ideally, retain operational independence.

Finally, it is important to train all managers across the organisation from the CEO to the front-line managers of peers in the peer support role, the philosophy of the peer support service and the empowerment approach.

Training and development of the peer workforce

There is no accredited Disability Peer Worker qualification in Australia. It is our contention that the development of such a qualification and its curriculum would be possible within a relatively short timeframe if there were a community/industry commitment to supporting the concept.

The NDIA is ideally placed to partner with disability service providers to request that such a qualification be developed. The qualification that we suggest is based on experience and knowledge of the course content of a related qualification, the Certificate IV, Mental Health Peer Work.

Many mental health peer work courses and curricula can be found in the USA, Canada, New Zealand and parts of Europe. Several of these are accredited to certain agencies, but there is wide variation in their expectations, consistency and levels of competencies. That is why peers in Australia emphatically wanted to develop a single qualification; they wanted consistency of expectation, agreed value sets, agreed standards of practice and a quality set of standardised core information units for those in the peer workforce. Development of the nationally accredited Certificate IV qualification in Mental Health Peer Work was completed in 2012 through the Community Services and Health Industry Skills Council. From 2014–15, Registered Training Organisations began to offer this qualification, and graduates give enthusiastic feedback around how challenging and effective the training and assessment process has been. Also, and more importantly, they have said how much it is enhancing their work and supporting their awareness of maintaining integrity of their practices in peer work.

The Certificate course has an approved curriculum, developed with strong stakeholder leadership and involvement in its content. There is a suite of learning tools that support trainers in appropriate course delivery and assessment, and a number of its learning units require that an experienced peer worker delivers them.

The six core units of the course are:

1. applying peer work practices in the mental health sector
2. contributing to continuous improvement of mental health services
3. applying lived experience in mental health peer work
4. working effectively in trauma-informed care
5. promoting and facilitating self-advocacy
6. contributing to work health and safety processes.

The course covers these topic areas:

- continuous improvement
- applying lived experience in work
- trauma-informed care
- promoting self-advocacy
- self-directed physical health.

In addition to the six core units of the course, a further nine elective units must be completed. At least one of these electives must be either 'Working effectively with culturally diverse clients/co-workers' or 'Working effectively with Aboriginal and/or Torres Strait Islander people'. The qualification has been designed for both consumer and carer peer workers. Students are required to undertake either two consumer peer worker units or two carer peer worker units, depending on their chosen stream. Experienced or advanced peer workers may access Associate Diploma-level training, encompassing leadership skill set and management skill set.

The Certificate IV is now highly recommended for all mental health peer workers, and it is being proposed that newly appointed peer workers be required (and supported) to complete it. The certificate has strong integrity as a relevant and appropriate qualification for those working in mental health peer work, and for that reason we see it as a valid base for our assertion that a Certificate IV in Disability Peer Work could be developed, based on the work already undertaken in this area.

In the general sense, training and development opportunities for peer workers are essential. In mental health, there are multiple opportunities for peer-led or peer-organised training opportunities, through Recovery Colleges in multiple states and through larger community organisations, some Registered Training Organisations or specialist peer focused training consultancies or conferences.

These opportunities have not always existed. They arose in response to the growth in the numbers of peer workers and the demand for appropriate training and development options. We can extrapolate from that that it is likely that the market place for training and development initiatives for disability peer workers will grow and become available as the workforce grows in numbers and expectations. Opportunities will expand alongside that growth.

One of the key insights from the *Health Workforce Australia Review of Mental Health Peer Workforce* (2013) is that training on its own is insufficient. The review found that training and development must be accompanied by continuous appropriate support and peer supervision (see next section): "Peer support encompasses a range of potential relationships … There is equal potential in each type of relationship for Peer Workers to be exposed to suicidal intent or experiences that are distressing or traumatising. 'You can't just have a bit', a provider argued, 'just training is not enough. There must be continuous support. Depth of training is probably less important than having a safe structure to work within. That means supervision'".

(The same review emphasised that several participants argued "strongly that the non-professional [that is, non-health, non-clinical] character of peer support – such as mutuality and equality in relationship – should not be lost with the emergence of a trained and paid peer support workforce. Peer support by definition is non-professional support. One provider, for example, adopts … a motto 'experts at not being experts' to describe the role. Few in the sector would want peer support taught within tertiary institutions by tutors who may have little or no practical experience in providing peer support".)

Professional supervision for a peer workforce

Effective supervision helps maintain integrity for the peer worker. A skilled supervisor, knowledgeable about the peer role, can help the peer worker to 'stay peer'. External supervision especially can assist the peer worker to step out of their role to understand and reflect both on what they do and on the personal reactions and motivations that may be influencing their work effectiveness. Effective supervision is crucial to the development of emerging roles such as disability peer work.

Supervision for a peer worker should take the form of:

- monthly one-to-one formal line management supervision with their team leader
- monthly one-to-one supervision with an external supervisor
- fortnightly structured group supervision
- fortnightly less structured group supervision.

Supervision is critical to the success of peer work and yet is the process that is most likely to be neglected or cancelled due to time constraints. Supervision is a specialised, professional process that needs to be conducted with skill and understanding. Although supervision in peer work is no different in process from clinical supervision, its content is different. This is not just because peers already carry vulnerability from their lived experiences, but also because the peer work role is so different from traditional support or rehabilitation roles.

Peer workers' supervisors need:

- an understanding of, and belief in, the peer work role and the service model and philosophy
- to be, ideally, people with similar lived experiences, and to have undertaken the same peer training as those they supervise
- training and experience in supervision
- to be external to the peer workers' team and, ideally, be external to the organisation.

Career trajectory for peer workers

When designing an appropriate career trajectory for peer workers, providers should:

- ensure appropriate senior peer supervision
- set wages at appropriate levels
- guarantee access to regular peer training and development opportunities
- ensure peer work positions are respected within organisational structures
- allow for development and specialisation of peer roles and offer advanced career paths.

As a summary of what human resource considerations should aim to achieve, we offer the following adaption of the National Mental Health Commission's (2013) outline of how lived-experience peer workers should be treated and regarded in the workplace.

They should be regarded as:

- an essential component, not an 'add on' to any support team, with equal status to their team colleagues
- professional experts supported by national competencies and standards.

They should be:

- remunerated appropriately at a level commensurate with their skills and training
- supported and sustained into and in the role with high-quality, ongoing training and appropriate supervision and a clear career trajectory.

As a summary, the following table, which is adapted from and based on Gates and Akabas (2007), proposes a number of strategies relating to human resource policy and practices, workgroup relationships and operations that can improve employment experiences of peer workers.

Table 3: Strategies that can improve peer workers' employment experiences

Factors affecting peer integration	Workplace strategies that promote integration
Attitudes towards disability	Clear disability position in mission statement. Leadership commitment to disability and peer work well communicated. Leadership support. Peer work viewed as essential expertise rather than an add-on.
Role conflict and confusion	Well defined recruitment strategies. Consistent application of workplace policies to peer and non-peer staff. Written job descriptions for all staff, including peers. Supervision to ensure that actual job expectations are the same as written job expectations. Training for staff and participants to provide understanding of roles. All new staff receive formal orientation.
Lack of confidentiality	Implement a formal disability support and reasonable adjustment process for peer workers. Do not allow peer workers to receive services in organisations where they are employed. All receive training on policies and practices related to confidentiality. Establish a formal process for sharing work-related information between peer and non-peer staff.
Job structure	Accepts experience in lieu of formal credentials as HR policy. Peer positions are permanent. Peer positions have a clear path for promotion. Apply the same performance standards to peers and non-peers. Compensate peers and non-peers in comparable positions equally. Provide benefits and supports by mutual agreement in relation to conditions, expectations and work hours.
Social support	Opportunities for interaction in agency life (team meetings). Include peer input in planning activities.

	Provide appropriate supervision. Meet formal disability support and reasonable adjustment requirements.

Recommendations

The concepts of peer work and peer support have been extremely successful across a range of human service areas and are shown to provide optimum outcomes for participants. It is our contention that a cutting-edge disability support service would be one that utilises such 'disruptive technology' to maintain quality leadership and supports.

In particular, we make the following recommendations.

1. Choice should be maintained through the provision of a range of peer support services. There is enough scope for a variety of different peer support philosophies and service structures to be maintained. The key consideration when choosing a provider is whether they offer appropriate, safe, effective, clearly defined and credible peer support work that will benefit participants. The success or otherwise of a service is ultimately determined by philosophical, organisational and individual factors that transcend particular models.

2. The NDIS should incorporate within its strategic plan specific goals, actions and targets relating to the development and growth of a disability peer workforce.

3. The NDIS should engage a disability peer work focus in national and state/territory rollouts. It should engage in promoting disability peer work implementation in NDIS strategic developments to ensure that this initiative places the NDIA in a leadership role, encouraging and shaping new service innovations and directions.

4. An NDIS Peer Worker Recruitment Guideline should be developed and supplied to those providers who are introducing a disability peer workforce.

5. Disability peer workers should receive credible training consistent with their role. The sector is strongly urged to engage in a debate about how to develop a minimum level of competency and a career pathway for disability peer workers.

6. An accredited disability peer worker qualification should be developed in Australia. Gaining industry commitment to facilitate development of this qualification and its curriculum would require the NDIA to partner with disability service providers.

7. There should be effective and appropriate supervision structures for disability peer workers.

8. Organisational capacity and capability should be developed. Insufficiencies of those and of management become serious obstacles to the continued development of disability peer work. Only credible individuals in organisations that can demonstrate both capacity and capability should provide disability peer support, and the sector has a responsibility to help to actively develop this. Building capacity and capability in disability peer worker supervision especially should be a sector priority.

9. Providers should develop a disability peer workforce strategy.

10. The NDIS should set up a recognition process for those disability peer work leaders who could be regarded as bringing subject matter expertise to their provider organisation. Additionally, the NDIS should support that organisation to utilise this expertise when appropriate. Disability peer workers should be remunerated at a level that recognises and reflects the value of their expertise, despite where their position may sit in the organisational hierarchy.

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