

Consumer Workers' Forum Project

Literature Review on the Mental Health Consumer Workforce



September 2010

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The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) is the peak, independent, statewide organisation representing the views of mental health consumers at a policy level, working to support and achieve systemic change. NSW CAG’s vision is for all mental health consumers to experience fair access to quality services that reflect their needs.

The Consumer Workers’ Forum (CWF) Organising Committee is made up of the experience and expertise of consumer workers. The CWF Organising Committee operates to ensure the efficient, effective and transparent management of the Annual Consumer Workers’ Forum. Part of the work of the CWF Organising Committee is to ensure that they work in consultation with consumer workers, developing best practice for consumer workers in NSW.

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NSW CAG & NSW CWF funded by the NSW Department of Health

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Executive Summary

The consumer workforce can be traced to the consumer movement of the 1960s and 1970s, following the deinstitutionalisation of people living with mental illness. Consumer advocacy groups were set up following this period, pushing for consumer participation in planning, implementation and evaluation of the mental health system. Through the active promotion of consumer participation, public, private and non-government mental health services began employing consumers as part of the paid service team.

Consumer workers have various roles and responsibilities including: peer support and mentoring of consumers; individual and systemic advocacy; role modelling and support and incorporating a recovery framework; education and training of mental health workers; supervising and debriefing consumer workers; and administration tasks. The varying tasks expected of consumer workers can result in unclear and often vague position descriptions for the workforce. Consumer workers also face inconsistencies in remuneration, titles, roles and responsibilities, and training and education.

These inconsistencies can lead to challenges and barriers in the employment of consumer workers in mental health services. Challenges highlighted in the literature include: role conflict and confusion; job titles that often do not reflect the work performed by the mental health consumer workforce; dual relationships and boundary issues; concerns regarding the inadequacy of remuneration of their work; discrimination and stigmatising attitudes from non-consumer staff; little support and supervision structures; limited access to education and training for professional development; addressing reasonable workplace accommodations for consumer workers; and the need for evaluation of the consumer workforce.

Consumer workers have also been recognised to bring a positive addition to mental health services in NSW, nationally and internationally. The lived experience, personal knowledge and consumer perspective that consumer workers contribute has been valuable to the consumers using the services, and the mental health service itself. Consumer workers have also benefited from active employment in mental health services as well.

In 1993, six consumer workers and a coordinator were employed at Rozelle Hospital, New South Wales (NSW). This was the first consumer worker service of its kind in Australia. Following the success of this service, consumer workers were employed across the state, often in an ad-hoc manner. It was later recognised that consumer workers often had nothing by way of clarification of their job roles and responsibilities and no consistent training and education or award rate. To improve upon the situation for NSW consumer workers, Stage 1 of the Consumer Workers' Forum (CWF) Project commenced to examine the

functioning and other aspects of the consumer workforce in NSW Area Mental Health Services and to make recommendations concerning standardised work practices.

Currently in NSW, there is estimated to be over 58 consumer workers employed in public mental health services. Stage 1 of the CWF Project reported on areas in need of improvement to move the consumer workforce forward in public mental health services. Areas included the need for: consistent titles, roles and responsibilities; standard remuneration awards for the workforce; adequate training and education opportunities for consumer workers; and, structured supervision and support for consumer workers during employment.

Progress that has been achieved in NSW has been uneven, with development needed to create a more stable workforce. Stage 2 of the CWF Project will build on the work conducted in Stage 1 to produce a framework for consumer workers that will be endorsed by the Mental Health Program Council that clearly sets out the roles, functions and responsibilities of consumer workers, minimum training and education standards, and a consumer worker Code of Professional Standards.

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG), contracted by the CWF through Sydney West Area Health Service, is currently conducting Stage 2 of the CWF Project with the support and funding of the NSW Health Department. Stage 2 of the project aims to develop a statewide framework, for the consumer workforce in public mental health services, that will be endorsed by the NSW Health Mental Health Program Council.

The purpose of this literature review is to examine the research on mental health consumer workers. This review assists in highlighting the current barriers and challenges that exist in the employment of consumers as paid members of mental health services, with the findings informing the focus for undertaking consultations with relevant stakeholders throughout the project and providing direction for developing the framework for the consumer workforce in NSW.

The review considers:

- The history of the consumer workforce
- Consumer workforce progress around Australia
- The current consumer workforce in NSW
- International consumer workforce progress
- Barriers and challenges that face the consumer workforce
- The benefits of the consumer workforce

1. Introduction

Mental health consumer workers are people with the lived experience of mental illness, employed in consumer designated roles within mental health services in various capacities to provide peer support, and individual and systemic advocacy for public mental health consumers (Bennetts, 2009). The workforce is seen as vital in the support and advice they offer to mental health services on a range of issues in New South Wales (NSW), nationally, and internationally.

Consumer workers are employed by mental health services to use the skills they have acquired from having experienced mental illness and their personal experiences of accessing mental health services. The role is diverse, including a wide range of roles and responsibilities as highlighted by the literature. The consumer worker role has diversified in order to respond to policy directions and to the growing recognition that the “consumer perspective improves the culture, quality, effectiveness and responsiveness of community mental health services” (Bennetts, 2009, p33).

Literature on consumer workers highlights that the consumer worker performs many roles and duties, suggesting that there is a need for a clearer definition of what a consumer worker is, and the work they should be performing within the mental health service. Consumer workers are often involved in:

- Targeted peer support and mentoring to consumers, including: counselling; training on how to use public transport; job site assessments; and conducting group sessions, group activities and outings (Cleary et al., 2006). The roles and responsibilities of peer support work can fall within the term Consumer Worker; however, for many consumer workers this may be the only duty (employed strictly as a Peer Support Worker) that they perform in their employment.
- Individual and systemic advocacy (Cleary et al., 2006). Some of the duties performed by consumer workers in an advocacy role include: improvement in justice and equity for the individual and/or peer group; focus on systems and social change; community development; community education; complaints management; advocating for rights as articulated in the *Mental Health statement of rights and responsibilities* (1995) and the *Charter for Mental Health Care in NSW* (2000); and health professional’s learning.
- Role modelling and supporting and incorporating a recovery framework within the mental health service (Nestor & Galletly, 2008; SAMHSA, 2001; Van Tosh, Finkle, Hartman, Lewis, Plumlee, & Susko, 1993).

- Enhancing the visibility of the consumer voice at both the individual treatment and service delivery level to inform cultural and structural change in service delivery and workforce development (Dixon, Krauss & Lehman, 1994).
- “Back-fill” duties; Watson (2007), voiced concern around the fact that many consumer workers feel that they are given tasks that should be carried out by other health or allied health staff. These tasks often fall outside of their job descriptions.
- Administration responsibilities; there has been a growth in the administration demands and responsibilities for consumer workers as they become involved in a wide range of tasks, development, reporting mechanisms and committee representation (Cleary et al., 2006).

In NSW consumer workers are employed within private, public and non-government (community managed) mental health services. Much like national and international consumer workforces, consumer workers in NSW experience a range of challenges.

The Consumer Workers’ Forum (CWF) identified the need for research to be carried out into the consumer workforce, to ensure the continuous quality and improvement of consumer workers in NSW. Through the support and funding of NSW Health, Stage 1 of the CWF Project was formed, with the commencement of an interim literature review, followed by a statewide questionnaire of current consumers and Area Health Service (AHS) Executives regarding the current consumer workforce. This process revealed the current situation of the consumer workforce and identified what work needed to be done to improve the system.

The aim of the first stage of the project was to examine the functioning and other aspects of the consumer workforce in NSW Area Mental Health Services and to make recommendations concerning standardised work practices.

The following specific aspects of the consumer workforce in the public mental health sector were investigated:

1. Functions
2. Employment conditions
3. Training
4. Supervision
5. Job descriptions/ Statement of duties
6. Code of Conduct
7. Recruitment

Stage 1 identified the following:

- The staff establishment (i.e. number of paid employment positions) of consumer workers is inconsistent across NSW AHSs

- There is a lack of consistency across the state with regard to the tasks and duties performed by consumer workers
- Job roles are diverse and ill defined. There is no consensus about role definition: it is unclear whether consumer workers possess the skills/training required to perform the diverse tasks and duties documented in position descriptions
- There is an absence of a standardised training program for consumer workers

The CWF Organising Committee made the following recommendations as a result of the findings of the project, to develop and improve the role of the consumer worker in NSW Area Mental Health Services:

1. With the active participation of consumer workers, develop a framework that will clearly articulate the role, functions and responsibilities of the consumer worker in an Area Mental Health Service context and from which standardised work practices can be derived. This framework should include allowances that facilitate a flexible working environment commensurate with the limitations associated with having a disability.
2. Within the context of the proposed framework, develop a NSW Health Mental Health Consumer Participation Policy.
3. Develop an education paper for wide dissemination that provides an evidence base and a plain English description of individual and systemic advocacy as it pertains to the work of the consumer worker.
4. Develop a comprehensive training program for consumer workers under the auspices of a respected academic institution such as the NSW Institute of Psychiatry. This objective will facilitate acknowledgement of consumer workers as an independent and autonomous profession in mental health.
5. Commission a working group of consumer workers and relevant stakeholders to review a proposal to establish a separate Code of Professional Standards and Ethics for NSW AHS consumer workers that would supplement the NSW Health Code of Conduct that is applicable to all health employees. This would be in line with similar discipline-specific standards that apply to the other health professionals.
6. Develop a core generic position description for NSW AHS consumer workers that would include a duty statement and a list of essential and desirable criteria for recruitment. This initiative would encourage the development of a professional identity.

7. Review the range of titles currently utilised by consumer workers in Area Mental Health Services and consider the advantages of having a generic position title for NSW.
8. Each AHS to establish a position of Consumer Worker Manager/ Coordinator that would be held by an experienced consumer worker. This person would oversee the Area's Consumer Participation Program, provide support and professional supervision to all consumer workers employed in the Area and would report directly to the AHS Mental Health director.
9. AHSs establish mandatory training for relevant management and human resource staff about interacting with staff with a disability
10. AHSs ensure that all consumer workers have easy and reliable access to supervision and professional support programs
11. Consumer worker staff establishment to be based on the following criteria:
 - All registered consumers in an AHS to have at least 0.014 hrs per week contact with a consumer worker
 - Salaries and wages budget to be not less than 1% of the Area's Mental Health Budget
12. MHDAO to provide recurrent budgetary support to the CWF Organising Committee to allow it to:
 - Ensure continuation of the Annual CWF and that this is to include secretariat support allowing the CWF to extend its support and networking activities
 - Continue to conduct research projects associated with the functioning of the consumer workforce.
13. Consistent with current AHS position descriptions for consumer workers (i.e. to sit on committees), membership of the CWF Organising Committee should be formally acknowledged and costs associated with membership funded by AHSs.

Stage 2 of the CWF Project was developed to directly address recommendations 1, 6, 7 and consider components of recommendations 4, 5 and 10. Stage 2 is being conducted by the NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG), contracted by the CWF through Sydney West Area Health Service (SWAHS) to achieve the specific objectives and deliverables of the Project.

Stage 2 of the CWF Project aims to develop a statewide framework for consumer workers. It will build on the work conducted in Stage 1, to produce a framework for consumer workers that will be endorsed by the NSW Health Mental Health Program Council that clearly sets out the roles, functions and responsibilities of

consumer workers, minimum training and education standards, and a consumer worker Code of Professional Standards.

The expected project deliverables include:

1. A fully articulated framework for consumer workers in NSW ratified by the Mental Health Program Council for implementation in NSW including:
 - a. Clearly defined roles, functions, responsibilities and titles
 - b. Position descriptions for remunerated roles
 - c. Clarification of remunerated award
 - d. Minimum standards for supervision, support and professional development for consumer workers
 - e. Evaluation framework for consumer worker roles
 - f. Minimum level of training and education for consumer worker remunerated roles
2. Report on best practice for delivery of consumer worker training, including professional development
3. A Code of Professional Standards for consumer workers ratified by the Mental Health Program Council for implementation in NSW

The project is limited to the mental health consumer workers within the public mental health system where consumer workers are employed by an Area Health Service in NSW. However, the principles and recommendations may also be applied to the non-government (community managed) and private sectors.

The project will be conducted in 4 phases.

1. Phase 1 will involve the development of:
 - a. Roles, functions, responsibilities and titles for consumer workers
 - b. Position descriptions
 - c. Remuneration standards
 - d. Supervision, support & professional development standards
 - e. Framework for evaluation of consumer worker roles
2. Phase 2 will involve the development of minimum training and education needs and an understanding of the best practice for the delivery of training
3. Phase 3 will involve the development of a Code of Professional Conduct for consumer workers in NSW
4. Phase 4 will bring the project together to culminate in the development of a Framework for the Consumer Workforce in NSW.

Consultations will be conducted with stakeholders throughout all phases of the project. Feedback will be sought on the draft findings of consultations prior to the finalisation of recommendations and findings.

This literature review is part of Stage 2 of the CWF Project, and will be used to provide stakeholders with a broad overview of the mental health consumer workforce in NSW, Australia and internationally. This review is intended to provide a general overview of the history of the consumer workforce, the barriers and challenges facing the workforce, as well the perceived benefits of consumer employment in mental health services and non-government organisations. The review will provide direction for the project and consultations, and help generate discussion. It is not meant as an exhaustive review of all the literature nor all the current efforts in the consumer workforce movement nationally and internationally, but to provide an overview of the current and historical situation.

A note on the language:

Consumer workers are often referred to in many ways such as consumer workers, consumer advocates, peer support workers, service user workers and consumer-providers. For the purpose of this literature review we use the term “consumer worker” to cover all consumer designated roles in public mental health services.

2. Methodology

The literature search was conducted during May and June, 2010. Literature was identified from the following sources:

- Journal database searches, including searches of PsycINFO, Journals@Ovid PsycArticles, Cochrane Library, Health Collection, PubMed, Informaworld Journals and Oxford Journals Online, using the keywords and phrases “consumer workers”, “mental health workforce”, “peer support workers”, “peer training”, “service user workforce”, “consumer movement”, “consumer participation”, “evaluation”, “challenges”, “Australia”, “United States”, “New Zealand”, “Canada”, “Scotland”, “United Kingdom”. These were either used singularly or in combination with each other.
- Google and Google Scholar was also searched with these keywords and phrases.
- Key references (references that featured predominantly in the literature) within the articles obtained from the above sources were accessed.
- Australia’s current and previous mental health policies.
- International mental health policies, including those from New Zealand, America, the United Kingdom and Canada.

Limitations in the sourcing of literature needs to be acknowledged. The two month time frame to write the review impacted on the extent of literature that could be incorporated into this review.

Certain countries were included in the search terms, as preliminary readings indicated that the United States, New Zealand, Australia, Canada and the United Kingdom have all made progress in the employment of consumer workers in mental health services, and provide examples of best practice and empirical studies conducted into the mental health consumer workforce.

3. History of the Consumer Workforce

The consumer workforce has its origins in the consumer movement and consumer participation. Consumer participation has largely been acknowledged as an international human rights issue, with mental health services only recently recognising the importance of incorporating the lived experience in improving the quality and responsiveness of mental health services (Mental Health Commission, 2000; WHO, 1993). It has also been demonstrated that consumer participation can empower consumers, and allows significant contributions to be made to service delivery through the active involvement of the expertise and lived experience of mental health consumers (Lloyd & King, 2003).

Active consumer participation has its origins in the social movements throughout the 1960's and 1970's, such as the civil rights movement and the development of self-help organisations (Tower, 1994). These social movements saw the rise of the 'consumer rights movement' worldwide and the deinstitutionalisation of people with mental illness (Mowbray et al., 1996 The Clearinghouse, 2000). During this time consumer groups came together seeking to reform the mental health system (Tower, 1994), and aiming to educate consumers about the mental health system, so that people with a mental illness could gain access to the best services and treatments available (The Clearinghouse, 2000).

Consumer advocacy groups formed out of the consumer movement and push towards promoting human rights. Here consumers met to action change in policy and service delivery, and to have more control over their treatment (Mowbray et al., 1996; The Clearinghouse, 2000; Tower, 1994; Unzicker, 2001). Many of these consumer groups oriented towards self-help and peer support (Tower, 1994), with several community groups going on to:

- Form clubhouses for meeting and recreational purposes;
- Educate consumers about mental illness and treatment;
- Extend services that include transitional and vocational skills training; and
- Provide mutual support to help avoid some of the adverse consequences of mental illness

(Mowbray, et al., 1996; Tower, 1994)

The Consumer Movement in Australia

In Australia, consumer participation in the planning, implementation and evaluation of the mental health system has been largely represented in the National Mental Health Strategies, and throughout Australian Mental Health Policy (Commonwealth of Australia, 1992; Commonwealth of Australia, 1997: Commonwealth of Australia, 2009; Commonwealth Department of Health and Ageing, 2002; Human Rights and Equal Opportunity Commission, 1993; NSW Department of Health, 2006).

The Second National Mental Health Plan stated that “consumers should have a key role in planning and evaluating the services they use and must be able to influence the way in which their service needs are met” (Commonwealth of Australia, 1998, p16). The *National Standards for Mental Health Services* (Commonwealth of Australia, 1997) and the *National Practice Standards for the Mental Health Workforce* (Commonwealth Department of Health and Ageing, 2002) also outline the importance of mental health services undertaking and supporting a range of activities which maximise both consumer and carer participation within the service.

Across Australia, a number of consumer-led organisations emerged – such as the Victorian Mental Illness Awareness Campaign (VMIAC) and GROW – out of a recognised need for increased consumer participation in health care and policy (Middleton, Stanton & Renouf, 2004). These groups actively campaigned and advocated for changes to the mental health system in Australia, including changes to policy and legislation, and increased consumer and carer participation in service delivery (Middleton et al., 2004). Various other consumer advocacy groups also formed to promote consumer participation in the planning, implementation and evaluation of services (Cleary et al., 2006).

It was through the active promotion of consumer participation led by the consumer-run organisations that public mental health services started employing mental health consumers to work alongside mental health service staff (Stewart, Watson, Montague & Stevenson, 2008).

Non-Government Organisations (or Community Managed Organisations) have also played a vital role in consumer participation throughout Australia, by involving consumers in service planning, policy development, setting priorities and training and evaluation (NSW Department of Health, 2008). NGOs are involved in providing people with a mental illness or disorder “with a range of psychosocial rehabilitation and support services, including social and emotional support, practical support to live at home, support in employment, social activities, helping link people with services and advocating on their behalf” (NSW Department of Health, 2008, p50). Services run by NGOs also actively advertise positions for and employ people with the lived experience of mental illness. Many NGOs also engage with a volunteer workforce involved in peer support, running support groups and administration (Aspire, 2009; NSW Department of Health, 2008; PRA, 2008). Consumer designated positions in NGOs fall primarily under peer support related activities and duties.

The Consumer Workforce in NSW

The development of meaningful consumer and carer participation mechanisms is a key priority in state mental health policy (NSW Department of Health, 2006). NSW mental health consumer workers have become a significant element in a broader mental health participation strategy in NSW, with the NSW Mental Health State Plan recognising the need for increased consumer involvement in the

community, and education and employment in mental health services (NSW Department of Health, 2006).

Consumer employment in NSW had its beginnings in the early 1990s following the implementation of the National Mental Health Strategy and the First National Mental Health Plan, when a group of consumer workers set up a training programme for advocates at the Rozelle Hospital (Cleary et al., 2006). Following the success of the consumer worker service in Rozelle Hospital, consumer workers were employed across the state, with services in NSW recognising that the inclusion of consumers as mental health workers “can increase the sensitivity of programs and services. Services in NSW that have consumer employees are capable of better understanding clients problems and their solutions, better able to develop trust and rapport with clients and better promote empowerment” (Mowbray et al., 1996, p59).

The inclusion of consumer workers was originally intended as a mechanism “to enhance the quality of mental health services through dialogue between service providers and consumer consultants and to improve the responsiveness of services to the needs of consumers” (Bennetts, 2009, p8). Over the years, the role of consumer workers has expanded beyond consultancy work, to include participation in service evaluation, advocacy, research activities, service delivery and input into education and training programs (Bennetts, 2009).

Following a rapid uptake of consumer workers within the state, Watson (2007) noted that most often consumer workers were employed in an ad hoc manner, with nothing by way of consistent guidelines, orientation, adequate training or clarification of their job descriptions, roles and responsibilities and award rates. The Annual NSW Consumer Workers’ Forum arose out of these concerns and the fact that there was no mechanism for Area Health Mental Health consumer workers to network and obtain peer support and development, with the first forum held in 1998 at Rozelle Hospital. There are now annual statewide forums for all Area Health Mental Health consumer workers to gather to network, share experiences and expertise, and have the opportunity for professional development.

Despite broad policy support for the incorporation of consumer participation in mental health service delivery, this has not largely translated in practice. The increased expectations of consumer workers in their roles and responsibilities has not been matched in terms of adequate funding, resources and support structures across the state, “with detrimental impacts on the sustainability of the consumer worker perspective” (Bennetts, 2009, p10). Also adding to the difficulties facing the consumer workforce is that,

“consumer workers often are employed within services that neither necessarily share similar goals or values with the consumer workforce,

nor cater well for its recourses, supervision or training requirements” (Bennetts, 2009, p15).

In 1996 NSW CAG held a consumer and community forum in Sydney to focus on models of consumer participation within the state. Participants on the day recognised the need for consumer workers and identified a range of roles that they would be responsible for. Some of these identified functions are already being performed by the current workforce in NSW (including working in mental health services to organise training and support). Given changes to the system since the consumer and community forum, it is timely to reconsider what is needed in our current consumer workforce in the state.

The establishment of the consumer workforce in Australia, NSW and more broadly internationally, has resulted in many challenges that need to be addressed to ensure an effective and sustainable consumer workforce. These challenges will be discussed further in this review.

4. Peer-Support in Other Health Fields

In many other fields such as substance abuse, deaf/hearing impaired, HIV disease, and spinal cord injuries, employing consumers as part of the treatment team has been traditionally common practice (Carlson et al., 2001). The concept of self-help and peer support is not a new idea, with people organising peer-support groups in other health fields to redress “civil and social wrongs, change policy in the public/private sectors, and promote education.” (SAMHSA, 2001, p5). This section briefly reviews the literature from these fields as an informative base for the mental health consumer workforce.

History of the Peer-Support Movement

The peer-support movement in human services and health can be traced back to the Alcoholics Anonymous (AA) group, founded in 1935 (SAMHSA, 2001). AA is a group of men and women who come together to share their stories, experiences and strengths in a group setting, hoping that together they can solve their common problems (Alcoholics Anonymous, 1994).

AA meetings formed out of a philosophy that people do not have to rely on the experts in order to improve upon their condition (SAMHSA, 2001). This thinking gained much attention in many fields of human services and health, with people moving towards a shift in thinking about the provision of help from professionals. During the 1960’s and 1970’s many other peer support groups in other health fields came together. Recovering individuals often ran these groups, serving the function of an effective role model and educator to their peers (SAMHSA, 2001).

The Substance Abuse and Mental Health Services Administration report (SAMHSA, 2001) into peer-support groups found that these recovering individuals were found to provide effective counselling, with their experience of having “been there”, enabling recovering substance abusers and recovered patients (diagnosed with cancer, HIV/AIDS etc.) to establish a rapport with current patients that professional staff cannot.

Notable aspects of peer-support groups include:

- A blurred distinction between the patient and professional staff
- The dominance of the common welfare and group unity
- An absence of any form of hierarchal governance, and
- In many groups the benefits of anonymity.

(SAMHSA, 2001).

Peer-support workforces are engaged in the following tasks and duties:

- Sharing their personal story or their experience, strength and hope with the patient
- Providing emotional support to patients that have been hospitalised

- Enhancing the patient's motivation to maintain abstinence (for active drug users)
- Encouraging the patient to attend meetings of self-help groups
- Organising and running peer support groups, and
- Acting as a role model for patients

(Blondell, Behrens, Smith, Greene & Servoss, 2008; Dunn, Stegninga, Occhipinti, & Wilson, 1999; Finn, Bishop & Sparrow, 2009; Marino, Simoni, & Bordeaux Silverstein, 2007)

The evaluation of peer-support programs, such as those designed to help support substance abusers, cancer patients and those diagnosed with HIV/AIDS, have reported a number of positive outcomes for patients. The results from these studies have demonstrated that:

- Peer visits are associated with higher rates of self-help initiation (Blondell et al., 2008)
- Peer-support programs contribute to the peer worker's own recovery journey (Blondell et al., 2008)
- Patients have felt less anxious after hospital visits from the peer worker (Dunn et al., 1999), and
- A decreased sense of isolation is usually experienced by those attending peer-support groups (Marino et al., 2007)

Volunteerism in Peer-Support Groups

Volunteerism is a growing global trend, with a reported 31% of the Australian population volunteering in 2005 (Commonwealth of Australia, 2005). Volunteers actively contribute to many aspects within the health field, with literature suggesting that they are most commonly involved in providing social support for patients and substance abusers (Macvean, White & Sanson-Fisher, 2008; SAMHSA, 2001).

Literature on peer-run services and support groups usually report the such services are made up of a large volunteer workforce; this is a clear distinction from the consumer workforce in NSW. Recovered patients usually volunteer their own services for people who are undergoing similar life situations to them, reporting that they often feel they have a significant contribution to make towards their health care and treatment (SAMHSA, 2001).

Support provided by volunteers in support programs include practical, emotional, informational, social and counselling (Macvean et al., 2008). Macvean et al. (2008) go on to report that a majority of peer-support programs offer training for the volunteers, however the literature does not detail the training that is provided. Supervision is also provided to a majority of volunteer programs, however, literature is limited in describing the processes that are involved (Macvean et al., 2008).

Literature on paid peer roles within other health fields is limited, further contributing to the idea that the majority of patient peer-run services and support groups are conducted by a volunteer workforce (Macvean et al., 2008). The volunteer is a recognised important aspect of providing peer-support to patients, suggesting that the volunteer consumer workforce needs to be further recognised and acknowledged in NSW.

5. Consumer Workforce Progress around Australia

According to the *Report on Government Services 2009* (SCRGSP, 2009), on average 27.9 FTE consumer workers per 10,000 clinical staff were employed in Australia. At the time of the report, there were no consumer workers reported to be employed within Tasmania, the Australian Capital Territory and the Northern Territory. Since the release of the report, some progress within the consumer workforce has been made in each state. The progress across Australia is examined below.

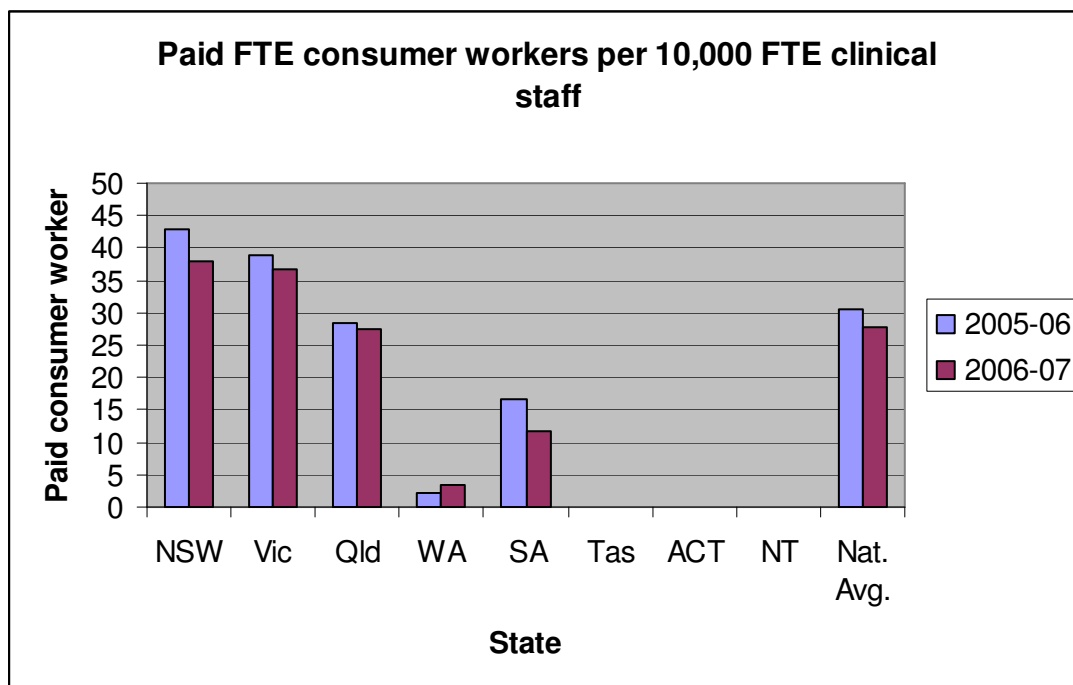


Figure 1: FTE consumer and carer workers employed per 10,000 FTE clinical staff (Full-time equivalents – FTE) – (SCRGSP, 2009).

Australian Capital Territory

Within the ACT, consumers have previously had little or no opportunity to provide ideas or input into how the services they receive should be operated to better meet their needs (ACT Health, 2007). Over the past two decades there has been a shift in this top-down approach so that health professionals and administrators are now including consumers and carers in decision-making about service development and delivery (ACT Health, 2010). The ACT has increasingly recognised the importance of the involvement of consumers in the decision making process about the services that they use (ACT Health, 2007).

In order to realise effective consumer participation in mental health services, organisations such as the ACT Mental Health Consumer Network and Carers ACT promoted the involvement of consumers and carers in the development of consumer oriented services and carer support mechanisms (Nestor & Galletly, 2008). Part of this promotion included an evaluation of the ACT Mental Health Strategy and Action Plan 2003-2008, with recommendations focusing on the need for stronger support for a consumer workforce within the Territory (Nestor & Galletly, 2008).

The current consumer workforce in the ACT consists of 2 consumer consultants, performing systemic and individual advocacy as well as peer support (Anglicare Tasmania, 2009). The consumer consultants also participate in: policy forums and at an executive level in mental health services; assist in educating staff; and visit community mental health services to speak to consumers (Anglicare Tasmania, 2009).

Strategies and structures to support consumer participation within the ACT have been outlined in a Consumer Participation Framework. This document sets out 22 principles for participation and the structures required for continuous improvements to quality service delivery and relationships (ACT Health, 2007). The Framework outlines the role of the consumer worker with the issues listed below.

Employment

Feedback to the Framework suggested that advocacy roles should be performed by persons employed outside of Mental Health ACT, but with a role remaining for a consumer worker to work closely with staff in the service. Clear job descriptions, connection with peers and good support are also considered vital for the workforce.

Skill Requirements

Respondents to the Framework believe that consumer workers need to remain representative of mental health consumers, with an importance placed on the need for a connection to exist between the consumer and consumer worker.

Role of the Consumer Worker

It was strongly highlighted that consumer workers should not be involved in individual advocacy services, instead focusing on the following tasks:

- Assisting with staff training and transition of staff attitudes,
- Assisting with orientation of new consumer workers
- Co-ordination of consumer roles in Mental Health ACT
- Facilitation of collaborative relationships with stakeholders
- Being available for staff consultation
- Being a contact person for local or national inquiries, and
- Referring issues to the Consumer Advisory Meeting

Peer Support

Respondents to the Framework realised the importance of peer support roles within the consumer workforce. Suggestions made include that Mental Health ACT should supervise peer support programs and work alongside the consumer workforce.

Victoria

VMIAC actively advocated for the employment of consumer workers within mental health services, as part of the models that were developed in two projects during the 1990s (Epstein & Shaw, 1997). One of these projects was the Understanding and Involvement (U&I) Project, which was a consumer evaluation of a psychiatric hospital undertaken in Melbourne that developed a model of deep dialogue between consumers and staff, in a quality improvement framework (Wadsworth, 2001). One recommendation from this discussion was the identified need for the employment of consumers in mental health services (Bennetts, 2009).

In 1996 consumer workers were first employed within the state under the title of Consumer Consultant (Bennetts, 2009). Bennetts (2009) reports that the introduction of paid consumer workers was intended as “a mechanism to enhance the quality of mental health services through dialogue between service providers and consumer consultants, and to improve the responsiveness of services to the needs of consumers” (p12).

The employment of consumers within mental health services is thought to have three main objectives:

1. To enable consumer perspectives to be included in all aspects of the mental health service’s planning, delivery and evaluation
2. To assist in the improvement of the mental health service’s responsiveness to consumer needs
3. To communicate the broad views of consumers to mental health services and other relevant services

(Department of Human Services, 2003).

The current consumer workforce in Victoria predominantly comprises of consumer consultant positions, usually funded by the Department of Human Services, with some consumers working in roles related to research, education, training, peer support, advocacy, mentoring, supervision, and in Consumer Advisory Groups (Middleton et al., 2004). Most work performed by the consumer workforce in Victoria is undertaken in Area Mental Health Services and in Psychiatric Disability and Rehabilitation Support services for adults (Middleton et al., 2004).

Consumer workers in Victoria are employed like any other employee and are directly accountable to the Department of Human Services, not mental health service users (Middleton et al., 2004). The consumer workforce is involved in the

ongoing day-to-day activities of the area mental health service and interact daily with staff and consumers, but are not employed as direct service providers (Middleton et al., 2004).

Activities performed by the consumer workers in Victoria include:

- Committee representation
- Peer support
- Organising consumer networking opportunities
- Education of consumers and mental health staff
- Input into staff training and daily contact with a variety of clinical staff, and
- Representation on community-based organisations such as the local Division of General Practice

(Middleton et al., 2004).

The employment of consumer workers in mental health services has also met many barriers and challenges in Victoria, including: suggestions that they have no real power or authority; that their job requirements may be impossible; and that the positions were created for political reasons rather than to improve the quality of services (Middleton et al., 2004; SPICE Consulting, 1999).

Within the forensic setting in Victoria, Forensicare is responsible for the statewide provision of adult forensic mental health services. Forensicare have a comprehensive consumer participation program in place in order to ensure appropriate mechanisms and systems exist to promote and facilitate consumer participation at all levels of the organisation. Forensicare employs consumer consultants in order to facilitate the consumer participation program, and bring their lived experience to the role and provide a legitimate voice for consumers within Forensicare. Other activities carried out by the consumer consultants include: encouraging and supporting consumers to become more involved in their own treatment; educating clinical staff in certain aspects of how services may be experienced from a consumer perspective; and participation on a range of key committees and working groups at Forensicare (Forensicare, 2009).

Queensland

One of the key objectives of the Queensland Mental Health Plan was to ensure that mental health services delivered high quality care that best meets the needs of consumers and that is accountable for the efficient and effective use of resources (Lloyd & King, 2003). The *Ten Year Mental Health Strategy for Queensland* (1996) also emphasised the need for formal consumer advisory processes and a push towards the employment of consumers within mental health services (Lloyd & King, 2003).

To meet the need for a consumer workforce, Austin (2010) worked on a consumer and carer workforce pathway in Queensland to reform participation within the state. Several consumer roles were created, including:

- Consumer Representative

- Consumer Companion
- Recovery Support Worker
- Specialist Consumer Consultant
- Consumer Consultant
- District Coordinator
- Senior Project Officer, and
- Manager Participation Team

(Austin, 2010)

Consumer companion roles are a relatively new position established in Queensland in 2008, to support inpatient consumers who were reporting loneliness, boredom and a lack of support (Austin, n.d.). Austin (n.d.) explains that the:

“Consumer Companion Program is an innovative program based on peer support offered to consumers in acute inpatient units. The support and interaction offered by companions assists consumers to become more positive about their care and treatment, thus increasing consumer comfort and making their stay in hospital less intimidating. Underpinning the program is the concept of shared experience and learning through peer support” (p1).

According to *Experts by Experience: Strengthening the mental health consumer voice in Tasmania* (Anglicare Tasmania, 2009), Queensland currently is estimated to have over 100 consumer workers employed (Austin, 2010). The work performed by these consumer workers involves practical support work as well as individual and systemic advocacy (Lloyd, Tse & Deane, 2006). The consumer and carer workforce pathways project aimed to clarify the role of the consumer worker and assist in establishing roles and career pathways (Austin, 2010).

South Australia

Nestor & Galletly (2008) report that in 1998 consumer workers were first hired in South Australia at four rehabilitation sites as part of a partnership project between the Schizophrenia Fellowship and the North West Adelaide Mental Health Service. As part of the employment of consumer workers, each person was required to take part in an eight month training program, to help prepare them for placement within the service (Nestor & Galletly, 2008).

Most of the workforce is made up of part-time and volunteer workers within non-government organisations and in public mental health facilities. Consumer workers are believed to be particularly beneficial in early intervention, helping young people recognise signs and symptoms of psychosis, assisting consumers to play an active role in their recovery, educating families to have a better understanding of psychosis, and providing role models for recovery and offering inspiration and hope for the future (Nestor & Galletly, 2008).

Peer Support Workers in South Australia have:

- A series of professional qualifications available (including tertiary level certificate courses, which can lead to a 2-year diploma course)
- Three levels of pay, depending on qualifications and experience (with the most senior level including administrative responsibility for coordinating the roles of other peer support workers and for supervision and mentoring), and
- Participation in a professional development program

(Nestor & Galletly, 2008).

Currently, training is made available through the Mental Illness Fellowship and Baptist Care SA, particularly for those involved in peer support (Baptist Community Services, 2008).

The South Australian Government is reportedly committed to developing a consumer workforce to provide clearer job descriptions, remuneration standards, selection criteria and training that consumer workers should receive (Anglicare Tasmania, 2009).

Western Australia

Consumer workforce development has been slow in WA, with an estimated three consumer project workers involved in specific projects rather than having a broader systems role (Anglicare Tasmania, 2009). The project workers are referred to as “consumer consultants”, and have been involved in work looking into improving consumer outcome measures, and developing a training program for peer support workers to encourage consumers to maintain their physical health (Anglicare Tasmania, 2009). Through the physical health program, eight peer workers were employed to work in the discharge process of one hospital to help link consumers to GPs and encouraging them to maintain their physical health (Anglicare Tasmania, 2009).

Further steps were taken in implementing consumer participation across the state through the creation of a senior consumer position in WA in 2008 (Anglicare Tasmania, 2009). This position is involved in:

- Implementing consumer participation in WA
- Establishing a quarterly forum for consumers to share information and input into training
- Establishing quarterly meetings with area health directors to input consumer feedback, and
- Education of nursing staff and social worker training

(Anglicare Tasmania, 2009).

Northern Territory

The Northern Territory has had little consumer involvement in service delivery. The small population base and the vast geographical area have been attributed to slow developments in consumer participation. Most of the work in the Northern Territory has been focused on the development of an Aboriginal Mental Health Workforce, to ensure involvement from Aboriginal people in rural and remote communities (Harris & Robinson, 2007).

Tasmania

Currently in Tasmania there exists little participation mechanisms within mental health services for consumers to be involved. According to the *National Mental Health Report 2007* (Commonwealth of Australia, 2008), Tasmania has no consumer consultants working within the state. However, this has not always been the case.

In 1996 a consumer-led initiative was funded to hire part-time consumer workers to be active in two hospital sites in Tasmania, to provide an information resource for inpatients about hospital and community services (Anglicare Tasmania, 2009). These consumer workers were trained by a consumer coordinator and worked in pairs within services (Anglicare Tasmania, 2009). In 2002 the funding for the consumer worker posts ceased.

The majority of consumer participation within Tasmania has been within the NGO sector, with organisations such as Aspire, Anglicare and the Richmond Fellowship engaging consumers to provide services for consumers within the community (Anglicare Tasmania, 2009).

NGO Consumer Workforce Initiatives

NGOs are often involved in promoting the involvement of “consumers and carers in the delivery and management of their services” (NSW Department of Health, 2008, p50). Part of this involvement includes employment of consumers as both paid and voluntary staff members within their services across Australia. The 2010 NGO Workforce Scoping Study conducted by Health Workforce Australia (previously the National Health Workforce Taskforce) found that 54% of the 800 mental health NGO organisations and/or programs operating nationally employ consumer workers and 35% employ carer workers (MHCC, 2010).

Below is a summary of some of the programs and organisations that actively employ people with the lived experience of mental illness to assist in program and service delivery. This list of NGOs is not intended to be a complete listing of all organisations that hire consumers to deliver services. Rather this list provides a sample of the consumer workforce in NGOs. While many organisations have consumers in volunteer roles, involved in service design and government, such as Board Members, the majority of paid, designated consumer roles in the NGO sector are for providing peer support services.

- The Personal Helpers and Mentors (PHaMs) Program: PHaMs aims to provide increased opportunities of recovery for people living with mental illness. The PHaMs program is delivered by NGOs that are funded by the Department of Families, Housing, Community Service and Indigenous Affairs (FaHCSIA). The PHaMs program has been responsible for employing peer support workers within NGOs across Australia to work alongside case workers to deliver the program (Australian Government, 2010). Since 2006, about 200 Peer Support Workers have been employed nationally by the NGO delivered PHaMs program (MHCC, 2008).
- Consumer Activity Network (Mental Health) Inc.: The Consumer Activity Network (CAN) is an independent, not for profit, consumer run organisation for people with a mental illness. CAN actively employs mental health consumers, with all of their program staff identified consumers. CAN's board is also made up of experienced consumers (CAN Mental Health).
- GROW: GROW is a national organisation that provides people with support through self-help groups using a 12 step program to recovery. GROW members are made up of those people with the experience of mental illness (GROW Australia).
- Psychiatric Rehabilitation Australia (PRA): PRA is one of the longest established disability service organisations in NSW. PRA has an affirmative action program as part of their employment process, encouraging in all of their positions for people with the lived experience of mental illness to apply. Certain positions at PRA (such as their peer support leaders and the independent consumer consultant) are consumer designated (PRA, 2008).
- Schizophrenia Fellowship: the Schizophrenia Fellowship is a not for profit, community based organisation working in the field of mental illness. The Fellowship provides a range of consumer support groups in the local community, aiming to reduce the difficulties and disadvantages that mental illness might cause in the lives of mental health consumers. Consumer volunteers remain a crucial aspect of providing support groups for the Fellowship (Schizophrenia Fellowship, 2008).
- Anglicare: Anglicare is a community care arm of the Anglican Church in Australia. Anglicare provides several services for mental health consumers, providing opportunities for consumer participation in providing support groups and recovery programs (Anglicare, 2010).
- Mental Illness Fellowship of Australia (MIFA): The MIFA is a national, not for profit, grassroots, support and advocacy organisation that is dedicated to improving the lives of people living with mental illness. MIFA provides a

range of peer support services across Australia, employing mental health consumers to deliver these groups (MIFA, 2010).

- Aspire: Aspire is a non government community based agency which provides non clinical services in mental health. Aspire runs peer support programs, and volunteer programs, all of which have the involvement of employed consumers in delivering these services within the area (Aspire, 2009).
- Neami: Neami is a non-government mental health organisation that provides rehabilitation and recovery support to people with a serious mental illness. Neami has long offered consumers the opportunity to be involved in designing and implementing services that are relevant and accessible for all consumers. Consumer participation is highly valued at Neami, with consumers involved in: active employment; input into the Board of Directors; and becoming group members of the organisation (Neami, 2009).
- Hope – Hearing Voices Network: The hearing voices network is the consolidation of Hearing Voices Groups, working towards the common goal of promoting recovery, acceptance and education about the experience of hearing voices. Voice hearers are actively involved in self-help groups, sharing experiences with consumers and non-consumers, exploring ways of managing and coping with voices and accessing information and resources and learning about the recovery process (Hope – Hearing Voices Network NSW, 2009).
- Richmond Fellowship: The Richmond Fellowship of New South Wales (RFNSW) is a not-for-profit organisation that provides support programs, accommodation and hope for people with mental illnesses. The Richmond Fellowship have independent organisations throughout each state in Australia, aiming to enhance the lives of people affected by mental illness. The Richmond Fellowship offers a range of programs which focus on community based recovery within an accommodation support framework, actively employing people with the lived experience of mental illness to be engaged in implementing these programs (Richmond Fellowship of NSW, 2008).

6. Current Situation in NSW

Consumer workers have been employed in various capacities in NSW Area Health Services (AHS) for some years. According to the Report on Government Services 2009 (SCRGSP, 2009), NSW employed 37.9 full time equivalent (FTE) consumer workers per 10,000 clinical staff, 10.0 FTE more than the average for Australia. There is currently estimated to be over 58 employed consumer workers (see figure 1) in mental health services across NSW (Stewart et al., 2008). A recent review of the workforce by NSW CAG revealed in 2010 there are approximately 62 consumer workers in a number of employed positions in public mental health services in NSW. It should be noted, however, that many workers are employed for minimal hours, often no more than 3 hours a week.

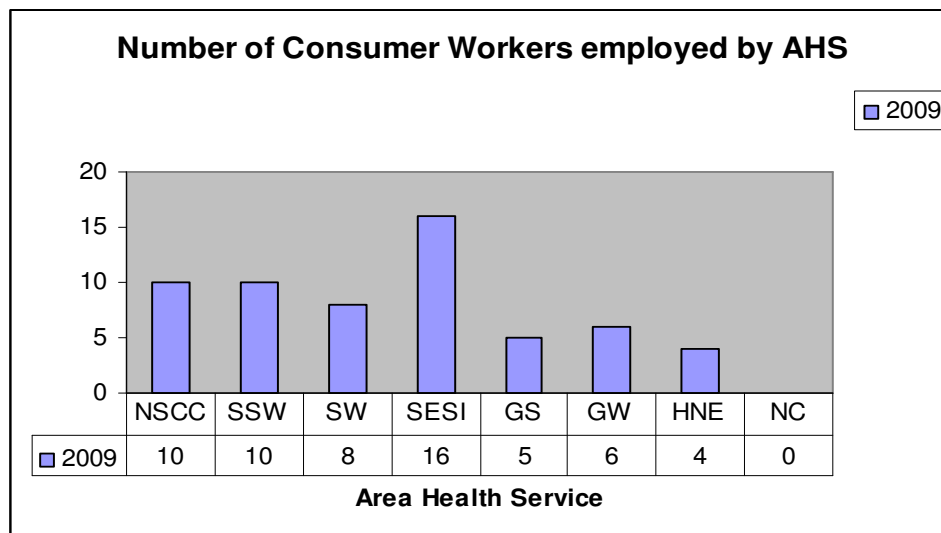


Figure 2: Number of Consumer Workers employed by Area Health Service (data from 2009 Consumer Workers' Forum)

Stage 1 of the CWF Project was conducted through the use of a questionnaire developed to obtain relevant information from the current consumer workforce in public mental health services in NSW. Stage 1 identified 57 consumer workers employed within NSW AHSs. The overall response rate for the questionnaire was 61% (n=35). The returned data was analysed and summarised in a final report submitted to the Mental Health and Drug & Alcohol Office (MHDAO). Most of the understanding of the NSW consumer workforce comes from this final report.

Titles, Roles and Responsibilities of the NSW Consumer Worker

Over time, the roles and responsibilities of consumer workers have adapted to incorporate functions that are may not fall within the skills of the consumer worker. Previously, the only criterion under which consumer workers were hired was that they had the lived experience of mental illness. According to the CWF

Project Stage 1 Report (NSW CWF Organising Committee, 2008) the duties performed by consumer workers have evolved, to become far more complex and sophisticated than it has been in the past. Consumer workers across NSW perform a set of wide ranging duties including:

- Liaison with consumers
- Committee representation
- Running peer support groups
- Education seminars for mental health service staff
- Individual and systemic advocacy
- Creating newsletters and consumer friendly documentation
- Feedback about treatment and care
- Participation in accreditation
- Attending tribunal hearings with consumers
- Complaints management
- Participation on interview panels
- Input into policy and strategic planning development, and
- Mental health service administration duties

(NSW CWF Organising Committee, 2008).

Despite performing similar duties and having similar roles and responsibilities, consumer workers in NSW have a range of position titles, each representing the same or very similar roles that they are responsible for. This has the potential to lead to confusion for the worker, consumer and the service provider (NSW CWF Organising Committee, 2008). Titles consumer workers operate under include:

- Consumer Consultant
- Consumer Advocate
- (Consumer/ Carer/ Other) Coordinator
- Consumer Support Worker
- Consumer Team Leader
- Coordinator Consumer Activities
- Coordinator Consumer Participation Services
- Area Coordinator of Consumer Initiatives
- Peer Support Worker
- Individual Consumer Advocate
- Independent Consumer Advocate
- Consumer Liaison Officer

(NSW CWF Organising Committee, 2008).

Remuneration

According to the CWF Project Stage 1 Report, consumer workers generally reported being paid under the Health Education Officer award (82% of those who completed the survey) (NSW CWF Organising Committee, 2008). Respondents to the statewide consumer worker survey reported that they would prefer their “own award and rates of pay”, and “should be paid according to qualifications, duties and experience” (NSW CWF Organising Committee, 2008, p14).

Training and Education

The most common formal training and educational courses undertaken by consumer workers in NSW include: advocacy courses, sexual assault classes, team leader training, anger management and computer literacy skill courses (NSW CWF Organising Committee, 2008). Little training or educational courses have been completed by consumer workers that related to other duties in line with their role and responsibilities within the mental health service.

The complex nature of the roles performed by consumer workers suggests the need for comprehensive and standardised training to be developed. The main types of training and education NSW consumer workers would like to see become incorporated into their training and professional development includes:

- Consumer advocacy skills, including individual and systemic advocacy
- Peer support training
- Educational courses on the role of the consumer worker, and a brief orientation to consumer work
- Mental health first aid training
- Courses on the Mental Health Act and other relevant legislation
- Sexual assault training
- Drug and alcohol training
- Computer skills training, and
- Communication skills

(NSW CWF Organising Committee, 2008).

Supervision and Support

The need for adequate supervision and support whilst on the job was identified as an important aspect for consumer workers in NSW (NSW CWF Organising Committee, 2008). The role of supervision aims to improve the services delivered by consumer workers in mental health services, allowing an opportunity for the consumer worker to debrief, seek guidance and focus on challenging aspects of the work performed (NSW CWF Organising Committee, 2008). Adequate supervision allows for consumer workers to have access to a staff member of the service to provide a supportive relationship to minimise any stressful impact on the consumer worker (Henry et al., 2002).

Those providing the line management for consumer workers include:

- The Nurse Unit Manager
- Manager of Planning and Performance
- Consumer Co-ordinator
- Rehabilitation Team
- Service Centre Manager
- Director of the Mental Health Service, and
- The Team Leader.

(unpublished raw data from the CWF Stage 1 Survey)

Consumer workers were also asked to comment on the support structures that existed within their service, reporting on those people within the mental health service that provided peer support, guidance or supervision. It became apparent that each AHS provided different structures and supervision guidelines. Some forms of support provided include:

- Regular nominated clinical supervision
- Support from the Employee Assistance Program
- Fortnightly clinical supervision
- Rehabilitation workers made available on call
- Support provided by the team leader
- Peer support meetings with the consumer workers at the service
- Independent counselling service
- Support from the Nurse Unit Manager
- An experienced consumer providing supervision and support
- External peer support monthly meetings, and
- Other mental health team members.

(unpublished raw data from the CWF Stage 1 Survey)

Some consumer workers also reported having no formal supervision and support structures put in place within their service.

Employment of Consumers within Non-Government Organisations

The current situation of the NGO consumer workforce in NSW is not well mapped out. Many NGOs across NSW actively employ identified mental health consumers – where lived experience is an essential or desirable criteria for the job – as part of their paid staff in a variety of roles, including: Peer Support Worker; Consumer Advocate; Consumer Representative; Consumer Trainer/Assessor; Mentor; and Consumer Team Leader/Manager (MHCC, 2010). Consumers may also be employed in any administrative, direct service or management role. 87% of mental health specific NGOs in NSW use volunteers and that is likely to include people with lived experience – that is sometimes out of financial necessity but mostly about the social inclusion and participatory values base of community managed organisations (MHCC, 2010).

In order to address the current consumer workforce situation in NSW, NSW CAG and the Mental Health Coordinating Council (MHCC) are collaborating to host a state forum to consider the particular challenges and needs of the consumer workforce in the non government (community managed) sector. The forum is currently in development with a reference group comprising of consumer and peer workers within the NGO sector (MHCC and NSW CAG).

Conclusions

The 2007 National Mental Health Report identifies that while substantial gains have been made in some respects to the consumer workforce, “progress is uneven and there is still some distance to travel before consumer involvement is genuinely and consistently meaningful” (Commonwealth of Australia, 2008, p61).

There is often a belief among consumer workers that within their role there is a degree of tokenism in their participation in “service planning and delivery is often seen as a bureaucratic requirement generated by ‘political correctness’” (Nestor & Galletly, 2008, p345).

7. International Consumer Workforce Progress

United States of America

In the 1970's and 1980's, consumer organisations began to develop across North America. The basis of these organisations was that mental illness was seen as a social and political construct and that people needed basic legal and human rights protections (Chamberlin, 2005). The consumer-run groups called for active participation by people who received services in the decisions that affected their lives (Chamberlin, 2005).

The late 1970's saw the then President commission a comprehensive review of mental health services that generated a series of recommendations (The President's Commission, 1978), including the need for improved community based supports (Daniels , Grant, Powell, Fricks & Goodale, 2010). This report led to an increase in peer support and employment of consumers within mental health services.

The increase of peer support services at the local, state and national levels indicated a trend towards a new culture of collaboration between consumers and the traditional mental health service delivery system (Campbell & Leaver, 2003). The consumer movement in America also allowed the opportunity for increased involvement of consumers in all aspects of the planning, delivery and evaluation of mental health services as well as in the protection of individual rights (SAMHSA, 2001).

A strong advocator for increased consumer involvement is Mental Health America (MHA), a mental health promotion organisation, pushing for all states and communities to incorporate peer support services into their community-based mental health and substance abuse services (MHA, 2008). MHA has been integral in the establishment of consumer worker positions in mental health services across the country, increasing the participation of consumers in multiple levels of planning and the implementation of peer support services.

Roles and Functions

Consumers are often involved in consumer-run organisations providing mental health services across the country. Consumer workers are employed by individual mental health community services, involved mostly in peer support programs (Daniels et al., 2010). Consumer workers are employed within the non-government sector in North America, and have involvement with public inpatient mental health facilities (Daniels et al., 2010).

The qualifications for consumer worker positions include an interest in the job, a willingness to work as part of a team, good communication skills, and basic entry-level computer skills (Henry, et al. 2002).

Consumer workers are primarily involved in peer support capacities, working under the title Certified Peer Specialist (CPS), with consumers to assist in regaining balance and control of their lives and to support recovery (Daniels et al., 2010). The CPS works from the context of recovery, frequently utilising language based upon common experience rather than clinical terminology, and person-centred relationships to foster strength based recovery (Daniels et al., 2010).

Apart from formalised peer support care, the range of tasks and services that are offered by consumer run organisations is expansive (SAMHSA, 2001). The ten most common services provided by consumer workers include:

1. Drop-In Centres: consumer workers serve as volunteer staff, providing opportunities for social interaction, and a variety of activities
2. Housing Programs: services provide a range of housing options including group housing to supported independent living
3. Homeless Services: consumer-run organisations provide street outreach and advocacy programs, assisting mental health consumers experiencing homelessness
4. Case Management: consumer workers run their own case management programs
5. Crisis Response: respite programs are offered by consumer workers for those in emotional crisis, providing safe, supportive, and comfortable settings where individuals can obtain some relief from their problems without stress, coercion and often public shame associated with traditional, professional crisis response services
6. Benefits Acquisition: consumer workers assist consumers in accessing benefits and services that they are entitled to
7. Advocacy: many consumer workers provide advocacy services to members in an effort to provoke fundamental systemic change
8. Research: many consumer-run research programs have pioneering consumer involvement in research, evaluation and data issues
9. Employment: employment programs are provided by consumer workers, including job training and placement efforts
10. Managed Care: consumers have become more active in organising and educating themselves on changes to the mental health system, to provide them the opportunity to take control of their life

(SAMHSA, 2001).

Medicaid Reimbursement

In 2001 the services provided by the CPS became Medicaid reimbursable (Fricks, 2005). In order for a service to be eligible for Medicaid reimbursement, training, continuing education, supervision and care coordination must be established and met. Certification for each service is defined at the state level, and is dependent on the establishment of core competencies (Daniels et al., 2010). Requirements for reimbursement include:

- Supervision provided by a qualified mental health professional;
- Services must be coordinated in the consumer's individualised treatment plan; and
- Services must focus on identified treatment goals within the parameters of medical necessity.

(Daniels et al., 2010).

Barriers and Challenges

According to a report into the review of 13 federally funded consumer operated services in America, a number of barriers have been identified in the employment of consumers within mental health services. These include:

- Inadequacy of funding: many services reported not having enough resources to be able to employ enough consumer workers, and provide efficient services
- High staff turnover: this has been related to a number of factors including a lack of training, interpersonal conflicts, the stressfulness of the job, and health reasons
- Conflict: consumer workers and service staff reported experiencing conflict, having to deal with political and philosophical differences, personality clashes and power struggles, and
- Unclear role definitions: consumer workers reported working within services without a clear definition of their role and expectations, and thus experiencing role conflict and confusion.

(Mead & MacNeil, n.d.; SAMHSA, 2001)

Supervision and Support

Supervision and support structures in America for peer support workers in the literature is limited. According to Henry et al. (2002) consumer workers usually receive direct supervision and training from the mental health service staff who are the managers or coordinators of the specific consumer-run program or project. Consumer workers would typically have their manager from the service visit their job site in order to help them get a sense of the job demands and the setting, to ease the initiation into their new role and to enable effective supervision (Henry et al., 2002).

Training and Education

Faculty and staff at the Centre for Mental Health Services Research have been developing consumer worker positions through transitional and supported employment programs. The goal has been to create training and employment opportunities for people interested in mental health services, and to develop a pool of individuals who could be available to take on paid roles within these services as consumer workers (Henry et al., 2002).

During their employment, consumer workers are given the opportunity to identify personal learning goals. General goals include enhancing general computer and research skills, becoming familiar with specific computer software programs,

learning to use the internet, gaining general office skills, and to improving interpersonal skills on the job (Henry et al., 2002).

Several training courses exist within America, providing consumer workers with basic training in peer support work within the mental health service. These training packages include courses on:

- Confidentiality training
- Active listening skills
- Accurate empathy
- Self-disclosure
- Boundaries
- Peer support exercises
- Recovery training
- Anger management
- Wellness Recovery Action Plan training

(CMHA, 2005b; Katz & Salzer, 2006; OAMH, n.d.)

One particular successful training course provided Georgia is the Georgia Certified Peer Specialist (CPS) Project (Georgia CPS Project, 2003). The training developed from recommendations made in the 1999 Surgeon General's Report on Mental Health, set up to prepare CPSs to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve (Fricks, 2005; Georgia CPS Project, 2003). Training provided by Georgia CPS Project is available for current or former consumers of mental health services in Georgia, who have an interest in peer support roles (Georgia CPS Project, 2003).

Evaluation of Services

The limited studies that are available on consumer-run services have largely focused on evaluating the impact consumer development initiatives have had on current consumers of mental health services (Trainor, Shepherd, Boydell, Leff & Crawford 2002). Two particular studies (Forquer & Knight, 2001 and Trainor et al., 2002) examined consumers' use of mental health services following the introduction of self-help groups and consumer-run services into the area. The studies looked into aspects such as frequency of using services after introduction to self-help groups as well as the importance consumers place on various components of the mental health system – such as the value of consumerism, consumer control and opportunities for decision making (Forquer & Knight, 2001; Trainor et al., 2002).

The range of benefits that consumer-run programs bring to the mental health system include: increased social supports; increased employment; increased education and knowledge; greater levels of independence, empowerment and self-esteem; suicide rate and substance abuse decreased significantly; and consumer-run organisations have proven to be more helpful for consumers than

traditional mental health services (Forquer & Knight, 2001; SAMHSA, 2001; Trainor et al., 2002).

New Zealand

National documents in mental health, largely published by the Mental Health Commission and the Ministry of Health, have stated that consumer participation at all levels of mental health services is extremely important. These publications include *Towards Better Mental Health Services* (Ministry of Health, 1996); *The National Mental Health Standards* (Ministry of Health, 1997) and *The Blueprint for Mental Health Services* (Mental Health Commission, 1999). One way in which services have dealt with this is by employing consumers.

According to the Mental Health Commission (2005) the consumer workforce in the mental health sector...

“is comprised of workers who have current or previous experience of using mental health services. This includes service users working in the specialist mental health system as well as those working with a mental health focus in anti-discrimination, public health and primary health” (p3)

Increasing consumer participation through the use of consumers as mental health workers is a fundamental strategy in New Zealand. It is seen to improve the quality and responsiveness of mental health services, and as a key objective of the national mental health strategy (Mental Health Commission, 2000).

Consumer workers have been employed within mental health services in New Zealand since 1990. Recently, New Zealand has stated its support for the development of a consumer workforce, through emphasising the importance of a knowledgeable, skilled, competent, recovery-focused workforce, identified in the report *Te Tahuu – Improving Mental Health 2005-2015* (Ministry of Health, 2005).

A commitment of the *Service User Workforce Development Strategy* (Mental Health Commission, 2005) is that “by 2010 people with experience of mental illness will be a skilled, powerful, pervasive and openly identified part of the mental health workforce in New Zealand” (p1).

Roles and Functions

Over the last decade there has been a huge increase in consumer workers in mainstream mental health services, especially in consumer designated roles, such as advisors, consultants, auditors and trainers. Consumer workers in New Zealand are involved in the following roles:

- Providing traditional mental health services
- Independent mental health services
- Training mental health service providers, families, carers or consumers
- Research
- Provision of consumer perspective advice to the mental health service
- Audit or evaluation of mental health services

- Advisory positions in public policy and program development (Doughty & Tse, 2005; Hansen, 2003; Mental Health Commission, 2005)

Barriers and Challenges

In relation to the workforce development needs of service users, a project initiated by the New Zealand Mental Health Commission in 2003 found a lack of consistency and an absence of guidelines for consumer roles, despite the wide acceptance of the value of service user involvement (Stewart et al., 2008). Remuneration standards has also been recognised as a point of improvement need within the New Zealand consumer workforce, with significant differences in pay between consumer workers and other mental health service staff (Stewart et al., 2008).

Supervision and Support

All consumer workers have recognised the need for supervision and support. Most consumer workers are supervised by health professionals within the service, with some having external supervision (paid for by the service), and others have supervision via telephone. In some services, consumer workers provide peer supervision for each other, and in some services no formal supervision support structures are in place at all (Mental Health Commission, 2000).

Training and Education

Training and education programs are delivered by Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development. In 2008, Te Pou delivered its first consumer advisory training program to 19 participants as part of a year long initiative, aiming to deliver to consumers a training package that allows them to understand and engage in enhancing their ability to be effective in their work (Te Pou, 2010).

Peer supervision training is also provided by Te Pou, aiming to:

- Introduce peer supervision as a professional development process for consumer workers in mental health services
- Introduce the peer supervision toolkit – seven tools for supervision groups
- Support professional and personal development to enhance the use of supervision
- Provide opportunities for participants to experience the power of peer supervision through small group practice and coaching
- Provide the necessary skills for participants to run peer supervision groups (Te Pou, 2010).

Evaluation of Services

Doughty & Tse (2005) looked at the effectiveness of consumer worker initiatives and employment within mental health services. The report found little to no evaluation of New Zealand consumer workforce developments, demonstrating that peer support programs and the New Zealand consumer workforce is a

development approach in mental health and further research is required (Doughty & Tse, 2005).

United Kingdom

The consumer movement in the United Kingdom emerged during the 1970s with the introduction of anti-psychiatry groups that formed within the community (Wallcraft, Read & Sweeney, 2003). The consumer movement saw a greater push for individual empowerment and involvement in all aspects of their care, with the Community Care Act 1990 being developed to enshrine consumer involvement in community care planning stimulating further growth of local consumer groups (Wallcraft et al., 2003).

Following the introduction of consumer involvement within national legislation, consumer-led services such as drop-in centres and crisis projects were developed. Here consumers gained confidence to put forward their own innovations such as advance directives and self-management strategies (Wallcraft et al., 2003).

Throughout the 1990's the UK saw an increase in the number of paid consumers within mental health services, as well as an increase within the volunteer sector and with consumers working in the community (Wallcraft et al., 2003).

Roles and Functions

A national survey in the UK was developed to assess the roles, tasks and duties that were performed by consumer workers employed within mental health services. The survey reported the following as the main tasks and duties performed by consumer workers:

- Self-help and mutual support – support includes elements of practical help with accommodation, employment, benefits advice and form filling, skills exchange, transport, emails and home repairs
- Consultancy and taking part in training or recruitment of new staff
- Education and training of external groups such as professional mental health workers
- Creative activities – these include theatre groups and poetry workshops
- Campaigning, and
- Drop-ins, befriending services, telephone hot lines, social enterprises and recovery support.

(Wallcraft et al., 2003).

Barriers and Challenges

Challenges that have been encountered by the consumer workforce in the UK include:

- Potential conflict in roles: some staff have reported feeling worried about how a person could be both a consumer and a provider of services at the same time
- Staff attitudes: negative attitudes held by service staff have been reported to be a significant problem for the consumer workforce
- Financial considerations: there has been some concern whether employees would be rendered off worse because of the loss of benefits

they receive due to employment (including schemes similar to the disability pension in Australia)

(Perkins, Buckfield & Choy, 1997).

Training and Education

In the UK most consumer workers provide their own consumer-led participation training courses funded by the mental health service. Wallcraft et al. (2003) report that the majority of consumer workers in the UK felt that the current training and education they received for their position was inadequate. Training that is typically provided for consumer workers includes short courses on chairing, meeting skills, confidence building and the use of office equipment (Wallcraft et al., 2003).

Canada

In the mid 1970s, the emergence of the consumer movement in Canada created conditions for the development of peer support workers in the mental health sector. The movement allowed mental health consumers the opportunity to unite and lobby for changes in the provision of mental health services and collectively reduce the stigma attached to mental illness (Government of Ontario, 1999). The ideal of having consumers actively involved in mental health service participation was realised in the Ontario mental health policy, calling for the “participation of service users in community mental health programs” (Government of Ontario, 1999, p4).

Hiring consumers as service providers in Canada was based on the recognition that not all the needs of people with mental illness can be met by professionals, and that peer support providers have something unique and valuable to offer (Grant, 2007). Over the past decade there have been several different models of service delivery that have emerged in mental health services, including:

- Self-help or mutual support programs
- Consumer-run organisations
- Consumers who work within non-peer directed programs

(Grant, 2007).

Consumer/Survivor Initiatives

In Canada, consumer workers work mostly within consumer run organisations under programs called “Consumer/Survivor Initiatives” (CSI), originally funded by the Consumer/Survivor Development Initiative (CSDI) (CMHA, 2005a). Running their own programs meant that consumers were made responsible for the decision-making process, as well as its outcomes and successes, with all staff, board of directors and advisory committees consisting of individuals with the lived experience of mental illness (CMHA, 2005a). The consumer-run groups are funded primarily by the CSDI of the Ministry of Health and Long-Term Care, beginning in 1991, with most programs having to seek core or project funding to source their work (CMHA, 2005a).

The Canadian Government has recognised the importance of the consumer worker in playing a critical role in mental health system improvements (CMHA, 2005a), contributing to the reduction in the use and cost of services – including community mental health programs, hospitals, psychiatrists and general practitioners, income support programs and other services (Trainor et al., 2005).

Roles and Functions

Consumer workers in Canada are primarily involved in the following tasks and duties:

- Facilitating or co-facilitating group programs: these involve orientation/intake groups, recreational programs, skill training and peer support groups (Moll et al., 2009)
- Providing individual support to consumers (Grant, 2007; Moll et al., 2009)
- Attendance at staff meetings (Moll et al., 2009)

- Documenting clinical notes (Grant, 2007)
- Involvement in policy creation (Grant, 2007)
- Teaching and education of staff (Grant, 2007; Moll et al., 2009), and
- Involvement in staff hiring (Grant, 2007)

Barriers and Challenges

The consumer worker movement within Canada has not come without its share of challenges and barriers in establishing effective consumer participation in service delivery. Some of the specific challenges that CSIs are facing include:

- Inadequate funding (CMHA, 2005a):
 - Several programs have to rely on time-limited project or contract funding
 - CSIs often cannot afford to hire replacements for staff on leave
 - There are undefined award rates for consumer workers, and many programs are unable to provide competitive wages to employees
- Consumer workers report feeling as if their role is tokenistic, and that the marginalisation of their group is a result of the stigma and discrimination faced by consumers in general (CMHA, 2005a)
- The consumer workforce also experiences role conflict and confusion, dual relationship and boundary challenges and inadequate remuneration for the work that they perform (Moll et al., 2009)

Evaluation of Services

A longitudinal study of consumer initiatives in Community Mental Health in Ontario was funded by the Ministry of Health and Long Term Care from 1998 to 2004 (CMHA, 2005a). The study demonstrated that consumer workers within mental health services:

- Significantly reduce consumer hospitalisations
- Reduce symptom distress reported by consumers
- Improve the social supports consumers have within the community, and
- Improve the quality of life reported by consumers.

Scotland

Consumer workers in Scotland are required to have a lived experience of a mental illness and or be living in recovery. The Scottish Government, in their *Delivery for Mental Health* (Scottish Executive, 2006) committed to “have in place a training programme for peer support workers by 2008 with peer support workers being employed in three broad areas later that year” (p2). To meet this commitment, a pilot scheme for pioneering formalised peer support working was put in place within five Health Board areas in Scotland during January 2008 (McLean, Biggs & Whitehead, 2009).

At the inception of the pilot project, peer support work was a relatively new concept in Scotland, with no previous attempts to formally introduce the model to mental health services in the country (McLean et al., 2009). The formalised peer support worker program provided an opportunity for mental health services to employ consumers under defined parameters, working within drop-in centres, stand alone teams, or increasingly within multi-disciplinary statutory teams (Woodhouse & Vincent, 2006).

Roles and Functions

The consumer workforce was found to be involved in the following aspects of service delivery:

- Run peer support groups
- Participate in team meetings about consumers
- Support the transition of consumers from an inpatient facility to the community
- Support staff to see the person from a strengths-based view
- Promote the use of the Wellness Recovery Action Plan (WRAP)
- Provide community based activities
- Provide formal referrals
- Awareness raising with staff about recovery
- Set outcome oriented goals with consumers
- Provide drop-in sessions in the community, and
- Provide brief contact with acute inpatient consumers

(McLean et al., 2009).

Barriers and Challenges

According to the evaluation report of the pilot project, the roll out of consumer worker roles in mental health services across Scotland encountered several barriers and challenges, these have been explored below.

1. Defining the role of the consumer worker

In all sites across Scotland, consumer workers commenced their positions without any definition to their roles, which many workers found to be unsettling (McLean et al., 2009). As the consumer workers became more integrated into the services that they were employed under, workers reported that it was easier to develop the role to become more integral to the wider multidisciplinary team

(McLean et al., 2009). In order to understand the full capacities of the consumer worker, each mental health service went through a process of defining the role, including:

- Understanding the core values of peer support
- Exploring the broad range of potential uses of peer support in their unique setting
- Considering the consumer worker's own individual style of sharing the lived experience and modelling recovery
- Developing the consumer worker role together, which for some services was an ongoing process facilitated by reflection and supervision

(McLean et al., 2009; Woodhouse & Vincent, 2006).

2. Work related stress factors

Dennis (2003) explains that the consumer worker role can be very stressful, with potential problems arising including:

“conflict, criticism, failed social attempts, emotional over-involvement resulting in stress, reinforcement of poor behaviours, diminished feelings of self-efficacy, lack of stability...” (Dennis, 2003, p323)

3. Boundary Issues

Consumer workers in Scotland encountered issues around their personal experiences of mental illness being seen as important to the role. This makes it difficult to develop team relationships based on equality (Woodhouse & Vincent, 2006).

4. Remuneration

McLean et al. (2009) reported that despite consumer workers across Scotland in the pilot program having very similar job descriptions, very different award rates were utilised in different health services. This led to a situation where consumer workers were performing the same role and paid different salaries, raising the concern that the role of consumer worker may not be viewed consistently across the country.

Training and Education

Part of the *Delivering for Mental Health Plan* (Scottish Executive, 2006) was to have in place a training programme for consumer workers by 2008. A conference held by the Scottish Government (Scottish Executive, 2007), discussed the training and education needs for consumer workers, approaches, accreditation and qualification models that were offered for consideration. These included:

- Accreditation linked to Scottish Qualifications Authority (SQA), NHS Education Scotland (NES) and the Scottish Social Services Council (SSSC)
- Peer support workers two week course and life experience
- WRAP training
- Scottish Mental Health First Aid (SMHFA)

National training provided for consumer workers includes training in the following sorts of topics:

- Boundaries, confidentiality, listening and roles – supporting others to make their own best choices
- Group work skills – particularly for those working with groups
- Basic counselling – to support people through problems that arise
- Health and safety – especially useful for consumer workers who go to people's houses or mentors who meet with people one-on-one
- Knowledge on issues the people they support might encounter – suicide prevention, sexual health, first aid, and other practice skills such as healthy cooking
- Assessing consumers' needs and progress – using different tools for evaluation

(Scottish Government, 2010)

Supervision and Support

Within the pilot project, supervision and support were provided in a number of different ways. Nationally consumer workers were provided with supervision at regular team meetings as well as protected one-on-one supervision that was provided by the peer graduate network (McLean et al., 2009). Each individual site also had their own supervision structures established, these included:

- Formal arrangements: one-on-one supervision provided fortnightly for one and a half hours. Small groups were also set up for the consumer workers and supervisors to get together each month to draw out main themes and issues within the role
- Informal arrangements: this relied on consumer workers having good relationships with team members whom they could regularly meet with to discuss their issues, problems, and training and development needs
- External arrangements: this involved having supervisors existing outside of the team that the consumer worker was employed under. This however resulted in issues of conflicting information, advice and guidance from an internal line manager, and the external supervisor

(McLean et al., 2009).

External training and educational courses are also provided for consumer workers, by the Scottish Mentoring Network, and Augment Scotland Training. These external organisations provide training courses preparing candidates in all aspects of meaningful Peer Support (Augment Scotland, 2010).

8. Barriers and Challenges Facing the Consumer Workforce

As has been highlighted, the employment of consumer workers in mental health services has not come without challenges. Carlson, Rapp & McDiarmid (2001) noted in their report that many services often perceive the barriers to hiring consumer workers as “formidable enough to prohibit such hiring” (p201) The literature on consumer workers has identified a number of barriers and challenges from the perspective of the consumer worker and the mental health service. These challenges include:

- Role conflict and confusion
- Job titles that often do not reflect the work performed by the mental health consumer workforce
- Dual relationships and boundary issues
- Concerns regarding the inadequacy of remuneration of their work
- Discrimination and stigmatising attitudes from non-consumer staff
- Little support and supervision structures
- Limited access to education and training for professional development
- Addressing reasonable accommodations in the workplace, and
- The need for evaluation of the consumer workforce.

The consumer workforce faces under-resourcing and inadequate infrastructure to support the ongoing improvement of the consumer workforce. Inadequate or limited infrastructure for good working conditions, such as clear job descriptions, well defined roles and responsibilities and fully-developed and formalised remuneration awards may result in inconsistencies within the consumer workforce (Bennetts, 2009). The barriers and challenges experienced in the mental health system through the employment of consumer workers are explored in more depth in this section.

Role Conflict and Confusion

Over time the roles and responsibilities of the consumer worker have expanded to include a wide range of tasks and duties. Position descriptions for the workforce are often unclear and vague as services struggle to clarify the role of the consumer worker, and develop a better understanding of what is reasonable to expect from the workforce (Moll, Holmes, Geronimo & Sherman, 2009). Service staff can sometimes hold unreasonable expectations about the capabilities of the consumer worker, with the workforce reporting that their workloads often increase or that they are required to undertake additional duties once employed that they may not be skilled in (Dixon et al., 1994).

It has been reported that at times some consumer workers have been required to perform clinical roles such as counselling without having adequate training or support (Middleton et al., 2004; Watson, 2007). Competent computer skills or policy writing skills may also be required, which is often out of the scope of the

advertised position (Dixon et al., 1994). Some consumer workers also reported feeling unclear about the role of the systemic advocate, with some in the workforce feeling like they have little ability to influence the system (Dixon et al., 1994; Middleton et al., 2004). Greater clarity is needed in consumer worker position descriptions to support the workers within these roles.

For the consumer worker transitioning from the role of consumer to that of service provider can also lead to experiencing difficulty in defining and understanding their role. Carlson et al., (2001) discuss the difficult task the workforce faces in balancing their consumer identity with their new professional identity. This balancing act can result in the following challenges:

- Consumers may perceive the workforce as part of the paid mental health service staff and lose trust in them (Carlson et al., 2001)
- Some mental health service staff have difficulty in accepting consumer workers as equals within their service. According to Carlson & McDiarmid (1999), some staff see that a consumer workforce blurs a delineation between those who are sick and those who are well, leading to these staff members having difficulty in accepting consumer workers as equals within the workplace
- Some consumer workers struggle to transition between being critics of the system, to being paid members of it (Carlson et al., 2001, p206)

The roles and responsibilities of consumer workers are often vague and unclear, leading to ambiguity in the workplace (Carlson et al., 2001). Consumer workers can be left with a juggling act as they try to define their role within the service, and establish clear definitions for themselves around their roles and responsibilities (Hansen, 2003). It is important for mental health services to address role confusion through creating clearer positions descriptions and encouraging a consumer worker friendly environment. Ensuring that other staff are clear on the purpose and scope of these roles is also essential.

Job Titles

Having a range of job titles that often represent the same or very similar roles can lead to confusion for the consumer worker, consumer and service provider (NSW Consumer Workers Forum Organising Committee, 2008; Watson, 2007). The following are examples of position titles used to represent consumer workers across NSW, Australia and internationally (N.B. This list is not exhaustive):

- Consumer Worker
- Consumer Support Worker
- Consumer Advocate
- Consumer Coordinator
- Consumer Team Leader
- Consumer Representative
- Consumer Liaison Officer
- Consumer Consultant
- Peer Support Worker

Job titles should be streamlined in order to reduce the confusion experienced by the mental health service around the exact function of the consumer workers. This could be achieved through reducing role conflict and confusion, and creating suitable position descriptions and selection criteria when hiring new employees. Ensuring position titles align with the job description is also critical.

Dual Relationships and Boundary Issues

Carlson et al. (2001) describe the ethical dilemmas that surround dual relationships and boundary blurring that can create barriers when hiring consumer workers. Professional associations have defined dual relationships as, “a situation in which a professional relates to a client in more than one relationship”, including professionally, socially, personally, or financially (NASW, 1996).

The dual relationships consumer workers may face are often considered unethical due to the potential harm to the consumer using the service (Carlson et al., 2001; Carlson & McDiarmid, 1999). Literature on how to best handle the boundary issues that exist between consumer workers and the consumer and service is limited, despite the vast information addressing boundaries in other professional codes.

The boundary between consumer worker and mental health staff

Watson (2007) describes that boundary blurring is common across NSW mental health services. Some staff have argued that mental health services should refrain from hiring consumers that were once treated by the services that are employing them (Carlson et al., 2001). Dixon et al. (1994) discuss the boundary issue occurring from the dual relationship consumers have as a colleague and client within mental health services, where “some situations consumer workers have been in treatment with members of the medical staff in the past” (p623).

Consumer workers may have to arrange support systems outside of the service (see **supervision and support structures** below) where they are able to seek treatment for their mental illness, to avoid conflict with their professional responsibilities and relationships (Carlson et al., 2001; Carlson & McDiarmid, 1999). In some small communities, including rural and regional parts of NSW, consumer workers face limited choice in service providers, with many unable to find alternate treatment options other than the service that they are working for (Dixon et al., 1994). This issue may result in consumer workers having to seek treatment within the service that they are employed by. Middleton et al. (2004) report that this can contribute towards the open hostility, suspicion and disrespectful attitudes consumer workers experience from some mental health service staff.

Consumer workers also speak about the tension that their role can cause within services as being both an employee of the mental health service and as an

advocate for the consumer. Consumer workers can find it challenging to be a paid member of the mental health service and to be an advocate for the consumer. Part of this advocacy can see the consumer worker dealing with complaints; they may then be placed at a loggerhead against service staff in trying to deal best with complaints management.

Cleary et al., (2006) also talk about the tension between service staff and consumer workers that “can arise if staff and consumers disagree about aspects of treatment” (p31). Crawford et al. (2003) found that some service providers did not believe that consumer workers were representative of the local consumers. Middleton et al. (2004) also discuss that tension can exist when consumer workers are made accountable to the mental health service, with no direct accountability to the consumer.

Boundary between consumer worker and consumer

Establishing boundaries between the consumer worker and mental health consumers is not easy, especially if the worker has had a prior relationship with the consumer outside of the service (Moll et al., 2009). The relationship between the worker and consumer is presumably less clear, with people having “difficulty with the blurred boundaries that develop when a consumer-provider continues friendships with consumers within the same agency they are working for” (Carlson et al., 2001, p204). In order to compensate for this, a different kind of relationship needs to be established between consumer worker and consumer that is less hierarchal than with other professional staff (Moll et al., 2009). This is particularly so if the service is expecting a peer support role and therefore a “peer” relationship.

Establishing clear boundaries between consumers and consumer workers can be a difficulty for the consumer workforce, with some consumer workers describing their role as a constant balancing act between a being peer and being a paid staff member (Moll et al., 2009). Cleary et al. (2006) speak about the boundary blurring that occurs between consumer workers and consumers where some workers have been known to:

“lend money to patients, withhold clinical information from staff, contact patients outside of work hours, and the boundary blurring where consumer consultants are hospitalised within their employing health service when they are unwell” (p7).

Consumer workers are often hired for their ability to relate to mental health consumers on a peer level, a person who has been through similar circumstances, and is able to share their experiences and knowledge (Nestor & Galletly, 2008). The dual relationship of being a peer and a service provider can, however, become blurred for the consumer worker without clear support and training. The consumer worker is not expected to become a friend of the consumer, but the worker is meant to serve the consumer’s needs (Dixon et al.,

1994). Effective support and supervision is vital to help consumer workers reflect on these dual relationships and the ways that these can occur within the service.

Remuneration

There are no set and clearly defined award rates or remuneration standards for the consumer workforce in Australia as there are for other fields within mental health (Wells, 2003). Currently in NSW consumer workers are being paid under two different award rates for performing the same or similar roles (CWF Organising Committee, 2009). Wells (2003) goes on to comment that the awards that consumer workers are paid under often do not reflect the work that they perform. Hansen (2003) reported that many consumer workers felt that they were being severely under-paid for the type of work they were doing when it was compared to others with similar skills, qualifications and experience employed at similar levels in mental health.

Hansen (2003) describes that the issues surrounding payment are primarily based on the inconsistencies among the workforce, such as their role definitions, responsibilities, and functions. Hansen (2003) also comments that there exists the expectation that the wages for consumer workers could be lower than for other open market jobs performing a similar function, contributing further to the stigma surrounding this workforce. This highlights a need for a consumer worker award rate or pay scale to be developed that reflects the individual's "prior qualifications, training, experience and skills, and to be sized alongside jobs of similar responsibility, skill level and outcome" (Hansen, 2003, p14).

Stigma and Discrimination

Stigma and discrimination continues to be a challenge that is encountered daily by people living with mental illness (Bennetts, 2009). Lloyd and King (2003) suggest that perhaps the most significant challenge that consumer workers face in the mental health system relates to the negative attitudes held by mental health professionals.

Consumers and service providers consistently report a culture where stigma is the norm and discrimination or abuse is tolerated. This sort of culture and the behaviours it generates can become a normalised part of interacting with mental health services, thus perpetuating the situation. McCann, Baird, Clark & Lu (2006) report on how the negative attitudes that exist amongst some clinicians towards consumer workers can limit the effectiveness of the consumer worker role.

A further important issue is the devaluing of the consumer worker role within the mental health service. Some mental health staff do not value the role that the consumer can bring to the service, with many consumer workers feeling tokenistic within their workplace. This has been attributed to the lack of understanding of, and respect for the consumer's lived experience, knowledge and perspective (Bennetts, 2009). It is reported that consumer worker roles

provide an important and valuable contribution to mental health services, challenging the traditional power relationships that exist between consumers and health care providers (Bennetts, 2009). The consumer worker can also highlight certain practices that may be stigmatising by educating mental health service staff around the consumer perspective and experience (Bennetts, 2009).

Negative attitudes also often arise from several of the challenges that are currently facing consumer workers across Australia. The issues of poor position descriptions, no consistent award rates, poor system structures for support and supervision and little training and education development opportunities can undermine and undervalue the consumer workforce (Bennetts, 2009). Some service staff can develop the perception that therefore the consumer workforce is not important to the mental health system, and does not contribute anything of value to the service (Lloyd & King, 2003).

Acknowledging personal prejudices that service staff hold around mental illness is a difficult issue for professionals (Lloyd & King, 2003). In order to improve the working environment for consumer workers, the stigma and discrimination surrounding mental illness needs to be challenged.

Supervision and Support Structures

Supervision and support for employees is essential in any workplace (Salzer, 2002). Supervision ensures that any program is “being delivered with some degree of fidelity and is useful for addressing any issues that may arise, especially any personal or interpersonal issues” (Salzer, 2002). Adequate supervision supports put in place for consumer workers also assist them in their transition throughout employment.

The current literature on the supervision structures for the consumer workforce is limited, with many services finding it difficult to provide adequate supervision guidelines that work effectively within their service and for the consumer worker. Further, research does not provide adequate details of the current supervision and support structures mental health services have in place for the consumer workforce.

In the consumer workforce, supervision and support structures need to exist to assist workers to master the particular requirements of the job, adequately input into the development and evaluation of policy and procedures and effectively manage their time and productivity (Mowbray et al., 1996). Adequate supervision and support structures are also needed for consumer workers to ensure that their own wellbeing and mental health is not compromised.

The role of consumer worker has been recognised as a stressor, with consumer workers having difficulty in distinguishing between emotional reactions to personal issues from their emotional reactions to professional work issues (NSW CWF Organising Committee, 2008). The difficulties consumer workers face in

their position can place them under additional burnout, prevention of development of trust and respect between consumers, carers and clinical staff, and compromised mental health outcomes for mental health consumers (Mowbray et al., 1996). These potential negative outcomes call for consumer workers to have access to adequate supervision to ensure they have someone to turn to for support, mentoring, advice and training on particular aspects of their job (Mental Health Commission, 2005).

Consumer workers have reported experiencing a feeling of isolation in their role, either by working as a sole consumer worker within a mental health service or working in a rural/remote setting (Watson, 2007). Watson (2007) goes on to say that support structures are important to establish, to ensure consumer workers have contact and networking opportunities with each other.

Supervision and support structures need to also address the possibility of consumer workers becoming unwell during their employment. Working in mental health can be very stressful. Consumer workers should be provided the opportunity to utilise the “same mechanisms as other clinical staff, looking to peers and supervision within the same clinical team for support” (Nestor & Galletly, 2008, p346). To help cope with the stress in the workplace, consumer workers should have regular supervision and support groups made available (Nestor & Galletly, 2008).

Supervision sessions need to be used to help establish an agreement between consumer worker and mental health service should the need arise where the consumer worker requires treatment for their mental illness (Nestor & Galletly, 2008). This plan may include having the consumer worker seeking treatment outside of the service that they are employed by or arrangements for transport if the worker becomes too unwell to drive (Nestor & Galletly, 2008). It is important for consumer workers to seek treatment outside of the area they work in as it assists in keeping “the boundaries between the work role and the patient role clearly defined” (Nestor & Galletly, p346).

Henry, Nicholson, Phillips & Stier (2002) also suggests that some consumer workers tend to over empathise with the consumer in the service and may need additional supervision to ensure they keep appropriate professional boundaries.

Currently there exists no perfect supervision structure in any service. More research into adequate support is needed in order to ensure that consumer workers have access to supervision and support that meets their needs.

Training and Education

Training and educational programs for the consumer workforce remain largely underdeveloped (Bennetts, 2009). Within Australia, there is no current standard for training and education for consumer workers or for those consumers occupying supervisory or managerial positions in services. Consumer workers

often report feeling unsure about the purpose of their role due to a lack an understanding of advocacy (Salzer, 2002). Watson (2007) also reports that consumer workers often experience problems in accessing on the job training opportunities.

Moll et al. (2009) reported that despite most consumer workers completing some form of training during their employment, many were put into situations that they didn't feel prepared for. Consumer workers have reported struggling with writing clinical notes where this is a requirement of their role, others with operating computers and/or photocopiers (Moll et al., 2009). For individuals who have not worked in many years, there were also challenges associated with getting used to the regular routine of work (Moll et al., 2009).

Lloyd and King (2003) believe that it is important that consumer workers are provided with ongoing education and training beyond recruitment. Clinical staff often receive training and education which may not be as easily accessible by consumer workers (Middleton et al., 2004). This points towards a clear disparity in access to training for consumer workers, which may likely devalue the role that consumer workers have within mental health services. Consumer workers living in rural and regional areas of NSW also face difficulties in accessing on the job training. Training and education should be made readily available for all mental health service staff, and not solely available for one workforce over another.

A report by the Commonwealth Department of Health and Aging (2002) into the education and training for consumer participation in health care found the following barriers in delivering training and education for consumer workers:

- Challenges in working with very diverse learning groups with differing educational backgrounds and skills
- A lack of training resources that can be used for the workforce
- Difficulties in maintaining the ongoing support and informal education needed for consumer workers
- A lack of peer support for the trainer.

These barriers highlight the strong need for resources to be provided to help develop these areas, and support consumer workers in having opportunities for educational development and training.

Reasonable Accommodation

Reasonable accommodations are any sort of adjustment at work that helps people perform their best (Mental Health Foundation of New Zealand, 2007). Providing reasonable accommodations is not just a requirement for people with the lived experience of mental illness, but for any paid member of staff. The Australian legislation protecting the right of people with the lived experience of mental illness to reasonable accommodation is set out in the Federal Disability Discrimination Act (Attorney-General's Department, 1992). It outlines that the employer should make reasonable changes to the workspace to assist a person in performing the duties of the position satisfactorily.

It is important for workplaces to recognise that reasonable accommodation is a joint responsibility, not reliant solely on the employee. Challenges that stem from reasonable accommodation in the workplace faced by consumer workers include:

- Workplaces not establishing an environment that is accommodating for all employees
- Workplaces not respecting the needs of all their employees, particularly those with a mental illness
- Workplaces not reviewing accommodations at regular intervals during the year
- Supervisors' being unaware of a workers' right to raise an issue
- Workers simply ignoring the situation or unaware of their rights under the Disability Discrimination Act for reasonable accommodations
- Workers being too afraid to raise an issue around reasonable accommodation to the relevant person
- Workers believing the stigma attached to the experience of mental illness is too great, and
- Workers believing the legal aspects of raising an issue are too complicated

(Weber, Davis & Sebastian, 2002; Zwerling et al., 2003).

Evaluation of the Consumer Workforce

The research that is available on the evaluation of the employment of consumers in mental health services is limited, with relatively weak research designs (Doughty & Tse, 2005; Solomon & Draine, 2001). Campbell (2005) reports that the evidence to support the effectiveness of consumer-run services has mostly consisted of descriptive or qualitative research, "seeking to identify the characteristics of people who choose to participate in these programs, the processes that lead to change, and the service recipient's perspective on benefits of program participation" (p17). Thus, what is lacking is an understanding of the impact of consumer participation in service provision and health outcomes for consumers.

Evidence to support the effectiveness of consumer-run services has provided the following results:

- Social support trumps isolation: Mowbray and Tan (1993) reported that consumers attended self-help groups to seek social support and because they felt more comfortable talking about their personal matters with their peers
- Mental health improves and symptoms decrease: through using pre-test scores as comparisons, research has demonstrated that participation in consumer-run services results in improvements in psychiatric symptoms and decreased hospitalisation (Kennedy, 1990), larger social support networks (Carpinello, Knight & Janis, 1991), and enhanced self-esteem and social functioning (Markowitz, DeMasi, Knight & Solka, 1996).

Doughty & Tse (2005) discuss that the current research into the efficacy and efficiency of the consumer workforce is a relatively new area which creates limitations. Research into the evaluation of the consumer workforce is primarily driven by professionals, in services where consumer workers are part of the mental health service. Consumers are not engaged with as part of the research and therefore outcome measures adopted by the studies may not be consistent with consumers' experiences of the service (Doughty & Tse, 2005). Consumers may see increased levels of hope as a strong indicator of an effective service; however no study has included this as an outcome measure.

In order to improve upon the current evaluation of consumer workers, increased levels of consumer input needs to be included from the early stage of research design through to data collection and analysis. Any workforce service or initiative should have research funding included as part of their plan and budget, in order to ensure consistent and continual evaluation of any consumer provided service.

Evaluation of the Australian Consumer Workforce

In Australia, little evaluation research has been performed for the consumer workforce. Reasons for this may include:

- The current consumer workforce in Australia is relatively new, and therefore has not gained much attention from the research field as yet
- The consumer workforce in Australia is still in the early stages of trying to define the type of services that it delivers, therefore making it difficult to determine best evaluation practice
- Mental health research funding is competitive, and the consumer workforce evaluation may not be seen as a priority by funders

Literature on the evaluation of consumer workers is insufficient to make conclusions about the effectiveness of consumer provided services (Solomon & Draine, 2001). Further research into evaluation of the workforce needs to be undertaken to help further Australian policy in mental health and consumer participation. The consumer workforce would also benefit from research into addressing the attitudes and concerns held by other staff members in mental health services.

Part of the current evidence base and informal evaluation of the consumer workforce consists of the benefits of consumer workers as paid members of the mental health service, which has been explored in **The Benefits of Consumer Workers p59**.

9. The Benefits of Consumer Workers

Consumer workers have more recently been viewed as a positive addition to the mental health service workforce, seen as a valuable entity by service professionals, clinicians and researchers in the mental health field (Carlson & McDiarmid, 1999; Carlson et al., 1999; Dixon, 1994). Consumer workers play an important role in the engagement of consumers, and identifying with consumers within the service, with numerous attributes and abilities noted in the literature that the consumer worker possesses (Dixon et al., 1994; Van Tosh et al., 1993).

Van Tosh, et al., (1993) reported in their research that consumer workers contribute:

“systems knowledge, street smarts, responsiveness, coping strategies, patience and flexibility, relationship emphasis, issue identification, engagement abilities, role modelling, advocacy against stigmatisation, and educational activity with co-workers” (p34).

Literature suggests that the consumer worker is effective within mental health services due to,

“The identification factor, in which one peer can offer another a sympathetic understanding of mental illness... something which is often defined out of professional-consumer relationships... [which] may add a special form of support and perhaps intimacy that can lower the social distance between provider and recipient. This identification with the ‘situation of the other’ and a firm understanding of the daily challenges created by mental illness can promote the relevance of supports, contribute to advocacy with employers, and underscore the necessity of interpreting mental illness to the larger society” (Mowbray et al., 1996, p59).

Carlson & McDiarmid (1999) noted that the benefits that the consumer workforce brings to the field of mental health extends to the consumers receiving the service, the consumer worker themselves, as well as the services that hire the consumer worker. These benefits are explored below.

Benefits to the consumers receiving services

Through employing consumer workers in mental health services, consumers have access to a service provider who has gone through similar life circumstances, providing them with an opportunity to relate personally with a member of the service staff. Consumer workers are able to engage with mental health consumers who may have previously avoided mental health professionals

(Dixon et al., 1994), and speak to consumers in a language that they can easily understand and identify with (Carlson & McDiarmid, 1999).

The consumer worker's ability to empathise with the consumer is an extremely important attribute, as they are able to make the service experience more normative and relevant, through their knowledge on mental illness (Carlson et al., 2001). Literature on the benefits of consumer workers suggests that this ability to empathise with the consumer can serve as a powerful tool in mental health service delivery (Carlson & McDiarmid, 1999). Consumer workers are often best able to relate to consumers, and provide the consumer with hope and belief that recovery is a reality through clearly demonstrating their "success with employment, education and independent living" (Carlson & McDiarmid, 1999).

Consumer workers have also demonstrated to have a personal expertise and special knowledge and skills as a result of their "personal experience of navigating the mental health system and the ability to share and reflect on personal experiences towards achieving personal recovery which can be an important tool in the treatment approach to help others" (Carlson & McDiarmid, 1999, p11).

The knowledge that consumer workers bring to their role including: intimate knowledge about outside services that exist; peer support groups in the community; and personal knowledge of mental illness, has been viewed as a beneficial tool for mental health consumers (Dixon et al., 1994).

Benefits to the consumer worker

Literature has described the benefits that the consumer worker experiences through employment in mental health services, including:

"increasing their sense of value and self worth; as well as providing avenues for personal growth and development; stable employment and reduced hospitalisation; personal growth, increased self-confidence, and development of specific skills" (Carlson et al., 2001, p201).

Increased employment opportunities are also available to consumer workers, as they are able to access education, training and professional development through their employment within a mental health service (Mowbray, Moxley, Jasper & Howell, 1997).

Benefits to the mental health service

The employment of consumer workers also provides a range of benefits to the mental health service they are employed by. The consumer workforce is able to act as an avenue for the education and training of clinical and administration staff, incorporating their lived experience and knowledge (Carlson et al., 2001). Consumer workers employed within the mental health system convey the message that the 'consumer' is important, and are able to bring a valuable

experience to the work that consumer workers' regularly perform (Carlson & McDiarmid, 1999).

Active employment of consumer workers can assist in having the consumer voice integrated in the planning, evaluation and development of services (Dixon et al., 1994). The lived experience of consumer workers allows them the opportunity to guide the change and nature of mental health services, helping to provide improved circumstances for consumers (Mowbray et al., 1996). Dixon et al. (1994) also report that consumer workers are able to influence the ways in which mental health service staff operate and provide treatment through their intimate personal knowledge. Such as knowledge on mental illness, medication and its impact on the person and community support services that consumer workers bring to their work.

The knowledge that consumer workers possess can also assist in challenging the stigma and discrimination that exists within most services. Consumer workers help mental health service staff become more aware of any prejudices that they hold about mental illness (Carlson & McDiarmid, 1999; Dixon et al., 1994) and highlight certain practices that may stigmatise consumers (Carlson et al., 2001). Carlson & McDiarmid (1999) write that it is through the employment of consumer workers that they "can heighten staff's awareness and sensitivity to the struggles faced by this workforce" (p13).

The negative attitudes held by service staff around the prognosis of consumers is also challenged by the consumer workforce (Carlson & McDiarmid, 1999). Carlson & McDiarmid (1999) explain that it is through the hiring of consumers as paid employees of a service that "attests to the values and philosophy of the mental health agency. It conveys to workers that consumers are important, they are capable as human beings, and bring valuable experience to the work" (p13).

The consumer workforce also assists in providing insight and "facilitating understanding which may help non-consumer [staff] face challenging situations with consumers" (Carlson et al., 2001, p201).

Mental health services benefit from the "different perspectives, understanding and diversity in the work environment" through the employment of consumer workers. The service further benefits from an enhanced sensitivity towards the consumers who use the service from the consumer worker presence (Carlson & McDiarmid, 1999, p13).

Benefits experienced by the consumer:

- Role modelling
- Ability to empathise with consumers
- Providing hope to the consumer in their recovery journey
- Intimate knowledge of the personal experience of the consumer

Benefits experienced by the consumer worker through employment in mental health services:

- Increased self-worth
- Personal growth and development
- Employment opportunities
- Reduced hospitalisation and enhancement of their personal recovery journey
- Increased self-confidence
- Access to skills development including education and training opportunities provided by the workplace

Benefits experienced by the mental health service through the employment of consumer workers:

- Opportunity for the education and training of mental health service staff
- Valuing the consumer voice in mental health services
- Enhancing the quality of experience for mental health consumers
- Improved mental health services and changes in staff culture
- Reduced stigma and discrimination within the service experienced through an enhanced knowledge of consumer issues in other team members

10. Conclusions

The consumer workforce in Australia was founded on the recognised need for increased consumer participation, support, advocacy, rights and protection within mental health services. Policy development in Australia (and internationally) has more recently promoted the importance of consumer participation in service implementation, delivery and evaluation. Following this trend, consumer employment within public, private and non-government mental health services has been realised throughout the 1990s in NSW.

It has been recognised, nationally and internationally, that consumers are better capable of understanding consumer issues and their solutions, better able to develop trust and rapport with clients and better promote empowerment. The literature on the mental health consumer workforce has promoted the important role that consumer workers play in mental health services. The benefits that consumer workers contribute to mental health services extend to the consumers receiving the service, the mental health service and staff, and to the consumer workers themselves.

Despite the various benefits that consumer workers contribute to the mental health service, many of the challenges and barriers that present themselves may be perceived as formidable enough to prevent the hiring of consumers. The consumer workforce may often be undervalued, and can face under-resourcing and inadequate infrastructure to support the ongoing improvement of the consumer workforce.

Consumer workers undertake various tasks and duties, as some services and staff struggle to clarify the role of the consumer worker, and face challenges in determining what should be expected of the workforce. Without clear position descriptions or roles and responsibilities, consumer workers may face role confusion and may be left to perform tasks that might fall outside of their advertised position. This also results in multiple job titles and remuneration awards that consumer workers are employed under.

Structuring issues such as inadequate supervision, support and mentoring as well as an unclear understanding of the position consumer workers have within the mental health service are also prominent issues facing the workforce. Supervision and mentoring needs to be put in place in order to assist and support the consumer worker during their employment, however, there currently exists no model program where this is being delivered.

A range of service and staff level barriers also present themselves when employing consumers as part of the paid mental health service team. Consumer workers may face boundary blurring within their role, as they try to navigate the

system as being both an employee, a client of the service and advocate for the consumer. This boundary issue can result in tension between the consumer worker and non-consumer staff member, leading towards negative attitudes, hostility, suspicion and disrespectful behaviour from some service staff members.

No standard for training and education exists for the consumer workforce. This also presents challenges in consumer workers having a full understanding of each component of their job role, as well as reducing their opportunities for professional development and career advancement.

In order to resolve unclear job clarification, structural issues, inadequate training and educational standards and support issues within the consumer workforce, a multi-pronged approach needs to be developed. Research into the evaluation of the consumer workforce needs to be developed to provide evidence to the effectiveness of the workforce, and provide perspective into how to address the attitudes of service staff and challenges that currently face the workforce.

The employment of consumers as providers of health services is not a new phenomenon. The fields of deaf/hearing impaired, HIV/AIDS treatment, spinal cord injuries and substance abuse have been commonly employing consumers as part of the treatment team for a long period of time. Multiple approaches and concepts of peer support exist and could be used as a model to assist in furthering mental health consumer workforce development in NSW.

It is vital to address the roles, functions and responsibilities of consumer workers and to develop minimum training and education standards, and create better structural support for the workforce in order to improve the current situation in NSW, nationally and internationally. The workforce needs to be appreciated for their understanding of, and respect for the consumer's lived experience, knowledge and perspective. Without positive change within the workforce, the issues of poor position descriptions, no consistent award rates and poor system structures will undermine and undervalue the mental health consumer workforce.

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