Families as peer workers in early intervention organisations:

Literature review

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Background and Scope

In 2017, the Australian Government established the Innovative Workforce Fund (IWF) to help to develop, expand and communicate innovations in workforce practices in the disability sector to support the Australia-wide rollout of the National Disability Insurance Scheme (NDIS). The NDIS is a national program providing funding packages to individuals with disabilities in Australia. The impact of the NDIS on the disability sector, including the Early Childhood Intervention (ECI) sector, has been significant, particularly with relation to existing workforce structures, practices and demands. The latest National Disability Service report on the Australian disability workforce (NDS, 2018) suggests that, in response to the NDIS rollout, support worker growth has been 11.1% per year, with 42% of all support workers employed casually. Such high casual employment comes with high turnover (9% per quarter). The IWF was thus allocated AU$4million to fund projects that would explore innovative workforce practices to re-examine existing workforce structures and practices in response to the NDIS rollout.

The IWF funded 29 organisations throughout Australia to undertake workforce related projects. Plumtree Children's Services, Inc. (Plumtree), an ECI service in the Inner West of Sydney, secured funding from the IWF to research and document the use of paid peer work in the ECI sector. Plumtree undertook to analyse its own experiences with paid peer workers to understand more fully the benefits of peer work to the ECI sector and its stakeholders, and to use those experiences to interrogate the conditions for success when utilising a peer workforce to complement and supplement traditional allied health, educator and professional ECI staff.

Plumtree has been employing paid peer workers since 2015. Initially, Plumtree employed peer workers to develop and facilitate its unique family capacity building program, Now and Next (Moore, Fong & Rushton, 2018). More recently, however, Plumtree has recognised the broader potential for a peer workforce in the ECI sector, and has employed peer workers in a variety of roles to complement and supplement its allied health and ECI workforce, since it recognises that families raising children with disabilities 'need more assistance and support than can be provided' by allied health and professional staff alone (Davidson et al., 2018, p. 1).

Plumtree has recognised the broad potential for a peer workforce in the ECI sector, and has employed peer workers in a variety of roles to complement and supplement its allied health and ECI workforce.

This Literature Review is one product of the research undertaken by Plumtree for its IWF project. The Literature Review is a key deliverable for the project because, although peer work is in its infancy in the disability and ECI sectors, peer workers have been utilised extensively in the mental health and associated sectors for the past two decades. Rather than duplicating many years of detailed research, this project was interested in understanding the major developments in the mental health sector to inform best practice in the disability sector. A summary of this Literature Review and its findings has been submitted in article form for peer review and publication (Heyworth & Mahmic, 2018).

Importantly, the broad concept of employing peer workers, defined here as people with a lived, personal experience who are trained and employed to support others (their peers) who face similar challenges, has been extensively researched in the mental health sector. The questions being addressed in mental health research are whether interventions provided by peers differ significantly from the same interventions provided by non-peer staff; whether there are specific interventions that can only be delivered by peers (that is, are there uniquely peer-delivered services); what the cornerstones of successful peer work are, and what outcomes are associated with success (Davidson et al., 2012)? These questions have equal relevance to the ECI and disability sectors. This Literature Review, then, is a broad overview of the multitude of research from the mental health sector and addiction agencies in relation to peer work, with reference to implications for the ECI and disability sectors.

Generally, research into peer support in the mental health sector can be classified into a number of thematic categories, including research concerning: informal peer support arrangements; peers participating in peer-run programs and services; self-help and mutual peer support; service-user employment in service delivery, and 'the employment of consumers/service users as providers of services and supports within traditional services' (Repper & Carter, 2011, p. 393). In this Literature Review, only the latter two categories are considered. This Review is not concerned with unpaid peer support, which is a distinct branch of peer collaboration that is well evidenced in not only the mental health sector, but also in the disability sector. Here, we are concerned specifically with the benefits, challenges, and potential of utilising a systematised, paid (that is, employed) peer workforce, and the research reviewed here is correspondingly only concerned with paid peer workers (on the definition of which, see further below).

This Literature Review considers both academic peer-reviewed journals and grey literature. In total, over one hundred documents and peer-reviewed articles, including other literature reviews, were considered to prepare this Review. The following is a synthesis of the findings, with reference to the implications for the project and the ECI sector.

Definitions

In the broader IWF project, Plumtree chose to use the terminology 'peer worker' and 'non-peer worker' to create a distinction between those employees utilising their shared lived experience to work more effectively with clients, and those without a shared lived experience. The project does recognise, however, that a third category of worker exists: those with a shared lived experience who do not explicitly utilise the expertise associated with that lived experience as integral to their role.

'Non-peer worker' is a deliberately broad term, since it intends to encompass the allied health professionals, educators, social workers, family key workers, psychologists, and associated therapists and professionals which might constitute an ECI team. As noted, the project accepts that many of this broad ECI team may have a lived experience with disability and developmental delay, whether their own, their child's, or a family member's. However, in their clinical capacity, the 'non-peer worker' group does not specifically and explicitly draw on any lived experience in their interactions with the families with whom they work. Indeed, for 'non-peer workers' there is an expectation of personal distance between clinician and family.

'Peer workers', on the other hand, deliberately and specifically draw on their lived experience to inform their roles and to work with families and ECI organisations (Harrison & Read, 2016b; Peer Work Hub, 2016b). Although Gates and Akabas (2007) offer a definition in which peer workers lack 'professional credentials' (p. 293), we feel this definition needs refinement since many peer workers do have a variety of professional credentials which they utilise in support of their peer work. However, what is crucial is that these professional credentials are less important than the lived experiences which they share with the clients with whom they work. This Literature Review will use the terminology of 'peer worker' and 'non-peer worker' to capture this fundamental distinction.

The project team acknowledges that labelling this broad workforce as 'non-peer' is not ideal, since defining any group negatively, by what they are not, implies a deficit that is not applicable, appropriate or intended here. At this time, however, the team were unable to find a more inclusive or descriptive term that would differentiate this team from their peer worker colleagues whilst still embracing and encompassing the broad diversity of ECI staff. We hope that, as research into peer workers in ECI sector continues, a more apposite term for these non-peer teams emerges.

This consistency of language is not reflected in the broader research, however. The research that this Review considers applies varied terminology to describe peer workers, including 'peer support workers', 'consumer-providers', 'peer educators', 'peer-to-peer support', 'peer specialists', and sometimes simply 'peers' (Chinman et al., 2014). These terms nevertheless designate the core feature of peer workers: people with a lived, personal experience who are trained and employed to support others (their peers) who face similar challenges (Bradstreet & Pratt, 2010; Gordon & Bradstreet, 2015). Within the health sector generally, a peer worker is

understood, then, to be 'an individual who shares common characteristics with the "targeted" group or individual, allowing him/her to relate to, and empathize with, that individual on a level that a non-peer would not be able to do… Emphasis is also placed on the idea that "peers" are considered to be equals' (Doull et al., 2005, p. 2). A similarly important aspect of peer workers is that they are consumers of services as well as providers of services (Davidson et al., 1999): this 'consumer-provider' aspect has important implications for the role that peer workers have in impacting service design and delivery.

The core feature of peer workers is that they are people with a lived, personal experience who are trained and employed to support others (their peers) who face similar challenges.

There are many principles which underpin the importance of peer engagement in health settings. As Bradstreet (2006) notes,

> peer support is a system of giving and receiving help founded on the key principles of respect, shared responsibility, and a mutual agreement of what is helpful… It is a model of provision that champions the use of personal knowledge and experience of a particular issue to help and support others who are experiencing that same issue (p. 34).

As noted, however, the use of 'peer worker' over 'peer support' type terminology implies our interest in evaluating paid peer workforce structures only, in which peer workers are paid employees, rather than in considering broader peer support systems. The bulk of evidence reviewed here concerns hiring or employing a peer with specific lived experience to offer services or supports to others in similar situations, whether those peer roles are uniquely offered by peers, or as part of traditional service delivery options (Chinman et al., 2014).

Introduction

As noted, although the concept of 'peer work' is emerging in the broader health sector, and peer workers are shown to make important contributions to health, health care and prevention (see, for example, Peers for Progress, 2014), the bulk of research concerning peer workers arises from the mental health sector. As Repper and Carter (2011) confirm, there exists 'literally thousands of descriptions of peer-led and peer-run mental health services around the world' (p. 392), including studies from the United States, Canada, the United Kingdom, Australia, and New Zealand. Importantly, however, many peer support workers in the mental health sector are not paid employees, and the concept of paid peer employment has been relatively slow to emerge even in that context.

Davidson et al. (1999) point out that although paid peer workers have been used in the mental health sector since the 1920s, and in earnest since the early 1990s in America (through the Colorado Division of Mental Health), it is really only in the 'last twenty years, [that] the practice of peer support has virtually exploded around the globe… Estimates place the number of peer support staff currently to be over ten thousand in the US alone' (Davidson et al., 2012, p. 123), although Gordon and Bradstreet (2015) note that 'in Scotland, despite a long-term policy commitment to recovery approaches, the creation of peer worker roles has been slow and patchy' (p. 160). Having said that, in the US, 'peer specialists make up one of the most rapidly growing segments of the mental health workforce' (Druss et al., 2010, p. 265).

The types of research undertaken in the mental health sector in relation to paid peer workers can be categorised broadly as follows (Davidson et al., 2012):

1. Feasibility studies, which examine the possibility of training and hiring/employing appropriate peer staff, and considering the criteria for the successful integration of peer workers into traditional workforce structures;
2. Comparative studies, which examine the roles adopted by peer and non-peer workers, and analyse peer workers' impact when taking on traditional roles, and
3. Specific, individual case studies, usually addressing the questions:
    a. In what ways do interventions offered by peer workers diverge significantly from the same interventions offered by non-peer workers, if at all?
    b. What interventions, if any, can only be provided effectively by peers who have a first-hand lived experience of mental illness, and how therefore is a peer worker's role unique?
    c. What criteria are required to achieve this unique peer potential, and what benefits or outcomes might successful peer intervention produce for stakeholders?

Importantly, across the available research internationally, the systemic introduction of peer workers in the mental health sector is recognised as beneficial (Davidson et al., 2018; Gillard et al., 2013). Globally across the mental health sector, peer workers 'have been shown to assist people with mental illness to improve social networks and quality of life, reduce symptoms and

hospitalisation, and improve self-esteem, coping skills, medication adherence and illness management' (Ashton et al., 2013, p. 247).

The evaluation of the National Peer Support Worker Pilot Scheme (developed as part of the Scottish Government's mental health service policy) by the University of Edinburgh and the Scottish Development Centre for Mental Health, concluded that:

> peer support can be successfully implemented in a wide range of settings… Despite being challenging to implement, it offered positive benefits for service users, peers and the service system… Peer support workers had a unique and distinct role, offering mutuality, empowerment, modelling hope and the sharing of lived experience with service users (Bradstreet & Pratt, 2010, p. 37).

Bradstreet and Pratt further noted that the 'peers clearly enhanced service effectiveness through unique contributions that strengthened team approaches and positively influenced service culture' (2010, p. 39). The Scottish Recovery Network (SRN) briefing paper on the role and potential development of peer support services (2005) concluded that there was sufficient evidence to assert 'that where peer worker specialists are added to existing mental health teams the outcomes for service users are enhanced' (p. 3). In 2011, then, the SRN issued comprehensive guidelines to systematise and formalise the development of peer worker roles across the mental health sector in Scotland, to ensure the successful implementation and effectiveness of the peer worker role.

The Scottish trial (as well as other UK models; see Gillard & Holley, 2014) was based on the successes of Arizona's META Services and their commitment to the recovery of their service clientele. In 1999, META Services committed to changing the traditional clinical narrative, which effectively discounted, disempowered and disrespected service users with mental illness (Ashcraft & Anthony, 2005). Peer workers were key to disrupting these traditional approaches and to asserting the importance of the concept of 'recovery' (Harrison & Read, 2016a). In META Services, peer workers were established from the outset as equal team members whose credentials and power lay in their lived experiences.

By 2005, META Services had trained over 500 peer workers and over half of their 350-strong workforce were peers (Ashcraft & Anthony, 2005). In a report of 2008, META Services (then trading as Recovery Innovations Inc.) employed 250 individuals as peer workers, which accounted for 63% of its then workforce (Recovery Innovations, 2008). Importantly, Recovery Innovations saw benefits for service users, as well as for their trained peer workforce. In that 2008 report, 72% of peers who had received education training had obtained employment as peer workers, with high job retention and fulltime employment rates. A key to the success of Recovery Innovation's integration of peers into their service delivery team was their commitment to training: their Peer Employment Training continues to be a comprehensive, highly interactive, skills-based curriculum which teaches both a way of being, as well as a way of partnering.

The Georgia Certified Peer Specialist Project (GCPSP) similarly identifies, trains, certifies and provides ongoing support and education to peer workers in the mental health sector in order 'to promote self-determination, personal responsibility and empowerment' (GCPSP, 2003). Since 2001, services provided by certified peer workers have been reimbursable by Medicaid in

Georgia, speaking to the integration of peer work into mainstream mental health service delivery (Salzer, Schwenk & Brusilovskiy, 2010). Indeed, it is on this Georgia model that several US organisations, including the Veterans Health Administration, have based their training for their peer workforce, and trained peer workers are not only recognised as providing evidence-based models of care by the Centers for Medicare and Medicaid Services, but also viewed as 'an important component of a state's effective delivery system' (Chinman et al., 2014, p. 431). The SAMHSA-HRSA (Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration, run by the National Council for Behavioral Health, US) Center for Integrated Health Solutions (CIHS) is another US based mental health service provider which utilises peer worker in its service provision (SAMHSA-HRSA CIHS, 2016). Indeed, SAMHSA 'has included peer-based services in its National Registry of Evidence-Based Programs and Practices' (Chinman et al., 2014, p. 430).

Peer workers are also utilised in the Australian and New Zealand mental health contexts. For example, Recovery Innovation's Peer Employment Training classes are available in New Zealand. Doughty and Tse (2005) note that in New Zealand, research on consumer-provider services show 'very positive outcomes for clients' (p. 4) when peer worker services are operated alongside clinical services in effective partnership models between peer and non-peer workforces. For a more comprehensive summary of the New Zealand context see Health Workforce Australia (2014, p. 21).

In their business case for implementing a peer workforce in Australia, Peer Work Hub (2016b) listed the employment opportunities for peer workers in the mental health sector across the public, non-government, not-for-profit and private sectors, and reference the many government policies currently in place to support the implementation of peer workforces, as well as the non-government programs that support peer workforce initiatives, development and implementation. These programs represent an Australia- and sector-wide interest in peer workforce initiatives. For example, the Western Australian Association for Mental Health's *Peer Work Strategic Framework* (WAAMH, 2014) encourages 'the further and continued embedding of peer work into the community mental health and alcohol and other drug sectors' (p. 2). As the authors state, in Australia, developing the peer workforce is a priority because

> there is increasing acceptance and endorsement of peer work at the broader policy, program, and service context. Support for peer work across a number of sectors is embodied in government policy and plans, workforce development strategies, consumer participation strategies and agency service delivery plans and programs. Peer work is consistent with contemporary human rights and social policy initiatives (WAAMH, 2014, p. 4).

Another example is Partners in Recovery (PIR), which 'is a recent Australian national policy initiative that employs Peer Workers who have a lived experience of mental health problems in a variety of roles' (Hurley et al., 2016).

Like in other global contexts, peer workers in Australia are seen as a cornerstone to support a national framework for recovery-oriented services (Department of Health and Ageing, 2014; Peer Work Hub, 2016b), although, despite policy support, Australia 'is identified as lagging behind compared to other parts of the world' in its implementation of a peer workforce (Hurley et al., 2016, p. 129). Nevertheless, the National Mental Health Commission (2014) recognised

the need in Australia for a peer workforce to be more systemically and systematically implemented, including training, support and formalised framework structures to define peer worker roles (see also ARAFEMI Victoria, 2013a).

Most recently, Mental Health Australia and KPMG (2018) recommended a trial of a paid peer workforce to consolidate an evidence base and establish a cost-benefit basis for employing peer workers in the sector. They recommend that, given current evidence, '1,000 places should be funded nationally specifically for peer workforce positions' both within community care and hospitals (p. 44). The report notes that in 2017-2018, AU$1.8million has been committed to a Peer Workforce Initiative in New South Wales, and that peer workers are currently employed in Victoria, Queensland and South Australia.

Importantly in Australia, the federal government has endorsed the concept of peer work by referencing it in its 2010 National Mental Health Strategy (Gallagher & Halpin, 2014) and 'by funding and accrediting the Certificate IV in Mental Health Peer Work qualification' (p. 44), and peer work is garnering more attention in various aspects of mental health care in Australia (for example, see Bellingham et al., 2018; Byrne et al., 2018). The release of guidelines such as the *Employer's Guide to Implementing a Peer Workforce*, published by the Peer Work Hub (2016a, 2016b), consisting of three documents (a case for organisations, a planning toolkit, and language guides), will aid the smoother implementation of peer workers in the future.

The Recovery Framework and Peer Workers

In many countries, including Canada, the USA, the UK, Australia and New Zealand, services in the mental health sector are underpinned a recovery framework (Health Workforce Australia, 2014). In these countries, peer workers are considered to be key to the recovery of service users (Gates & Akabas, 2007; Gordon & Bradstreet, 2015; Health Workforce Australia, 2014; Peer Work Hub, 2016b; SRN, 2011). As Gillard and Holley (2014) suggest, recovery 'focuses on how people learn from their experiences of mental illness to maximise their potential and live well with their mental health problems' (p. 286). Although 'recovery' as a framework is not specifically applicable to the ECI and disability sectors, the principles and aims of recovery are relevant, and an understanding of the relationship between these principles and peer workers is vital to an analysis of the potential benefits of peer workers in any sector.

Bradstreet (2006), understands the fundamentals of 'recovery' in mental health services to be the provision of hope and optimism; offering holistic and inclusive services and approaches; fostering the active participation of service users, extending their personal participation beyond that of a passive recipient of therapy; promoting self-management of interventions and developing coping strategies, and acceptance of adversity as educative and developmental. META Services defines the guiding principles of 'recovery' as instilling in service users hope and high-expectations for the future, and as offering services informed by customer insight and strengths-based approaches, which transition service users from 'helpee' to helper, celebrate accomplishments, and create community (Ashcraft & Anthony, 2005). Although 'recovery' itself does not pertain to the disability sector, then, the principles underpinning it should inform service delivery in disability contexts. If, then, as Bradstreet (2006) points out, 'we believe that one way to translate these recovery principles into practice is to promote and develop formal

peer support worker positions, training and employing people as peer specialists based on their own lived experience of recovery' (p. 34), peer workers offer great promise to the disability and related sectors.

Bradstreet's argument is based on the idea that the peer work model 'assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation' than those who do not have a shared lived experience (Repper & Carter, 2011, p. 394). Given this relationship between peer workers and recovery, certain essential elements have been formulated as underpinning peer work, including mutuality (the giving and receiving of help and support respectfully from the basis of shared lived experience), empathy from personal experience, engagement, a focus on wellness and strengths, and the potential for friendship (Bradstreet, 2006; Mead, 2003; SRN 2005).

Peer work, then, is often cited as characterised by adopting a strengths-based approach, which eschews a pathologised illness model and is founded in reciprocity, with explicit opportunities for sharing experiences and the giving and receiving of support. Paid peer workers give support and care using their own experience of overcoming adversity to support those currently struggling, and build 'up a mutual and synergistic understanding that benefits both parties' (Repper & Carter, 2011, pp. 394-395). Reciprocity, then, is integral to a peer work approach as differentiated from an expert approach (Repper & Carter, 2011). At its broadest, peer workers enable 'a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful' (Mead, 2003).

One distinction between voluntary peer support structures and paid peer work, however, lies in the exact nature of that reciprocity and mutuality. Paid peer workers occupy their own space. Unlike in unpaid peer support groups, the expectation for peer workers to receive support from service users may be muted or downplayed. Nevertheless, in order to be effective, paid peer workers cannot simply approximate or replace traditional professional-patient relationships: it is exactly the expectation of reciprocity and *shared* lived experience that makes peer workers unique (Davidson et al., 1999; Mead and MacNeil, 2006). We will return to this point presently.

Cost-Benefit Analysis

An important aspect to any workforce innovation is cost-benefit analysis of cost effectiveness. SAMHSA-HRSA CIHS (2016) emphasise that a key to the successful integration of peer workers into existing workforce structures is ensuring the financial sustainability of the peer worker model. Gordon and Bradstreet (2015) concur that understanding the budgetary aspect of employing peer workers is paramount for organisations considering hiring peer workers. They conclude that a business case or costed argument and 'evidence on cost-effectiveness and on cost-benefits would be compelling to decision makers' who are considering peer workers (p. 163). Whilst the question of whether peer workers represent 'value for money' is less well attested than some other considerations of peer work, some studies do address the cost-benefits of employing peer workers (see Solomon, 2004).

In the UK, for example, the Centre for Mental Health 'calculated that £4.76 would be saved for every £1 invested in peer support' (Flegg, Gordon-Walker & Maguire, 2015, p. 283), specifically from shorter hospital admissions and fewer readmissions to hospital (Knapp et al., 2014; see also Simpson & House, 2002). Similar findings were cited in an Australian pilot (AU$3.27 per AU$1 invested; SVA Consulting, 2016) and in another UK study, which concluded that there is 'preliminary support for the proposition that adding peer support workers to existing mental health teams may result in cost savings' (Trachtenberg et al., 2013, p. 11). Ultimately, the Centre for Mental Health suggest that there exists enough promise in initial cost-benefit analyses of peer workers to warrant further investigation into the costs and effectiveness of peer workers (Knapp et al., 2014).

Gillard and Holley (2014) also cite cost outcomes as a potential benefit of peer work, especially with regards to hospital readmissions (see also Gillard et al., 2013; Health Workforce Australia, 2014), and Kelly et al. (2014) show that consumers accessing peer worker support not only experienced fewer pain and health symptoms than those receiving traditional care, but also sought care from primary care providers rather than from hospital emergency rooms. In the Australian context, Lawn, Smith and Hunter (2008) demonstrate that in addition to personal benefits to consumers and peer workers, peer workforce models may offer 'substantial savings to systems' (p. 498). Health Workforce Australia (2014) conclude that 'peer workers may offer benefits in relation to cost-effectiveness' (p. 13).

The recent Mental Health Australia and KPMG report (2018) specifically addresses targeted investments that will improve the mental health of individuals and communities. With its emphasis on economic and productivity gains, the report offers 'actionable, scalable and context-specific solutions – solutions that not only provide demonstrable health and social benefits, but quantifiable economic returns to taxpayers and to the community' (p. 2). Among these solutions is the suggestion to trial a peer workforce. Whilst ultimately the report concludes that the savings of implementing a peer workforce are not estimable, it suggests a figure of an AU$3.50 return per AU$1 investment, and also notes that 'peer workforces represent a potential opportunity to increase employment rates and reduce Disability Support Pension costs by employing people with lived experience as peer workers' (p. 42).

Interestingly, the potential cost benefits identified by this 2018 report are not related to costs saved on service users, but rather to savings associated with the peer workers themselves, who represent a 'relatively low-cost option for increasing the mental health workforce' and who may therefore rely less on Disability Support Pensions (p. 43). The report also specifically suggests that peer workers have a role to play in supporting increased workforce demand with the rollout of the NDIS (on which see NDS, 2018). Ultimately, it suggests that 'there is potential for this intervention to be a "win-win-win" for employers, peer workers and consumers in reducing workforce shortages, increasing the financial stability of the peer workforce, and improving outcomes of people with mental health issues' (p. 44). The report recommends an investment of AU$100 million into a national trial of a peer workforce, with potential savings of AU$350 million.

Peer Work Benefits Service Users

> In employing peer workers within mental health services there is an acknowledgement of the expertise of lived experience and how this can be used to offer hope, empower, support and educate consumers and carers who are navigating mental health services.
>
> Gallagher & Halpin, 2014, p. 5.

In the mental health sector, studies attest to the benefits of a peer workforce for all stakeholders, including service users, the peer workers themselves, the non-peer workers with whom they work, and the organisations which employ them (Gallagher & Halpin, 2014). As Davidson et al. (2018) summarise:

> Training and hiring persons in recovery to provide peer support represents a win-win situation for resource-strapped systems. Patients receive support from trained peers who instill hope, model self-care, and help navigate the health care system. Peer support providers are gainfully employed in a role that supports their own recovery by allowing them to do personally motivated work. Systems gain a trained, effective workforce that pushes providers beyond the basic [expected] outcomes … to include other outcomes that also matter to patients and their loved ones, ie, those associated with reclaiming a meaningful life (p. 2).

However, Pitt et al. (2013a) and Cabral et al. (2014) note that client perspectives of peer workers are not well understood, nor are the effects of peer workers on service users. Nevertheless, as inherently person-centred (Peer Work Hub, 2016b), Gates and Akabas (2007) conclude that 'the weight of the evidence suggests that services provided by consumer employees in traditional settings can be as effective, or more effective than, nonpeer provided services' (p. 294). In this section, a summary of benefits to service users is offered.

In their longitudinal, qualitative study, Ochocka et al. (2006), found significant benefits for service users engaged in initiatives administered by peers. Similarly, Doughty and Tse (2005) note that in the New Zealand mental health context, evidence 'indicates that people who work and/or participate in peer operated programmes are stronger self advocates, more engaged in recovery practices, and are building new roles that help establish meaningful community integration' (p. 3). They further identify multiple potential benefits that service users experience when their mental health recovery is supported by peer workers. These include, but are not limited to, 'role modelling recovery, instillation of hope, providing empathy and emotional support, sharing practical information and coping strategies, and strengthening social supports' (p. 12; see also Gallagher & Halpin, 2014; Gillard & Holley, 2014; Gillard et al., 2015;

WAAMH, 2014). In addition to these benefits, other studies cite the likelihood for service users to become more actively involved in their treatment by transcending traditional models and roles of 'patient' (Repper & Carter, 2011).

Peer Workers as Role Models and Beacons of Hope

Service users consistently indicate that peer workers are the most effective role models for recovery (Peer Work Hub, 2016b), and are uniquely motivating and positive as role models (Gillard et al., 2015). Because peer workers demonstrate tangibly a realised potential for recovery, and for achieving success through adversity, they correspondingly increase service user confidence in their own ability to recover and succeed (Health Workforce Australia, 2014). The encouragement and support of peer workers is especially inspiring to service users because it is underpinned by real-life proof and testimony of lived experience (Ashton et al., 2013). As Cabassa et al. (2017) suggest, peer workers are thus 'an added value to health interventions as they bring credibility, trust, resiliency and hope to people with Severe Mental Illness. They also serve as positive role models that use their experiences to provide instrumental, informational, and emotional support' (p. 81). Bradstreet and Pratt (2010) also cite a peer worker's primary role as offering a lived example of progression, growth, strength and hope.

Intimately related to this concept that the peer worker is living proof of recovery, is that peer workers are often perceived by service users as beacons of hope (Bradstreet, 2006; WAAMH, 2014). As Repper and Carter (2011) argue,

> one of the essential benefits gained from peer support is the sense of hope – a belief in a better future – created through meeting people who are recovering, people who have found ways through their difficulties and challenges… The inspiration provided by successful role models is hard to overstate (p. 397).

By definition, peer workers use their mental illness to their advantage to gain employment and help others, and thus help to counter stigmas, undermine cultural stereotypes, and offer service users the hope of a better future (Davidson et al., 1999; WAAMH, 2014). Importantly, peer workers can foster hope because of the low-distance between peer worker and service user. The shared lived experience between peers allows for a relatable, high-trust relationship, foundational to which is a collapse of the perceived gap between 'us' (service users) and 'them' (service deliverers). Peer workers become a bridge between 'us' and 'them' since they are both service user and service deliverer (Bradstreet & Pratt, 2010).

Empathy and Emotional Support

Another unique benefit of employing peer workers is their ability to offer genuine empathy to service users, as distinct from service users perceiving themselves to be the object of a non-peer worker's sympathy. Peer workers 'are uniquely placed to offer consumers genuine and direct empathy through shared lived experience and as such have the building materials of a relationship that would otherwise not be possible between consumer' and clinician (Hurley et al., 2016, p. 131). This idea of empathetic acceptance underpins a broader benefit of increased

emotional support (Mead, 2003), since 'consumers believed that the experiential knowledge provided by Peer Support Workers created a "comradery" and a "bond", which made them feel that their challenges were better understood' (Repper & Carter, 2011, p. 397). The implications of empathy are twofold. On the one hand, service users who access peer workers within their support team 'reported having greater feelings of being accepted, understood and liked' (Repper & Carter, 2011, p. 397). On the other, empathy builds trust which increases health and wellbeing outcomes (Cabral et al., 2014). Gillard et al. (2015), cite building trusting relationships through empathy and shared lived experience as a key mechanism for change for service users.

Peer workers, then, offer benefits because they are authentic peers, sharing core characteristics with the service users (Aston et al., 2013). Importantly, the kinds of 'empathetic and therapeutic' relationships that can develop between peer worker and service user are not usually possible between service user and professional (Bradstreet, 2006, p. 35), so that a peer worker's ability to understand personally the service user's journey represents a great strength of the peer model (Repper & Carter, 2011). Peer workers, then, foster a sense of empathy, acceptance, and shared relationship which in turn increases the service user's feeling of emotional support (Repper & Carter, 2011, p. 397).

It is important to note, however, that some studies have found that peer workers are more likely to foster support-dependence in the service users with whom they work, and that a power differential between the supported and the supporter remains, mimicking a traditional clinical power imbalance (Bracke, Christiaens and Verhaeghe, 2008). Interestingly, Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) observed phases in peer support relationships; during the last of those observable phases, the relationship deteriorated, trust was undermined, and mutual avoidance and withdrawal was noticed, although this was speculated to occur in tandem with an increase in service user satisfaction, optimism and self-confidence. Service users essentially 'out-grew' their relationships with their peer worker.

Living Well and Fostering Active Participation

Although peer workers are often beacons of hope and empathetic role-models, they are equally repositories of information about living well with mental health problems (Gillard et al., 2015). For example, Kelly et al. (2014) demonstrate that consumers adopted behavioural strategies from peer workers which resulted in fewer emergency room visits as well as fewer health and pain symptoms.

There are many studies which attest to the idea that peer workers can improve a service user's self-esteem and confidence, in part by engaging in the 'the mutual development of solutions, the shared exploration of "big" feelings and the normalisation of emotional responses' (Repper & Carter, 2011, p. 396). As Gates and Akabas (2007) summarise:

> consumers who receive peer provided services have fewer hospitalizations, use fewer crisis services, reduce their substance abuse, and experience improved employment outcomes, social functioning and quality of life when compared to those who receive only professional services… Further, peer support can stabilize participation in treatment by helping to counter the sense of

> loneliness, rejection, discrimination and/or frustration that consumers can feel when dealing with the mental health system (p. 294).

Evidence also suggests that peer workers positively impact the relevance and applicability of intervention programs on service user outcomes. For example, Ashton et al. (2013) document the success of peer workers in a smoking-cessation program; the program's success was in part because peer workers were 'an integral part of the project, involved in the decision making, development and delivery of the group programmes and the training of health workers' (p. 247). Indeed, the 'potential for peer workers to act as *bridge* between the service user and mental health professionals' in the sense that they translate professional knowledge into accessible, relevant knowledge, and make services more practical and meaningful for participants, is a key and unique role for peer workers (Gillard et al., 2015, p. 440).

Although not within the mental health context, in relation to parents of chronically ill and dying children, Konrad (2007) suggests that peer workers are not only empathetic and personal mentors to other parents, but equally support fellow parents to become more educated and informed, and teach parents effective advocacy skills. In this context, peer workers are documented to increase patient activation and to increase health-related quality of life outcomes (Druss et al., 2010).

In essence, peer workers make service users more effective patients by disrupting the traditionally restrictive role of service user as passive patient to encourage service users to be actively engaged in their service provision (Davidson et al., 1999). Interestingly, because peer workers operate within a 'neutral frame of reference' (Doughty & Tse, 2005, p. 3), service users perceived no conflict of interest or power imbalance, allowing them to activate their own agency in their recovery more readily. As the SRN suggests (2011), by empowering service users to gain confidence in their own agency and capacity, peer workers give power to service users, thereby creating 'an environment which is conducive to people taking a greater degree of power and control in their own recovery' (p. 12).

Strengthening Social Support

Social isolation and exclusion are significant challenges for service users in the mental health sector, and peer workers offer the possibility to create new relationships, explore identity, make friends, and access social support in safe and supportive environments (Repper & Carter, 2011). As Ochocka et al. (2006) note, one specific benefit associated with peer-led initiatives is that they offer social contexts to meet and interact with peers, and peers effectively facilitate a reintegration into the community.

> One benefit of peer workers that is repeatedly confirmed is the positive relationship between peer workers and a decrease in social isolation.
>
> Health Workforce Australia, 2014

This reduction in social isolation, accompanied by a corresponding increase in a sense of community, leads service users to experience increased hope and autonomy. Moreover, social integration (or reintegration) is the process by which people with (or affected by) mental illness are given the opportunity to participate in and access their community fully (Davidson et al., 1999).

Unique Potential

Pitt et al. (2013a) conclude that 'involving consumer-providers in mental health teams result in psychosocial, mental health symptom and service use outcome for clients that were no better or worse than those achieved by professionals employed in similar roles' (p. 2). While there were no adverse outcomes for service users, they argue, no positive benefits were rigorously evidenced either (Pitt et al., 2013b). However, this conclusion is not supported by the broader literature. By contrast, Gallagher and Halpin (2014) suggest that 'peer workers have a unique understanding of the challenges faced by consumers and carers and this service should continue to be promoted and offered to all consumers and carers accessing mental health services' (p. 6). Akin to Pitt et al. (2013), Repper and Carter (2011) did not find compelling evidence to support the contention that peer workers directly impacted the mental health outcomes of service users, but they nevertheless concluded that

> what Peer Support Workers appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity (p. 400).

Ultimately, as Rogers et al. (2007) note, despite significant variance between specific programs and peer worker roles, service users receiving services from peer workers generally report higher levels of empowerment than those in control interventions (see also Health Workforce Australia, 2014; SRN, 2011).

Davidson et al. (2012) identify three benefits for service users that are potentially unique to peer workers:

1. Hope through positive self-disclosure,
2. Role modelling function through past and continued experiences,
3. Special relationship based in trust, acceptance, understanding and empathy.

Peer workers, like non-peer workers, operate with compassion and commitment, but it is their shared lived experience which instils hope, empathy and acceptance, and which is unique to the 'peer worker' category (Cabral et al., 2014; SAMHSA-HRSA CIHS, 2016). Peer workers themselves identify the sharing of lived experience as most important to the quality and outcomes of their relationships with clients (Cabral et al., 2014).

The three potentially unique benefits of peer workers to service users are hope through positive self-disclosure; role modelling function through past and continued experiences, and special relationship based in trust, acceptance, understanding and empathy.

Mead and MacNeil (2005; 2006) suggest different, unique criteria for peer workers. They suggest that peers:

1. Don't necessarily invest in medicalised and problematised narratives about mental health, and are instead focused on building relationships,
2. Are not involved in assessments and evaluations, and instead focus on mutual responsibility and communication, and
3. Rely on reciprocity and mutuality, where support is both ways, power structures are collapsed or negotiable, and each party learns from the other.

Peer workers, then, are unique not only in their use of their shared lived experience to inform their interactions with service users, with specific and unique benefits as hopeful and empathetic role models: they operate in a different space than traditional clinicians within a frame of mutuality.

It is also worth noting that evidence suggests that peer workers have special impact on hard to reach populations (Health Workforce Australia, 2014; Peers for Progress, 2014), especially on service users who are financially and/or socially disadvantaged and those typically disenfranchised in traditional service delivery models. In such populations, improvements were greatest when peer workers were involved (Druss et al., 2010; Peers for Progress, 2014). For example, in their longitudinal study, Sells et al. (2006) found that especially early in treatment, peer workers were especially valuable in making connections quickly with persons 'typically considered to be among the most alienated from the health care service system' (p. 1179).

Peer Work Benefits Peer Workers

One important aspect of peer work is that it is mutually beneficial: it 'has been argued to provide equal benefits to both parties', peer worker and service user (Flegg, Gordon-Walker and Maguire, 2015, p. 284). As Bradstreet & Pratt (2010) note, the use of peer workers benefits service users (for example, reducing hospitalisation duration and decreasing social isolation), but peer work benefits peer workers themselves, who experience increased well-being, empowerment, control and confidence (see Health Workforce Australia, 2014; WAAMH, 2014). The benefits of employing peer workers, then, extend beyond simply service users to impact positively the peer workers themselves (Gillard & Holley, 2014).

Peer workers cite increased empowerment, control, confidence, self-esteem and independence as key benefits that peer work offers them personally.

Benefits of peer work to peer workers include an 'an increased sense of independence and empowerment' (Repper & Carter, 2011, p. 396), as well as an increase in self-esteem and confidence, feeling appreciated, self-empowerment and value (Rogers et al., 2007), personal growth, money, and skill development (Repper & Carter, 2011). As Gates and Akabas (2007) summarise:

> the peers' individual healing benefits from their helping role… Peers can benefit from the social support they receive from the consumers they serve and their nonpeer co-workers, from the experience of helping others identify and resolve problems, and from interacting with other peers who successfully cope with their mental health conditions… Finally, peers benefit from the self-sufficiency due to increased income and a sense of self-efficacy and purpose to life that work brings (p. 294).

Thus, peer work is a critical employment opportunity and chance to improve financial stability for peer workers (Bradstreet, 2006; Gillard & Holley, 2014; Health Workforce Australia, 2014), in which an individual's adversity is turned into something purposeful and valuable (Bradstreet & Pratt, 2010; Gillard et al., 2013). In addition, employment as a peer worker brings 'the experience of valued work in a supported context, permission to disclose mental health problems – which are positively valued – [which] all add to self-esteem, confidence and personal recovery' (Repper & Carter, 2011, p. 400).

Certainly, the idea of 'giving back' (Bradstreet, 2006, p. 35) is often quoted as beneficial for peer workers, since peer work offers training and employment which values adverse lived experience in the act of giving back to the community (SRN, 2005; SRN 2011). This 'helper principle', as Mead and MacNeil (2006) call it, exploits the idea that helping another is also instrumental in self-help and self-healing. Thus, in their study of the reciprocity and balance of providing and receiving support in peer networks, Bracke, Christiaens and Verhaeghe (2008) concluded that not only are peers important in the care of individuals with mental health concerns, but that peer workers equally experience improved feelings of self-worth, competence, self-esteem and self-efficacy through providing support.

Vandewalle et al. (2017) note that peer workers perceive that they have an authentic and meaningful contribution to service delivery, and that their peer work helps them to construct a positive self-identity through meaningful employment by turning the adversity of their own lived experience into an asset. Peer work, then, is liberating and subverts stigmas, although Vandewalle et al. note that sufficient support and training is necessary for peer workers to maintain this sense of wellbeing.

Benefits to peer workers are also practical. As Gillard et al. (2013) suggest, 'the flexible terms and conditions of employment offered to Peer Workers were often appreciated, enabling Peer Workers to work when they felt well and reducing experiences of pressure resulting from the role' (p. 194; see also ARAFEMI Victoria, 2013a). It is important to note, however, that Harrison and Read (2016a) suggest that an assumption that peer workers require or desire part-time employment is dangerous and may undermine other benefits if peer workers are seeking full-time employment, and Gallagher and Halpin (2014) recommend that more full-time positions be created for peer workers desiring such work.

Flexible work conditions are beneficial to some peer workers, although care should be taken to ensure full-time positions are created for those peer workers desiring such employment.

Non-Peer Worker Responses to Peer Workers

One aspect of employing peers as workers in the mental health sector that is less well documented is the non-peer response to, and perception of, peer workers. Whilst the impact of peer workers on non-peer staff is discussed (for example, increasing non-peer staff's positive attitude towards service users; Simpson & House, 2002), and whilst good outcomes are discussed at length for both service users and the peer workers themselves, the impact (positive or negative) on non-peer staff is a less extensively examined field of study.

Gallagher and Halpin (2014) report that in South Australia, non-peer staff broadly both understood the benefits of peer workers and had positive experiences of working with them. Similarly, Bradstreet and Pratt (2010) report of the Scottish experience that 'wider service system staff were mostly very positive and appreciative of the role, seeing it as complementing the overall goal of supporting… service users' (p. 38; see also SRN, 2011). They also report that although staff became more aware and reflective about their language and practice with the influence of peer workers, 'there were some staff who were resistant or sceptical about the role', which led to challenges (p. 38). Phillips (2018) also reports instances of resistance or scepticism, stating that 'ambivalence towards peer support workers is common among professionals when experiential ways of knowing attempt to be integrated with clinical knowledge' (p. 11). This sentiment is echoed in Gillard et al. (2013), who found that 'some staff identified resistance in the existing workforce to the introduction of Peer Workers into the team… the source of this resistance might lie in the training and background of existing staff [and] a sense that their roles and responsibilities might be threatened by a new Peer Worker role' (p. 194).

Interestingly, in their study, Walker and Bryant (2013) suggest that peer workers experience discrimination and prejudice from their non-peer colleagues, as well as collegial relationships with them. In another study, although non-peer staff felt that they included peer workers in teams, that perception was not necessarily shared by peer workers (Gillard et al., 2013). Clearly, the future challenge is to ensure that collegiality is experienced more by peer workers, and that instances of discrimination and exclusion are lessened. Indeed, Walker and Bryant (2013) suggest that the positive quality of non-peer/peer staff relationships are vital to the ongoing viability of the peer workforce model.

Davidson et al. (2012) cite common professional concerns as:

1. the fragility of the peer staff to handle the stress of the job,
2. whether peer workers can manage the administrative demands of the job,
3. the perception that peer workers have the potential to cause harm by breaking confidentiality and crossing boundaries, and
1. lack of surety about whether peer workers make non-peer staff's jobs easier or harder.

The solution to easing these concerns, they argue, is adequate and proactive training of non-peer staff addressing these areas of concern prior to the implementation of a peer workforce.

Other studies posit other reasons for the disquiet felt by non-peer workers towards their peer colleagues. For example, unease may arise because of the peer worker's status as 'mental health patient'. The potential for non-peer professionals to fail to treat former patients as colleagues and equals is attested, and this power inequality is discriminatory and must be actively addressed by organisations before the integration of peer workers (Repper & Carter, 2011). Whilst it is less likely that such stigmatisation would impact parent peer workers in the ECI sector, it is important for the disability sector to consider the potential for such discrimination against peer workers with disabilities.

Some non-peer staff hesitation may also lie in the relationship between peer workers and cultural change (Harrison & Read, 2016a). As Doughty and Tse (2005) note:

> employing service users … as providers can facilitate cultural change within mental health workplaces by stimulating open dialogues on the attitude and behaviours of mental health professionals. It helps the mental health system to provide more client-focused health services. It also promotes a vision of inclusion and the full participation of service users in society (p. 12).

Cabral et al. (2014) concur, citing non-peer staff education as one of a peer worker's most important roles, in which peer workers can effect positive change towards more respectful, recovery-focused service delivery (Health Workforce Australia, 2014). However, whilst cultural change ultimately benefits service users and the sector more generally, challenging the status quo can provoke unease and, potentially, hostility (Gates & Akabas, 2007) in existing workforces.

Research does offer some solutions to counter non-peer worker resistance or unease to peer workers. Most importantly, as Bradstreet (2006) argues, peer work should be established not as a replacement for existing services, but as a complement to them. Flegg, Gordon-Walker and Maguire's research (2015) speaks to the non-peer perception that, whilst peer workers were largely beneficial, their services were not always 'appropriate', and should be provided in addition and as a complement to traditional, non-peer services.

The organisational challenges for implementing a peer workforce are discussed in more detail below, but it is worth noting here that Gates and Akabas (2007) list five key reasons which might potentially interfere with the successful integration of peers into existing service providers. These are:

1. non-peer worker attitudes towards peer workers as consumer-providers;
2. role conflict and confusion, including boundaries between consumers and providers, disclosure of peer status, and peer access to client records;
3. lack of clarity around confidentiality, particularly with regard to the disclosure and transmission of confidential information between peer and non-peer staff;
4. poorly defined peer jobs, including confusion around peer recruitment, lack of training and supervision, and unclear job descriptions or poorly defined jobs, and
5. lack of opportunities for networking and support, since peer workers still experience social isolation.

In particular, confusion or a lack of clarity about peer roles often results in peer worker isolation and exclusion in the workplace (Kemp & Henderson, 2012), and often underpins non-peer reserved views on peer workers. Hurley et al. (2016), however, offer a different lens by which to understand non-peer resistance to peer workforce implementation. They concede that a certain reluctance or resistance by 'mental health staff of all disciplines' exists, but suggest that such resistance may stem from 'a lack of willingness to go along with integration of an ill-defined role' for which 'a well-defined scope of practice does not exist and support mechanisms have not been established' (p. 132). Thus, resistance can be viewed positively as voicing reasonable concern that should be addressed before implementation. As Byrne et al. (2018) note, the perceived value and benefits of peer workers is in part dependent upon appropriate organisational practical supports and strategies being in place, so that lack of clarity and poorly defined job descriptions impact negatively on non-peer staff perceptions of peer workers' value and benefits.

Evidence thus suggests that lack of clarity of the role of the peer worker is instrumental in how peer workers are received by their non-peer colleagues. Peer workers themselves, as well as non-peer staff, often feel that role clarity is desirable but lacking (Cabral et al., 2014). To prepare non-peer staff effectively for the entry of peer workers into their teams, SAMHSA-HRSA CIHS (2016) suggest:

1. readying non-peer staff by training them on the role of the peer workers and promoting the right organisational culture,
2. proactively addressing boundary issues (especially those of confidentiality and privacy, and peers receiving services within the same organisation they provide services),
3. offering formal training to peer workers,
4. having clear job descriptions for peer workers, and
5. ensuring that peer workers have trained supervisors.

Studies such as Hutchinson et al. (2006), show the importance of standardised peer worker training on the longevity of peer worker employment and impact, on maintaining peer worker empowerment and recovery, and –significantly – on non-peer perceptions of peer colleagues.

The suggestions made by SAMHSA-HRSA CIHS (2016) are also echoed in Cabral et al. (2014), who cite the need for adequate supervision both for the benefit of peer workers themselves, as well as to increase non-peer staff trust and receptiveness to peer workers. Supervision that is tailored to the unique needs of peer workers, involves other peer workers, and is grounded in specialised supervisor training, is crucial, they argue, because it provides role clarity, positively impacts relationships with non-peer colleagues and job satisfaction, and reduces role strain (ARAFEMI Victoria, 2013a; Peers for Progress, 2014; Phillips, 2018). Importantly, however, as Beddoe, Davys and Adamson's (2014) research suggests, supervision and support is often most profitable and positive to peer workers when given by immediate peers – in this case, other peer workers.

Potential Peer Worker Roles

There are certain qualities which make effective peer workers. Flegg, Gordon-Walker and Maguire (2015) suggest that characteristics such as being supportive and respectful, displaying empathy and humour, being able to manage boundaries, being assertive, and having a commitment to equality and anti-discrimination, are all qualities of excellent peer worker employees. Davidson et al. (1999) propose that peer workers may be more able 'to empathize, to access social services, to appreciate clients' strengths, to be tolerant, flexible, patient and persistent; and to be aware of and responsive to clients' desires' (p. 178). But what roles might such peer workers fill? As Gordon and Bradstreet (2015) state, 'the type of activities that peer workers undertake depends on the setting in which they are working' (p. 161), but might include working directly with clients, running education, information and support groups, and supporting people to implement practical strategies in their lives. Peer workers, then, are often employed to assist with 'advocacy and mediation; mentoring and role modelling; peer support, education and counselling; and assistance with meeting needs of daily living, such as housing and work' (Davidson et al., 1999, pp. 439-440).

Health Workforce Australia (2014) list no less than thirty-three varied titles assigned to peer workers in the literature informing their review, which they classify as sitting within the seven broad functions of individual advocacy, peer support, systemic advocacy and representation, health promotion, education and training, quality and research, and coordination and management. These functions are closely echoed by the eight broad categories the Peer Work Hub (2016b) identify in which peer workers might operate, although they add practice supervision to the list. Similarly, in Georgia, although its certified peer workers were engaged in a core set of activities, peers engaged in a variety of work settings and roles (Salzer, Schwenk & Brusilovskiy, 2010). Likewise, Gates and Akabas (2007) cite a list of varied potential peer worker roles that expand beyond support of clients, to encompass supporting other staff, administration and 'non-specific' tasks (like writing a manual, or greeting and registering new clients), and community outreach (p. 299). As these examples suggest, peer workers' potential roles are multidimensional. This vast range of roles has implications for training and supervision, which needs to be reflective and individualised.

In Scotland, Bradstreet (2006) points out that peer workers can offer new services, and service alternatives, based on a better understanding of service user's needs, and are often innovative and progressive in response to their own experiences. Regarding the Scottish peer worker pilot program, Bradstreet and Pratt (2010) show that

> activities undertaken by peers included running groups, drop-in sessions, having formal caseloads, developing and working towards recovery goals, supporting people to use wellness recovery action plans, supporting people through transitions, participating in team meetings and raising staff awareness. The types of activities offered also depended on how the peer felt best able to share his or her lived experience (pp. 37-38).

This observation – that peer worker activities should be developed in response to individual preferences for sharing lived experiences – is formalised in the SRN (2011) guidelines, which recommend that peer worker activities be developed in response to how the individual peer worker feels best able to share their lived experience for best results. The guidelines thus recognise 'the potential variety of peer roles and settings as well as the qualities and skills of the peer worker' (p. 6), and advocate for choice and options rather than a prescriptive approach to peer worker roles. Organisations, then, should develop roles within the context of their needs and the skills and preferences of their individual peer workers. To do so, Harrison and Read (2016a) suggest that organisations should ask themselves specific questions designed to aid meaningful reflection before role implementation.

Importantly, the SRN (2011) states unequivocally that

> peer workers are not intended to replace any existing mental health services or roles, but rather are an opportunity to enrich the provision of mental health services through the direct participation and expertise that people with experience of mental health problems and using services can bring (p. 5).

Peer worker roles, therefore, should not mimic or simply supplant traditional services, but should be designed to complement and supplement existing services. Whatever their role, peer workers should not be positioned to approximate their non-peer colleagues.

Significantly, as Chinman et al. (2014) demonstrate, the evidence for peer integration is not static across programs and roles. The evidence for the benefits of peer workers depends on both the roles which peer workers adopt, and the organisation and organisational culture into which peers are integrated. These authors identify three main service delivery types in which peer workers might operate, and which may overlap: 'a distinct set of activities or a curriculum that includes education and the development of coping and problem-solving strategies…, activities that are delivered as part of a team that may include nonpeers…, and traditional activities … that are delivered in a way that is informed by a peer's personal recovery experience' (p. 431). It is, however, the right organisational culture and a commitment to person-centred roles to match person-centred approaches, that predicates peer worker success. Doughty & Tse (2005) thus highlight a number of cultural markers that indicate a readiness to accept peer worker partnerships, including a commitment to peer workers, flexibility to achieve genuine collaboration, willingness to act on consumer views, and proactivity with regards to developing and articulating roles in response to the needs of all stakeholders.

Challenges in the Peer Worker Model

As the previous discussion indicates, incorporating peer workers into existing workforce structures is not without its challenges and complexity (Harrison & Read, 2016b; WAAMH, 2014). As valuable as is the unique potential of peer workers, training, guiding, supervising and evaluating peer workers are all organisational challenges (Cabral et al., 2014), and peer workers 'are inherently disruptive role innovations' (Harrison & Read, 2016b, p. 3).

The successful integration of peer workers into existing organisations can face challenges and barriers, both operationally and culturally.

Studies show that often the implementation of a peer workforce faces barriers. For example, as Gates and Akabas (2007) show, the 'integration of peers on staff was undermined by misperceptions and stigma among nonpeer staff about consumers as workers, role conflict and confusion, inadequate policies and practices around confidentiality, poorly defined job structure, and a lack of opportunities for networking and social support' (p. 302). Typical challenges to successful implementation, then, include how to design and deliver training to peer and non-peer workers alike; how to employ and support peer workers; how to identify appropriate teams and roles for peer worker integration, and how to ensure peer workers become valued team members (Bradstreet, 2006). The SRN (2011) guidelines identify potential hurdles in peers gaining the trust of the staff; isolation when working alone; potential for overwork and overextension; inflexible job duties; loosing peer work uniqueness; a fear of speaking up, and a lack of job development. These lists indicate the many potential hazards which can undermine the successful implementation of a peer workforce.

In 2015, Canada's Self Help Centre for Excellence in Peer Support, which implements and supplements peer workers within the Canadian Mental Health and Addiction departments, launched a Peer Support Research Project, one purpose of which was to investigate 'the common implementation issues that peer staff face' (Harrison & Read, 2016a, p. 3). Their research suggested a number of implementation issues, which, left unaddressed, resulted in implementation challenges (Harrison & Read, 2016a; 2016b). These include:

- Accommodations to allow peer workers to function effectively given their lived experience of mental illness and their often-ongoing journey to recovery;

- Appropriate application and recruitment processes, since traditional recruitment often creates barriers to employment for those with a lived experience of mental illness;
- Career pathways, since advancement opportunities are often limited for peer staff;
- Clarity of purpose, including a purposeful role and clear expectations, a lack of which negatively impacts both peer and non-peer staff;
- Co-optation, in which peers become professionalised and lose their unique identity as peers;
- Employment status, since most peer workers are employed casually or part-time. This may be a benefit for some, but may also be a hurdle to those peers wanting the security of and access to full-time work;
- Identity conflict, since peer workers are both consumers or service users, as well as service providers, and can experience conflict in understanding where they 'fit' within organisations (impacted by a lack of coherent role description);
- Isolation, especially when peer workers are employed to work individually, or there is not a robust peer team;
- Mental health and wellbeing, especially since peer workers are vulnerable to stress, emotional exhaustion and burnout due to the expectation of using their personal lived experiences;
- Overwork and overextension in high stress environments, which presents challenges in maintaining positive mental health outcomes;
- Relationships with non-peer colleagues, which can be negative or enact a power imbalance. Such relationships are adversely affected by lack of role clarity, which can result in non-peer staff dismissing, devaluing and disrespecting peer workers, who experience discomfort, prejudice, low-level work, isolation, exclusion, and bigotry. Such outcomes are more likely when peer workers work with non-peer staff from whom they have received services in the past;
- Relationships with service users, since peer workers experience the usual frustrations faced by non-peer staff;
- Resources to meet job requirements (access, for example, to a desk, computer, information, training, and client details);
- Lack of role clarity, including uncertainty about the peer worker role and having unclear expectations of the tasks expected of them;
- Supervision that is adequate and based on clear role expectations;
- Training, relevant to the peer worker's role, and
- How to use lived experience intentionally, effectively and within boundaries.

A strong pattern of challenges to implementing a peer workforce thus appears within the literature. Whilst some challenges are specific to the mental health sector (for example, stigma around mental illness), these challenges have important implications when extrapolated into the ECI and disability sectors. This impact for the ECI context will be discussed further below, but a brief examination of some key barriers is warranted given the pervasiveness of them in the mental health research.

Role Clarity

The single most important factor to come out of the mental health research is the crucial importance of ensuring the role and job description of a peer worker to safeguard clarity of purpose for all stakeholders, since poorly defined jobs, role conflict and confusion, and lack of clarity are the most pervasive peer workforce barriers (Health Workforce Australia, 2014). The Canadian Mental Health Association department, Self Help & Peer Support, notes a number of trends that account for the lack of such role clarity, including 'that peer worker roles tend to be implemented haphazardly and without full organizational support' (Phillips, 2018, p. 1). For the peer workers themselves, according to Moran et al. (2013), lack of clarity of job description was one of the most detrimental challenges to the success of their employment (followed by a lack of training and supervision, overwork, and a lack of acceptance and appreciation by other colleagues).

The single most important factor to come out of the mental health research is the crucial importance of ensuring the role and job description of a peer worker to safeguard clarity of purpose for all stakeholders.

Associated with lack of role clarity is a lack of information about what peer workers offer and do, about the benefits for stakeholders, and a lack of evidence for effectiveness of peer workers in achieving outcomes. These, as consequences of lack of role clarity, are repeatedly cited are major stumbling blocks for the broader implementation of a peer workforce (Gordon & Bradstreet, 2015). An increase in knowledge about the role and potential benefits of peer workers thus needs to occur in both professionals and service users to diminish the potential for discrimination and effect corresponding increase in employment stability (Davidson et al., 1999).

Stress and Emotional Distress

The risk for peer worker stress and emotional distress are high within this vulnerable sector of the population (WAAMH, 2014), especially given their work of revisiting past experiences (Nestor & Galletly, 2008). Some peer workers expressed concern that in their work they would potentially be exposed to client experiences which were 'too close to their own' (Gillard et al., 2013, p. 193), and this became a deterrent to taking on a peer worker role. Moreover, Moran et al. (2013) suggest that peer workers felt they lacked adequate skills in being able to use their lived experience to help others effectively and not to the detriment of their own mental health outcomes; this factor was key in work dissatisfaction ratings. Ongoing training and support for peer workers can mitigate this risk (Repper & Carter, 2011).

Boundaries and Privacy

As Bradstreet (2006) notes, 'there are many hurdles and practical considerations to be considered before a peer specialist workforce can be developed…, not least of which is the challenge to our understanding of professional boundaries and roles' (p. 36). Repper and Carter make the important point that, by necessity, alongside a peer worker's potential for empathy is a potential for boundary issues: as peer workers are encouraged to share their stories and disclose their personal journeys, the possibility arises for service users to consider peer workers as more 'friend' than 'worker' (Repper & Carter, 2011). Whether this is problematic, however, depends on the organisational culture into which peer workers are included. Harrison and Read (2016a) question whether 'the "boundaries" that peers negotiate in order to engage in a unique and effective practice [are] compatible with the service model and legal and ethical framework of the organizations in which they are employed?' (p. 3). Ultimately, understandings of boundaries must be balanced and nuanced in order to retain the quality of 'peer' without violating confidentiality and privacy requirements. Again, training and peer staff induction on the privacy implications of sharing information and to clarify referral processes are effective ways to mitigate boundary and privacy risks (Bradstreet & Pratt, 2010).

Professionalisation or Co-optation

> Where peer workers are to be introduced as members of the multidisciplinary mental health team there are arguments in favour of standardising and regulating the role… However, others have suggested that such formalisation will undermine the peer "essence" of the role…, that there is a risk of peer workers becoming socialised into the working culture around them, and of the distinctiveness of the role being lost (Gillard & Holley, 2014, p. 289).

Perhaps the most insidious challenge to implementation is making sure that the distinctiveness of peer workers is maintained, so that peers do not become part of the traditional therapy professional set (Repper & Carter, 2011). Davidson et al. (1999) contend that a 'healthy tension between the clinical and consumer perspectives, while perhaps optimal, appears hard to achieve and maintain' (p. 180; see also Franke, Paton & Gassner, 2010; Deegan, 2017), but is nevertheless vital to retain those benefits unique to peer work.

Peer workers rely on reciprocity for their unique benefits, and yet it is precisely this reciprocity that often causes unease. Although peer workers felt that their lived experience was their most important and unique offering, this insight was not necessarily echoed by non-peer workers, and 'this apparent conflict between "giving of personal experience" as a Peer Worker and "trying to be a professional" (to maintain the prescribed, boundaried role) seemed to encapsulate the tensions inherent in the Peer Worker role' (Gillard et al., 2013, p. 197). Organisations thus must resist the urge to 'professionalise' the peer worker role to preserve its unique status and quality, since 'professionalisation' decreases peer worker impact and value (Davidson et al., 1999). As Deegan (2017) so eloquently argues, peer workers are not clinicians, and although their perceptions and purposes may overlap, they occupy distinct spaces.

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>
> Deegan, 2017

As Peers for Progress note (2014), it is both necessary and possible (although challenging) for peer work to be 'defined and standardized while remaining flexible and responsive to the people and communities it serves' (p. 3). Clear job expectations allow peer workers to function effectively without acting like their non-peer, professional colleagues, which threatens to undermine the core of their mutual shared experience (Davidson et al., 1999). Organisations therefore must support peer workers to 'navigate a professionally dominated service area and develop successful survival strategies without losing sight of their unique value base, mission and philosophical approach' (Hardiman et al., 2005, p. 106).

Professionalisation or 'co-optation', however, does not always result from pressure from non-peer staff and management for peer workers to sit more comfortably within 'professional' boundaries, although undoubtedly peer workers may adopt an expert role for this purpose (Chinman et al., 2014). It may also be an adaptive strategy by peer workers to 'fit into' traditional, clinical settings (Harrison & Read, 2016a). Workplace isolation can lead to peer workers adopting a clinical approach, or becoming a junior clinician, to find a place for themselves (Phillips, 2018). As Gillard et al. (2013) note, peer workers experience a conflicted identity, not quite wholly clinical staff, and not quite wholly service user, and so may 'professionalise' themselves to better fit in. Again, non-peer acceptance of peer workers within their unique frame, and positive peer/non-peer relationships, are vital to the success of the model (Phillips, 2018), since, as Mead and MacNeil (2006) suggest, maintaining a non-professional frame is vital if people are to get the unique experiential benefits from peer workers. Finally, the risk of professionalisation does not imply that peer workers should not be incorporated into clinical settings; in fact, the opposite is true since it is within clinical settings that peer workers have access to more service users (Davidson et al., 1999).

Evidence Base for Peer Workers

One limitation of the peer worker model is the dearth of a reliable evidence-base (Gillard et al., 2015); in particular, 'there is a lack of quantitative empirical evidence that unambiguously supports the positive impact and efficiency' of peer workers (Hurley et al., 2016, p. 130) despite the plethora of qualitative studies. The studies of Pitt et al. (2013a; 2013b) speak to the limited data available to assert rigorously the evidence of peer workers' efficacy, although as Salzer and Shear (2002) point out, peer work is unique and different from traditional services, and so requires correspondingly unique and different approaches to study its benefits and effects. Similarly, Hurley et al. (2016) suggest that it is not an empathetic relationship between peer

worker and consumer that is contested, but 'whether this relationship … is a therapeutic relationship' (p. 131). The primacy of quantitative, randomised and traditionally tested empirical type studies thus may be a less effective measure by which to judge peer work than qualitative or participatory action research studies.

As this Literature Review shows, there is a surfeit of articles about peer workers in mental health care roles. Most of these, however, are qualitative studies, and 'evaluation [of peer workforce models] has lagged behind implementation of peer workforce roles' (Health Workforce Australia, 2014, p. 8). Cabassa et al. (2017) thus argue that 'the strength of the evidence generated from these studies [on peer-based interventions] is limited due to several methodological limitations', and that 'efforts to strengthen the evidence of peer-based interventions require a research agenda that focuses on establishing the efficacy and effectiveness of these interventions across different populations and settings' (p. 80). Mahlke et al. (2014) similarly note that 'there is an urgent need to strengthen high-quality research on peer support worker efficacy and effectiveness' (p. 280). By contrast, Cook (2011) argues that the evidence of randomized controlled trial studies 'show that outcomes of peer-provided services are as good or better than services from non-peers' (p. 88).

The case that there exists a deficit in rigorous evidence for peer workers, then, is echoed in a number of sources. Chinman et al. (2014), for example, concluded that 'many studies had methodological shortcomings' (p. 429) and also reported far more varied outcomes than other studies, noting that 'the effectiveness [of peer delivered services] varied by service type' (p. 429), and that only studies documenting peers adding and delivering new curricula as their role in service delivery were consistently favourable for peer inclusion. Nevertheless, even Chinman et al. (2014) do concede that on sum, there is 'moderate' evidence which 'has value in contributing to the consideration of effectiveness' (p. 436). In order to address methodological shortcomings, then, future research should focus more specifically on the roles and services peers are undertaking, with longitudinal consideration, and with consistency in language and outcome measures.

Research to attest to the effectiveness of peer workers and peer-led services in the mental health sector are thus encouraging and promising, but not definitive (Hardiman et al., 2005). Thus Hurley et al. (2016) can conclude 'that there can be some confidence around Peer Workers supporting positive consumer outcomes' (p. 131). Indeed, Mental Health Australia and KPMG (2018) note that emerging evidence of positive outcomes shows great promise, but needs strengthening, although the evaluation research reported in, for example, Gallagher and Halpin (2014), indicates that such research is currently being undertaken.

Finally, Gordon and Bradstreet (2015) point out that the current lack of evidence does not necessarily concern how appropriate or effective peer workers can be, but how, practically speaking, organisations can go about employing peer workers and 'making it happen' (p. 164).

Implications for the ECI and Disability Sectors

Although voluntary peer support arrangements are widely utilised, the concept of paid peer work remains in its infancy in the disability sector and is virtually unknown in ECI sector. The Empowering Parents Empowering Communities (EPEC) program establishes a peer worker-type model through a peer-led parenting program, but this program is not specific to the ECI or disability sectors (Day et al., 2012; Parenting Research Centre, 2016). In ECI, however, utilising parents of young children with disability and developmental delay to support other parents with young children with disabilities is one possible avenue not only to fulfil work shortages in the wake of individualised funding programs, but also to encourage family agency and leadership, thereby relieving pressure from the sector more broadly. Parent peer workers offer benefits to the sector in terms of supplying cost-effective workers as service-demand increases, as well as employment opportunities for those who have a personal lived experience of disability.

The benefits of unpaid parent-to-parent support have been attested in various literature from within the disability sector (Schippke, Provvidenza & Kingsnorth, 2015). For example, decades ago, Santelli et al. (1996) suggested that pairing a 'veteran' parent (someone with lived experienced) with a parent earlier in their journey with their child's disability, in a targeted, individualised support arrangement could be mutually beneficial. Solomon, Pistrang and Barker (2001) explored what parents of children with disability found helpful about mutual support groups with other parents, including increased agency, community building, self-change and identity. Similarly, Law et al. (2001) explored the substantial perceived positive benefits of parent-led support groups for parents of children with disabilities. Studies also show that parent-to-parent peer support is particularly relevant and helpful to parents of children with disabilities in CALD (Culturally and Linguistically Diverse) communities, in which contact with peer parent counsellors significantly reduced psychological distress of parents, and increased social connection and support (Leung, Leung & Fong, 2013; see all Moore, Fong & Rushton, 2018).

The evidence to support benefits of peers for families of children with disability is promising but limited. Shilling et al. (2013) conclude that 'qualitative studies strongly suggest that parents perceive benefits from peer support programmes, an effect seen across different types of support and conditions. However, quantitative studies provide inconsistent evidence of positive effects' (p. 602), although those positive effects were attained in relation to social inclusion and identity, practical knowledge and wellbeing. Schippke, Provvidenza and Kingsnorth (2015) concur with this conclusion. Sartore, Lagioia and Mildon (2013) note that parents of children with complex needs 'often show poor results on markers of psychosocial well-being such as quality of life and life satisfaction, and show elevated levels of psychological distress such as depression, anxiety, or stress' (p. 1; see also Parenting Research Centre, 2016).

Peer support, they argue, may benefit parents by offering social support, emotional support and hope, reducing isolation and stigma, fostering advocacy, increasing feelings of self-efficacy, providing knowledge and access to support services, and reciprocity or mutuality. The Parenting Research Centre (2016) reports that parents of children with disability and developmental delay experience improved wellbeing, increased empowerment, less isolation, have more coping throughs and have less depression, guilt and loneliness when they are supported by peer-provided interventions. Clearly the benefits of voluntary parent-to-parent peer support arrangements in the disability sector echo some of the benefits of paid peer work in the mental health sector, so what benefits might come from employing parents of children with disability as peer workers with specific expertise to support other parents?

The notion of peer workers as 'parent educators' is not new, especially in relation to general parenting programs, and especially to support hard to reach communities (Iscoe, 1995; Pang, 2011). Indeed, using 'parent educators' to empower, educate and represent other parents, and to include families' voices and perspectives in early intervention service delivery, is documented (Gallagher, Rhodes & Darling, 2004). Although these experiences are not comprehensively researched, they suggest that parents as paid peer workers in the ECI sector may have similar potential benefits as peer workers in the mental health sector. Although it is not a prevalent focus of research in the mental health sector, the potential for peer workers to be drawn from families of those with mental illness, and to benefit families of those with mental illness, is confirmed. As Gallagher and Halpin (2014) note, 'the introduction of employees with a lived experience either as a consumer *or as a carer* is an example of innovative practice that adds value to the professionally trained clinical workforce as well as to consumers *and their families*' (p. 5, emphasis added). In Australia, this potential was observed by WAAMH: 'peer work has positive impact for families and carers by reducing stigma, decreasing feelings of burden and improving family functioning' (2014, p. 10). Indeed, one element from the Health Workforce Australia literature scan (2014), is to elucidate the benefit of peer workers for carers. The conclusions are worth stating in full, because they relate intimately to the experiences of carers of children with disability and developmental delay. The report states:

> Caring for a family member or significant other with a mental illness can have a tremendous impact on families and carers. It can affect relationships, work and finances, people's sense of personal freedom, recreational life and the mental and physical health of carers as a whole... Families and carers experience higher rates of depression and anxiety, social isolation, and decreased quality of life compared with the rest of the community… Families and carers often feel excluded when the person for whom they care is receiving mental health services. They may feel also, that professionals have a critical attitude towards them, are disrespectful, or that they are not welcome at the service. The limited available literature indicates that carer peer workers can improve outcomes for those with whom they work in a range of areas (p. 11).

The report goes on to conclude that peer workers drawn from families and carers of those with mental illness

> have a lived experience, which many parents/carers and staff might benefit from. They can offer hope to families who are overwhelmed by their child's admission to hospital. They can share with the staff the vulnerabilities they experienced when they were using the mental health system. In a very practical way, they can help ease the burden for families. By sharing the load, they can

> empower families and staff to communicate more sensitively and to work more collaboratively (p. 11).

In the mental health sector then, parent or carer peer workers benefit other carers through empowerment and knowledge (by educating and improving knowledge about the illness, by decreasing the burden of distress and anxiety, and by improving feelings of self-efficacy); by improving relationships (including assisting carers with managing conflicts and challenges with professionals, and accessing self-care), and through social support (including increasing social connection and community, and decreasing isolation) (Health Workforce Australia, 2014). Peer workers act as change agents for the families with whom they work.

Plumtree's Peer Workers

In 2018, the University of Sydney's Centre for Disability Studies (CDS) conducted a qualitative study of the efficacy of peer workers in aiding ECI service delivery at Plumtree, an ECI service in Sydney (O'Brien, Taylor & Riches, 2018). Using the nominal group technique, the CDS conducted focus groups to understand better the perspectives of all stakeholders when parents of young children with disability and developmental delay are employed to support peer families.

This report indicated significant and substantive correlations between early trials of peer workforce models in the ECI sector, and the experiences of the mental health sector. These correlations are both in terms of barriers and challenges to implementation, as well as in terms of potential benefits to stakeholders.

In the ECI context, parent peer workers were shown to provide a number of benefits directly analogous to the benefits experienced in the mental health sector. Indeed, families who accessed the services of peer workers universally 'were highly positive about the implementation of peer facilitators within the Plumtree service' and 'saw the shared life experience of peer facilitators as enabling a level of empathy and trust' (O'Brien, Taylor & Riches, 2018, p. 27). Specifically, families identified that Plumtree's peer workers provided them with emotional support, encouragement and empathy through shared lived experiences; a decrease in social isolation and loneliness by facilitating friendships, companionship, social bonds, and community access; a generally more positive outlook and mindset; assistance in accessing service delivery (specifically within the NDIS context, but also more broadly) and by increasing trust between parents and non-peer ECI staff, and increased trust in the Plumtree organisation which was seen to offer more credibility and personal experience with the employment of peer workers.

Families identified peer workers as leaders and mentors, but also noted their trust for peer workers, peer workers' capacity for empathy and emotional support, and their role of empowering other parents, particularly in the areas of goal-setting and positive mindset. Interestingly, one parent observed that peer workers offer 'unbiased advice' and another suggested they 'balance' therapy models (O'Brien, Taylor & Riches, 2018, p. 34, p. 42). As one parent noted, peer workers are not just concerned with 'a transaction-i.e. paying for a service. They provide a sense of belonging and community' (p. 52); another observed that peer workers

'add an extra level of depth of understanding, caring and knowledge that you can only get through personal experience' (p. 50). Families did list the concern that peer workers may not have sufficient training to give advice in all areas, or that they might be exploited through unfair work conditions.

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The CDS report likewise notes that peer work was, as in the mental health sector, also seen to benefit the peer workers themselves, who 'saw the ability to use the experiences they had gained by facing the challenges of being the parents of a child with a disability as offering them a sense of purpose, which in turn lifted their self-esteem' (O'Brien, Taylor & Riches, 2018, p. 23). The benefits peer workers recognised for themselves included practical considerations, such as income and flexible job conditions, but also included enriching their own experiences, learning and training opportunities, meaning and relevance, giving back, and building a sense of self-efficacy and self-esteem. They found 'meaning' in their employment and saw future employment opportunities as a result of their peer work experience and training.

Peer workers also reflected on the benefits they understood themselves to provide to service users. The peer workers perceived themselves 'to be the link between professionals and parents with a child with a disability' (O'Brien, Taylor & Riches, 2018, p. 30), and located their unique potential in their shared lived experiences and in their holistic approach. Because they share their lived experiences with parents of children with disability, and not the children themselves, the peer workers also identified that they were uniquely situated to advocate for and support parents and families with realistic strategies, rather than individual children, who were still best supported clinically by their non-peer colleagues.

The general benefits cited by parents in the CDS research are supported by findings recently released in a report by Murdoch Children's Research Institute (MCRI). The MCRI was commissioned by Plumtree to evaluate the outcomes of Plumtree's peer worker-led program, Now and Next (Moore, Fong & Rushton, 2018). The MCRI evaluation found that Now and Next was 'highly successful in providing all parents with the experience of developing and achieving short-term goals', and that it 'was also successful in empowering parents and growing participants sense of wellbeing' and 'is also increasing participants sense of agency' (p. ii); these findings correlate closely to Plumtree's peer worker impact as indicated by the CDS report.

It would be inappropriate to ascribe the benefits identified in the MCRI evaluation to peer workers solely or directly, rather than to the Now and Next program that they were employed to deliver, since the MCRI report was not specifically concerned with the role and impact of peer workers. However, the MCRI report identifies one of the potential 'active ingredients' or unique features of the Now and Next program as its facilitation by peer workers (p. 28), and Now and Next, as a participatory action-research program, was co-designed with the direct influence and considerable input of peer workers and is only offered by peer workers. Indeed, peer worker employment as a Now and Next Peer Facilitator is one ongoing support pathway to continue parents' capacity building and leadership.

Interestingly, in the CDS report, peer workers, like the parents they support, recognised their potential to provide 'advice that is not biased by organisations, only [by] real experiences' (O'Brien, Taylor & Riches, 2018, p. 34). This underlying theme of organisational bias/peer worker neutrality speaks to a latent broader sector issue of perceived conflict of interest, perhaps arising from an unease with a system in which professionals who diagnose, evaluate, and assess children are also active providers of therapy and intervention. Peer workers saw a particular role in engaging families more actively in their responsibilities and involvement in their child's development, that is, in increasing family leadership, capacity and agency. Although they viewed themselves as an intermediary or bridge between parents and professionals, peer workers saw their core role as building parents' ability to translate professional knowledge into practical strategies for themselves.

Importantly, all stakeholders, including non-peer staff, identified that parent peer workers 'provided an alternative for families to a purely clinical approach to supporting the needs of children with disabilities and their families' (O'Brien, Taylor & Riches, 2018, p. 27). This impact is significant because it addresses a pervasive challenge in the ECI sector: how best to engage parents in their children's intervention given the deference to professional expertise and the reticence families feel to build their capacity and leadership, despite evidence to suggest that families have the most significant impact on their child (Mahoney & Perales, 2011; Heyworth, Mahmic & Janson, 2017). In the NDIS- and individualised funding-contexts, it is vital that parents are encouraged to build their own agency to alleviate pressure on therapy services providers. This early evidence suggests that peer workers might provide one way in which family agency can be developed.

The response of Plumtree's non-peer staff to peer workers was generally positive, although non-peers had a number of reservations and caveats qualifying their positivity. Whilst non-peer staff acknowledged that shared lived experience distinguished peer from non-peer staff, they were especially concerned to emphasise the non-clinical nature of the peer worker role, in which the peer 'personal' point view is differentiated from the clinical, professional point of view (O'Brien, Taylor & Riches, 2018); indeed, they saw peer workers as having a distinct ethical frame and mindset to non-peer staff. Non-peer staff recognised peer workers' potential to 'provide advice and guidance around accessing services' (p. 13) and to fulfil families' social and community needs.

Non-peer staff were divided about whether peer workers provided them directly with any benefit, especially in relation to alleviating caseload. Given the mental health experience, in which peer workers are seen as instrumental in alleviating pressures on hospitals, for example,

and in which peer workers make the service users more active patients who are less reliant on professional services, the CDS were interested in whether ECI non-peer staff experienced similar easing of caseload pressure relevant to the ECI context, with the implementation of a peer workforce. Whilst the peer workers themselves saw that their roles supporting families would indeed positively impact their non-peer colleagues, there was little consensus within the non-peer group as to whether this potential had been realised. Interestingly, when non-peer staff did see positive benefits for themselves, it was when peer workers adopted a therapy assistant role (preparing resources; supporting NDIS planning). This reflects mental health accounts, in which peer staff were co-opted or professionalised to become junior therapists or therapy assistants (Phillips, 2018). Similarly to the mental health system, then, care must be taken in the ECI sector to ensure that such reductive understandings of peer workers' benefits do not result in the professionalisation of their unique potential. Finally, whilst non-peer staff appreciated the emotional support provided by peer workers to families, and saw that peer workers had actively positively affected families' abilities to set goals, they did not necessarily translate those benefits to themselves.

Of most importance to the non-peer participants of the focus groups, was the need to define peer roles, and by extension, to define explicitly the peer role as non-clinical. This emphasis is entirely appropriate since no non-clinical staff should adopt a clinical role and peer staff should complement clinical care (Davidson et al., 2018). However, a lack of role definition, and lack of job clarity, amplified the need to define peer workers as non-clinical staff, and was a concem for all stakeholders. Non-peer staff also emphasised the need to limit peer workers' access to confidential information. Although peer workers were also concerned to emphasise their non-clinical focus, the non-peer staff conflation of clinical status with professionalism and with full access to information covered by confidentiality and privacy agreements, was unique to the non-peer group. As was indicated by mental health precedents, non-peer staff also experienced unease with the identity conflict of peer workers, whose children might be receiving services from non-peer colleagues. Practical issues around boundaries were voiced (for example, a perceived curtailing of non-peer staff's freedom to discuss other parents and children in front of peer workers). Ultimately, however, there was a distinct unease expressed by non-peer staff about peer workers. Comments included concerns about how, as a Not for Profit organisation, Plumtree would pay their peer workers, about peer workers taking advantage of having free access to their child's therapists within work hours, about infringement on the physical spaces in which non-peer staff could work and socialise without peer worker presence, and about peer workers' abilities to manage conflict of interest: these all indicate the level of unease non-peer staff have.

Whilst the CDS report itself does not account for why non-peer staff experienced such unease, the explanation may be found in analogous experiences in the mental health sector. In a semi-structured interview with Plumtree's CEO, the evolutionary nature of Plumtree's implementation of a peer workforce became evident. Because the employment of peer workers at Plumtree arose in response to participatory action-research (Moore, Fong & Rushton, 2018), implementation was not undertaken in a systematic and strategic way. Thus, Plumtree's non-peer staff were not given the types of training and induction on the integration of peer workers as is identified as desirable and recommended by the mental health context. Many implementation challenges witnessed at Plumtree (as cited by non-peer staff) echo the

challenges experienced in the mental health sector literature. Thus, Plumtree's non-peer staff noted their desire to 'create clear boundaries', 'define the roles of peer facilitators', 'clarify roles and responsibilities', and have adequate training for themselves and their peer colleagues (O'Brien, Taylor & Riches, 2018, p. 21). It may be, then, that the resistance felt by Plumtree non-peer staff to peer workers stems from the same 'lack of willingness to go along with integration of an ill-defined role' for which 'a well-defined scope of practice does not exist and support mechanisms have not been established' (Hurley et al., 2016, p. 132) as is noted in the mental health sector. Because of the evolving nature of Plumtree's peer work arrangements, the appropriate organisational practical supports and strategies that would have assisted non-peer staff acceptance of peer colleagues (Byrne et al., 2018) were not in place prior to implementation. If the ECI sector is to benefit from a peer workforce, then, it must learn from Plumtree's experiences, as well as from mental health best practice.

Learning from Implementation Challenges

As Nestor and Galletly (2008) point out, in the mental health sector 'there have been a number of obstacles to the successful employment of peer support workers. These obstacles have generally been more pronounced in units where the peer support worker program has ben introduced with little buy-in from staff' (p. 345). Plumtree is now actively addressing its implementation challenges, especially by including the views and experiences of its non-peer staff as crucial in the development of tools and guidelines to help peer workforce implementation in ECI (Heyworth, 2018). However, this step has been taken *ex post facto*. As the CDS report recommends, it is imperative for organisations to define clearly the role of the peer worker, especially in relation to the role of the non-peer worker, and for management to consider ways in which peer and non-peer staff can work together towards relevant codes of practice and understandings of distinct roles through training so as to build a collegial and congenial community in which peers and non-peers are mutually supportive and beneficial for families (O'Brien, Taylor & Riches, 2018). Fundamentally, it is vital for these measures to be executed proactively, before peer workers are expected to begin work in their role.

If the ECI and disability sectors are to invest in peer workforce structures, they should do so with the experience of the mental health sector – as well as Plumtree's very similar experiences – firmly in view. Plumtree has published a comprehensive toolkit for implementation, the aim of which is exactly to synthesise mental health and early ECI experiences to build best practice strategies for peer workforce integration in ECI (Heyworth, 2018). As Gillard and Holley (2014) note, 'given the current impetus to introducing peer workers… and that the energy and commitment required to develop a new role is considerable, it is vital that those organisational lessons are learned' (p. 290).

It is clear, then, from the previous discussions that successful implementation is predicated on identifying, anticipating and addressing potential challenges faced by all stakeholders proactively and pre-emptively. Gallagher and Halpin (2014) identify four key areas that are indicated are most vital to address prior to, or as an integral part of, implementation to mitigate potential barriers, and maximise opportunities for success. These are:

1. Ensuring clarity of peer worker role, achieved by training of peer and non-peer staff, by advertising peer workforce models, roles and benefits to stakeholders, by addressing job conditions early, and by writing and effecting policies and procedures, including on supervision, confidentiality and boundaries,
2. Offering training, including orientation training and relevant ongoing training and evaluation to peer and non-peer staff,
3. Having clear job specifications, including a consideration of hours, and career development for peer workers so that they are treated like other non-peer employees, and
4. Establishing supervision and mentoring structures, including peer buddies, supervisors who are distinguished from a direct line manager, and adequate training of supervisors in peer roles.

The SRN (2011) guidelines dedicate a substantial section to achieving successful implementation. They recommend:

- Planning and preparation, including ensuring organisational commitment and appropriate organisational culture prior to implementation, securing funding, developing a job description, preparing the team, anticipating and addressing concerns, establishing line management and supervision, and training;
- Developing relevant and sensitive recruitment processes;
- Supporting peer workers, including providing induction, supervision, sustaining wellness, establishing professional standards, and maintaining 'peerness' (or: resisting co-optation), and
- Developing and sustaining peer workforce models, including conducting evaluations and reviews, addressing career development, providing ongoing training and development, and celebrating achievements.

Many of these findings are again echoed in Vanderwalle et al. (2016), which explores peer workers' experiences of barriers to the implementation of peer worker roles. From a peer worker perspective, lack of credibility and role clarity, negative attitudes from non-peer colleagues, boundary issues, struggles to integrate within a non-peer team, conflict of identity, inappropriate organisational culture, inadequate training, and dissatisfaction with contracting and recruiting were all barriers faced, which should be addressed proactively to limit implementation challenges.

Organisational considerations

Organisational culture and preparation is key to success (WAAMH, 2014). For Gates and Akabas (2007) the effective integration of peers must begin with an assessment of the organisation to evaluate its preparedness for employing peers both operationally and culturally. Success depends upon whether the organisational culture exists to indicate not only managerial, but equally broader stakeholder, receptiveness to the values represented by the employment of peer workers. It is only after such an organisational scan that the creation of understanding among all stakeholders of the roles of peers, and of the policies and practices

that will be implemented to support their employment, can be considered. Such operational considerations may include the formalisation of a recruitment process which defines peer roles; the provision of clear and consistent job descriptions including expectations in regard to boundaries and confidentiality, and the provision of on-going support to both peer and non-peer staff to maximise the inclusion of peers in organisations (see also Peer Work Hub, 2016a). The Centre of Excellence in Peer Support has recommended similar steps which should be adopted by management and HR to achieve the successful and beneficial implementation and operation of a peer workforce (ARAFEMI Victoria, 2013a, 2013b; see also Peer Work Hub, 2016a).

Gates and Akabas (2007) further conclude

> peer integration was more successful when leadership created an understanding of the peer role to agency mission, provided training to peers, nonpeers and consumers that reinforced that commitment, clearly defined peer and nonpeer staff roles and helped all staff understand how to work together effectively, established clear policies and practices around sharing information, recruitment and hire of peers, and ensured effective communication and support through supervision and training (p. 302).

For Gates and Akabas, the introduction of Human Resources policies and practices to promote integration ensured a 'commitment to peers by recognizing and supporting peers as an essential part of the agency's staffing pattern' and by 'responding to issues of role conflict and confusion' (p. 302). They suggest demonstrating a commitment to peers by implementing:

- Relevant and responsive hiring policies;
- Job structures that indicate the importance of peers to organisations;
- Policies that include peers in the workplace and encourage their participation;
- Orientation and training for all stakeholders to ensure clarity of roles;
- Clear guidelines on staff-client relationships;
- Written job descriptions, and
- Clear and transparent communication, including modelling strong leadership of values.

In the mental health sector, these values are recovery-focused; in ECI, they align with family-centered best practices. Thus, 'where recovery was embedded into the service and where other supportive factors were in place, Peer Workers were described as being more effective and hence creating greater beneficial outcomes for the consumer, carer and themselves' (Hurley et al., 2016, p. 132).

Kemp and Henderson (2012), argue that it is necessary for managers to have and then to communicate a clear understanding of the distinct role and place of peer workers within their organisation to non-peer workers. Gillard and Holley (2014) concur, summarising that 'the potential benefits of introducing peer workers can be undermined where expectations of the role are not shared' (p. 290). Shared expectations of the peer worker role, along with an explicit account of how peer workers align with an organisation's values and mission, and with practical support (including training and supervision) from the organisation, are all crucial to successful peer worker integration. Kilpatrick et al. (2017) also stress the need for engagement with non-peer staff at all organisational levels to develop clear roles and decrease the potential for tokenistic peer employment that is constrained or diluted (co-opted). In all studies, clear and

defined job roles and specifications are recommended to ensure that all stakeholders share understanding of peer worker roles; this clarity is the cornerstone of success.

Recruitment and hiring procedures are represented in many studies as requiring consideration by prospective employers. In the case studies analysed by Gillard et al. (2013), a less formal recruitment procedure was successful, and included 'past experience of using the service' as a desirable asset (p. 192). Similarly, Harrison and Read (2016a) suggest that peer workers experience challenges in traditional recruitment processes, which should be addressed. Alternatively, WAAMH (2014) strongly encourage employing and incorporating peer staff in the same way new non-peer staff are hired and inducted. This parity demonstrates to all stakeholders that peer workers are part of the organisational team, and are considered equal to their non-peer colleagues. Minimising arrangements that make peer staff appear different is vital (WAAMH, 2014). In ECI, recruitment should be sensitive to the lived reality of parents' career-progression (parents often have a professional hiatus as they care for their child with disability), but be equally mindful of hiring peers as equals to their non-peer colleagues. Equity is thus desirable.

Undoubtedly, the concept of boundaries should be proactively addressed. Gillard et al. (2013) note that 'peer workers, managers and non-peer staff all made specific reference to the importance of boundaries both within the team, and between Peer Workers and service users' (p. 194), and this concern has been echoed in Plumtree's experiences in the ECI sector (O'Brien, Taylor & Riches, 2018). These boundaries are at least in part to protect the peer worker and their non-peer colleagues from exposure to situations in which 'professional and social contact might overlap' (Gillard et al., 2013, p. 195), a concern relevant to the ECI sector.

Whilst it might be argued that all these organisational measures and formalisation may 'undercut the informal, mutually supportive nature from which peer support originated' (Chinman et al., 2014, p. 439), in order for peer workers to enjoy longevity of employment, and quality outcomes related to their employment, and in order for stakeholder benefits to be realised, 'stakeholders must develop commonly accepted peer support service definitions, types, values, standards, models, manuals, training curricula, and fidelity measures' (Chinman et al., 2014, p. 439), and organisations must support and advertise these measures.

Training and Supervision

Along with clarity of roles, one of the most important and oft-repeated requirements for peer workforce integration is training and supervision. A valuable model for peer workforce implementation is described in Franke, Paton and Gassner (2010), who propose a peer specialist model employing trained peer workers in the mental health sector in South Australia. They emphasise three vital elements to the successful integration of a peer workforce:

1. Training, which not only upskills the peer workers in relevant knowledge and skills areas, but also prepares peer workers 'for dealing with issues around workplace culture… and how to communicate with staff and clients' (p. 182). Training must be of sufficient rigour, intensity and depth to be relevant and adequate;

2. Ensuring service users understand the role and benefit of peer workers, since utilising a peer workforce is a massive cultural shift not only for non-peer staff, but also for service users themselves. Since it is the strength of the relationship between peer worker and peer that most recommends a peer workforce, service users need to have a clear grasp of what peer workers offer, and how so that the 'consumer–peer worker relationship is seen to be empowering, honest, humanising, relevant, and a valid addition to already existing clinical teams' (p. 183), and
3. Preparing organisationally and culturally: 'Strong organisational leadership and commitment to peer work was seen as the most fundamental determinant for the successful integration of peer workers' (p. 183). Leading by example, management should not only set the cultural scene to welcome peer workers, but prepare the policies and procedures to support their employment adequately.

Citing the often-significant culture shift required to incorporate peer workers into traditional services successfully, Davidson et al. (2012) cite a number of essential factors, including:

- Creating 'clear job description and role clarification – fully endorsed by key stakeholders … with relevant competencies, and a clear policy for evaluating competencies and job performance' (p. 127),
- Involving non-peer staff, management, and service users throughout process of creating peer positions, including hiring,
- Identifying and valuing the unique contributions of peers, and articulating how each organization will use its peer workers differently non-peer staff, and not simply as adjuncts to non-peer staff,
- Telling and distributing success stories to show hope,
- Ensuring that at least two peer staff are employed together to support each other and decrease workplace isolation,
- Having a peer worker 'champion' drawn from the non-peer senior administration to address any issues that arise,
- Identifying supervisors for peer workers, in which supervision based on skills, performance and support,
- Training and developing appropriate peer worker skills, and
- Training and educating non-peer staff, especially in regards to disability discrimination legislation, respect, accommodations and boundaries (relating to both peer *and* non-peer staff).

Training and supervision, then, are repeatedly recognised as key component to success (Health Workforce Australia, 2014). Training is required to prepare organisations and peer and non-peer team members, and to ensure role clarity (Phillips, 2018; Harrison & Read, 2016a). Effective and supportive supervision ensures that peer worker roles are appropriate, that issues of confidentiality and privacy are addressed in an active and ongoing way, and that peer workers have adequate support to perform their roles within their unique frame; thus, 'supervision has been identified as an important indicator of the success of peer roles' (Phillips, 2018, p. 2).

Conclusion: Beyond the Mental Health Sector

Parents of young children with disability and developmental delay are a vulnerable population. Raising a child or children with disability is linked to unsatisfactory work-life balance, under-employment, social isolation and marginalisation, decreased mental health and quality of life outcomes, and increased incidences of clinically significant stress, depression and anxiety (see, for example, Brown & Clark, 2017; Gilson et al., 2017; Patton et al., 2018; Ricci et al., 2017). Yet, research suggests that parent-to-parent peer support can mitigate the severity, intensity and duration of negative outcomes, and indeed, effect positive outcomes for parents. As Bray and colleagues (2017) describe, parent-to-parent support encouraged parents of children with disability on a transformational journey from a 'surviving' mindset (just 'getting by') to embrace a 'thriving' mindset in which parents felt able and supported by their peers to thrive, grow and flourish. They explain that

> the ability of parents to share their feelings, worries and anxieties with another parent who had travelled a similar journey and had 'been there' was described as the most important characteristic of the support scheme… They were able to thrive through the supportive meaningful relationships… The qualitative findings are supported through the quantitative evidence demonstrating improvements in emotional and psychosocial well-being… The parents in our study were facilitated to face and start to embrace the key components of a thriving person; to become future orientated, develop strong connections with others and, after adversity, to surpass their past levels of functioning (pp. 1542-1543).

Although this study is concerned with unpaid peer support, Davidson et al. (1999) suggest that it is beneficial to consider such mutual support groups, since the principles of them 'may find additional expression' when peers are employed as workers (p. 167). The potential impact and benefits of employing peer workers who are trained and supported organisationally to provide such assistance to their peers is exciting indeed, especially when coupled with the potential for peer workers to build family capacity and agency (Moore, Fong & Rushton, 2018). Undoubtedly further research into peer workers in the ECI sector, and the benefits they offer, is warranted.

The ECI and disability sectors are fortunate to have such wealth of research and experience from the mental health sector to inform future trials into peer workforce implementation. Further research in the ECI and disability sectors should address the many recommendations arising from previous mental health experiences, and further interrogate their relevance to these sectors, although Plumtree's experiences indicate preliminarily that they have equal relevance across sectors. Nevertheless, further work needs to be undertaken to define the particular branch of peer workforce service delivery offered with ECI and disability services, to ensure consistency and specificity (including addressing setting, service delivery mode, background of peers, functions, and levels of service delivery structure). In other words, further work should not only ask, '"do peer support services work?" but also, "under what specific

conditions do peer support services work?"' (Chinman et al., 2014, p. 439). Other research questions might include, what outcomes are the best indicators of impact in our field, in our context? What valid and reliable tools are needed to measure outcomes? How (and how actively) do service users engage with peer services? What is the impact of race, ethnicity, or sex on the effectiveness of peer support services, and how do cultural modifications impact service delivery?

Further research in the ECI and disability sectors should address the many recommendations arising from previous mental health experiences.

Peer workforce models as adopted by Plumtree have the potential to effect positively ECI and disability service delivery. As O'Brien, Taylor and Riches (2018) recommend, the model of peer workers needs to be further documented and disseminated within Australia, internationally, and within mainstream and disability settings. Given the promise of peer workforce structures in associated health sectors, in which peer workers represent a cost-effective and innovative workforce offering significant benefits to all stakeholders, it behoves ECI organisations to examine and scrutinise further the benefits available to families within that context. And just as governmental policies have emerged to ratify and encourage the presence of peer workers in the mental health sector, further research should stimulate such interest and endorsement at the highest levels.

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