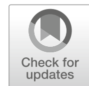

Peer Work in Rural and Remote Communities and Mental Health Services

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Abstract

Peer Workers are the most underutilised, valuable resource available to rural and remote mental health services and communities. Evidence has confirmed the efficacy of peer work, yet their historically slow uptake has robbed communities and individuals of the opportunity to be supported by staff who can provide an added layer of assistance as part of a multidisciplinary team or beneficial alternative to conventional treatments. This chapter seeks to inspire confidence in all stakeholders involved in rural and remote communities to engage with the valuable, fast growing, competent, and readily available Peer Workforce. It discusses the evidence, value, and efficacy of peer work in rural and remote mental health services and communities.

The high level of stigma and discrimination surrounding mental health in rural and remote communities and the desperately low level of "homegrown" mental health personnel who know that the local people, customs, languages, and land can be rectified by the employment of Peer Workers from within the community they live. This chapter asserts that the ethical and practical conclusions regarding peer work in rural and remote communities are that supported, respected, and valued Peer Workers are vital to the much needed reform of mental health services. It sets out the main reasons for this by utilising recognised, published research and academic papers, along with case studies utilising peer work in three very different rural and remote areas in Australia which are utilised to demonstrate and authenticate the desperate need for and beneficial effects of Peer Work.

Introduction

In rural communities, people see their crops and livestock suffer, the earth crack, dams, rivers and creeks dry up in times of drought. They see fire devastate the bush leaving charred remnants behind with the vile smell of the burnt flesh of domestic animals and wildlife. Their livelihoods and sometimes the people they love perish. The smell of death and loss lay heavily in the air, in their lungs, and in their memories long after the flames have enforced their will in their lives.

They see their homes, soil and crops washed away with floods. They know the might of banks as they enact their legal right to take away their farms and homes. They know the devastating effect of this on relationships and on the small businesses and communities. All these things conspire to make it feel impossible to keep going.

And yet the country recovers. Rivers flow again after the drought breaks and the grass and trees sprout again with the first rain. People rebuild after flood waters subside (van Kessel et al. 2014) as they did after the 2019 Queensland floods which dumped 1.4 meters of rain in less than 2 weeks – double London's rainfall in a year (Morton and Smee 2019) The floods destroyed homes and livelihoods, and killed people, domestic and wild animals. In rural parts of the State, the flood killed an

estimated 500,000 cattle devastating graziers already struggling with the impact of prolonged drought. Yet these graziers and their families continue to farm the land.

Rural communities go through these ebbs and flows of nature together. They are devastated and rebuild together. However, it is a cruel fact that some individuals and families will not find the hope to continue. They may have been crushed by the blows once too often. The suicide rate for Australia's farming people is double the general male population, at 32.2 compared with 16.6 per 10,000 (Bryant 2018).

Droughts, floods, unplanned fires and climate change impact heavily on Aboriginal and Torres Strait Islander communities. "Climate change raises distinct challenges for Aboriginal people, cultures, lands and resources. It poses a threat to the health, cultures and livelihoods of Aboriginal peoples in NSW. This occurs in coastal and flood prone areas, salt inundation of freshwater supplies, changes to mangroves and fire regimes, coastal erosion and rising sea levels as well as for those Aboriginal communities affected by long-term drought and desertification, among other impacts" (Manton 2008) The indigenous male suicide rate is 39.6 deaths per 100,000 persons (ABS 2017).

Parallels can be drawn between the experiences of living in rural and remote communities and people experiencing trauma and mental health issues. These issues often arise out of devastating experiences. They wreak havoc long after the trauma has passed. The destructive thoughts and feelings can pervade all aspects of a person's life, often driving them to the point of "breakdown" or thoughts of suicide. Eventually, hope, income, and relationships fall away; and yet most manage, with time and the support of their community, to rebuild their lives (McGowan 2018).

The rebuilding of lives devastated by weather changes or mental health issues is always easier with the support of people "who have been there and done that" and who live within the community (Helsloot and Ruitenberg 2004). For people with mental health issues, Peer Workers are the "been there" people (Austin et al. 2014).

At a time when people with mental health issues are at their most vulnerable, the person most approachable, most easily able to relate to and bring hope back to people in psychological distress is "someone" who has already passed through similar distress, "someone" who has emerged out the other side and has shown that recovery and healing is achievable (Watson 2019a). Peer Workers are the "someone" that people can turn to. They are wonderful examples of mental health recovery, demonstrating that it is possible to live meaningful, connected and contributing lives in their community (Watson 2019a).

This demonstration is vital in the fight against stigma and discrimination which is so often experienced by people with mental illness, their families and carers (Amsalem et al. 2018). Stigma and discrimination can be devastating for people who live in small rural communities. With limited specialist services to support people with mental health issues and without the connection to "someone" who has been through similar experiences, people often feel very alone and experience marginalisation. The benefits of Peer Workers and family and carer workers in these contexts cannot be overstated (Candelaria et al. 2014).

> *'All truth passes through three stages. In the first, it is ridiculed. Then it is opposed. And finally, it is accepted as self-evident.'* Attributed to Arthur Schopenhauer (1788–1860)

Distinctive Features

The importance of peer work to effective rural and remote practice and communities is confirmed in this chapter through the establishment of the evidence, value and efficacy of peer work in rural and remote mental health services and communities.

It leads to the legitimate conclusion that supported, respected, and valued Peer Workers are vital to the much needed reform in mental health services and to positive change in culture, stigma and discrimination in rural and remote services and communities. It sets out (NSW MH Comm. 2015) how peer work leads to:

- Improved outcomes in multiple aspects of service delivery
- Much improved attitudes toward mental health by individuals, communities and service personnel
- Inclusive, multifaceted teams focused on sustainable recovery, hope and healing alternatives to conventional practice
- A decrease in seclusion and restraint
- Increased well-being of rural and remote populations

Rural and remote services must strive to provide best practice, evidence-based and innovative services if they are to meet the needs of the people. Good, effective services are not governed by outdated, inaccessible, stigmatising and discriminating languages, cultures, and practices. Services responding to the outcry for positive change, for help to be available when and where people need it and utilising the least restrictive practices possible, are embracing Peer Work. This chapter demonstrates and authenticates the desperate need for and beneficial effects of, peer work through utilising recognised, published research and academic papers, along with case studies utilising peer work in three very different rural and remote areas in Australia.

The employment of Peer Workers from within the community that they live can greatly reduce the desperately low level of "homegrown" mental health and well-being personnel. Local workers know the people, customs, languages, connections and land. They can also rectify the high level of stigma and discrimination surrounding mental health in many rural and remote communities.

Voluntary peer support has been recognised as an important part of the lives of people with mental health issues in Australia for more than 30 years. Paid peer work roles, under various names, began in the early 1990s. However, informal peer support and mateship have always been a strong element in mental health and rural and remote communities. In these communities, the support of a person with lived experience of mental illness and recovery by someone else with mental health issues has been essential for reframing experience and developing hope in a better future.

Research and personal stories by people who have experienced the support of Peer Workers across Australia have led to the recognition of the importance of this workforce by state and national Mental Health Commissions and by their respective governments. The National Mental Health Commission notes that:

> *'Increasingly, the Australian Government is recognising the importance of the Peer Workforce*. . .*. Mental Health Peer Work has been an area of focus for the Commission since our establishment in 2012. The development and promotion of the mental health Peer Workforce has been recommended as part of our 2012 and 2013 National Report Cards and the 2014 Contributing Lives, Thriving Communities report*.' (Nat. MH Comm. 2019)

Defining Peer Work

Shery Mead, the founder of Intentional Peer Support which is both a philosophy and a way of working with peers, defines peer support as*:*

> *'*. . .*a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on* . . . *models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others whom they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles*.' (Mead et al. 2019)

While peer work has its roots in voluntary peer support relationships, paid employment of Peer Workers is expanding (Watson 2019a). Those engaged in peer work are called by a variety of names such as Peer Worker, peer specialist, peer support worker, lived experience worker or consumer worker. They undertake a wide range of tasks which is of necessity, like many other roles and may be more varied and flexible in rural and remote communities.

This flexibility is important. However, it is essential that Peer Workers are not undervalued by being given menial tasks which are not expected of other staff. They must also not stray into clinical practices or be utilised in coercive practices, even if through good intention (Watson 2019b), (Mead et al. 2013). These practices change the nature of the mutual peer relationship (Craze and Plant 2018).

The variety of tasks undertaken in Peer Worker roles was highlighted during a workshop hosted by Flourish Australia, in Sydney in 2018. Leading Peer Workers from across Australia gathered together to discuss the current Peer Workforce across Australia (Ibid). The workshop identified over 75 roles and activity areas, including the major categories shown in in the table below (Fig. 1).

Peer Workers are the fastest growing workforce in mental health in Australia (Nat. MH Comm. 2015). Their roles are different to that of other mental health workers (Ockwell and Pearce 2019). Fundamentally, they *require* a person to openly, thoughtfully and purposefully utilise their lived experience of mental health issues – of services and treatment, psychological distress, trauma and recovery – to support and bring hope to other people with mental illness. The supports they offer people ("consumers," "patients"), and the relationships they build with the people they support, are based on mutuality, reciprocity, sharing experiences, honesty, hope, and

Peer support	Promotion of wellness and physical health	Representation
Service navigation	Policy advice and development	Systems advocacy and service reform
Assessment	Change leadership	Veteran support
Care and service coordination	Managing and leading teams	Training and teaching
Working with specific groups	Individual advocacy	Research and evaluation
Peer worker supervision, coaching and mentoring	Staff orientation, induction and professional development	Program administration
Accreditation assessment and quality improvement	Facilitating co-production projects	Lived experience academics and casual/sessional lecturers
Community development and education	Facilitating engagement and participation	Consultant and advisory roles including policy development

Fig. 1 Roles and functions of Peer Workers as identified by workshop participants (Craze and Plant 2018)

a strong belief that each person is able to recover and live a meaningful, connected and contributing life (Repper 2013).

The Peer Worker has "a professional role that is distinguished from other forms of peer support by the intentionality, skills, knowledge, training and experience that Peer Workers bring to their role. Peer Workers are employed as professional subject matter experts who can be a key conduit between a consumer, their other support people and the services they use" (Meagher and Naughton (2018). These "role models of recovery" are able to give hope to people with long-term mental health problems (Slade 2012).

Local Connection and Dedication: Peer Work in Rural and Remote Communities

In rural and remote communities, clinical services may be sparse or nonexistent; the presence of Peer Workers is all the more urgently needed.

The Australian Government Senate Community Affairs Reference Committee, which reported on the accessibility and quality of mental health services in rural and remote Australia in 2018, stated:

> *'In many of the communities it visited, the committee heard about the important role played by peer support workers, who provide support to people experiencing mental illness and often fill a gap left by the shortage of mental health professionals in rural and remote communities.*

> *The committee recommends that peer support workers be given appropriate training to enable them to continue their role in helping people experiencing mental health issues. The committee further considers that peer support workers should be recognised as a valuable support service by being paid to perform this role in rural and remote communities*.' (Aust. Fed. Gov. 2018)

Peer Workers like all service health staff in rural and remote areas may be asked to extend their role to fill gaps in service provision; they may have a need for flexibility around what is required of them compared to their city cousins who are generally part of a large multidisciplinary team. However, Peer Workers must stay true to the peer work ethos and practices, or their unique skills may become diluted. They may be co-opted or willingly fall into performing tasks they are not trained in and that change the nature of the relationships and value the peer work brings to the individual and community.

Greg Hunt, Federal Minister for Health noted recently that '*The types of health services needed in metropolitan communities differ dramatically from those of communities in remote and regional areas'* (Aust. Fed. Gov. 2019).

Peer Workers break down barriers and bring stories of acceptance, hope, recovery and living meaningful and contributing lives to their rural communities. The openness of rural Peer Workers leads to an acceptance and valuing of lived experiences, which changes community attitudes toward mental illness. Contributing lives is essential in rural and remote communities where everyone is expected to "pull their own weight." Peer Workers are a great example for individuals and communities experiencing adversity that there is hope for a better tomorrow (Repper and Carter 2011) and that "things can and will improve" (Brown 2019).

For the majority of people living in rural communities, becoming "unwell" with severe psychological distress is rarely private. Once services have been sought, one way or another, the news spreads that a person has been "unwell" (Komiti et al. 2006). Stigma and discrimination are frequently cited by people in rural and remote communities as reasons for not seeking help. The very act of becoming a Peer Worker in a rural or remote community defies and overcomes this discrimination. It demonstrates that with the right support, mental health recovery is possible and people who have had mental health issues are valuable members of the community. This impacts positively on the well-being of small communities.

Peer work can also provide a different and affirming experience of mental health services. It builds on, strengthens and makes accessible the informal mental health support that has always been experienced in many rural and remote communities, where:

> *'Generally, these (peer) support services are provided by people who have had their own lived experience with mental illness but have received no formal training in mental health support and are not employed or paid for the support services they provide. Many rural and remote communities rely on these outstanding members of the community.*' (Senate Community Affairs Reference Committee)

It must be noted that the report refers to people with mental health issues and traumatic experiences, who use what has happened to them in the service of others as "outstanding members of the community" rather than "the mentally ill" as so often referred to in the language of services, media and government agencies.

These outstanding community members deserve to be paid for their work, supported and trained to manage the emotionally vulnerable positions they may find themselves in when identifying their lived experience to others in their rural communities.

Local Peer Workers Bridge Gaps Between Transient Workers and the Community

In rural and remote Australia, a significant proportion of the mental health workforce is transient. In addition to a small number of long-term local staff, it is not uncommon for a rural mental health team to consist of people working anywhere from 3 months to 3 years before they move on (Humphreys et al. 2010). The ready availability of Peer Workers, like other dedicated mental health and well-being staff who are drawn from the community they live in, know the community, its history, people, languages, connections, beliefs and land. This local connection and knowledge are a priority if early intervention, suicide prevention, healing and sustained recovery are to be commonplace. Peer Workers can be a bridge between the mental health team and the community. They are the right people, in the right place, at the right time.

The shortage of mental health personnel in rural and remote communities has led to an increasing number of "blow-ins" filling the small number of roles in country areas. These "new comers" may be agency staff, new graduates from other areas or may have immigrated to Australia. They may stay for only a few months or a few years as they progress their careers. Some do become "locals"; however as many of us moving to a new area have experienced, becoming a local can take quite a few years.

It takes time for rural and remote people to trust "new people." Local Peer Workers are a strong link for the local community to the new staff. Peer Workers are very adept at quickly determining if the staff members are people who can be trusted. The Peer Workers will actively break down the barriers, welcome the new staff and introduce them to their new community if they feel the new staff member will be good for their service and community (Gordon 2014).

Obviously in rural and remote areas, knowing the local community is a great asset. Knowing the Aboriginal Elders, the coach of the footy club, vet, church ministers, the publican, the school principal, and the Royal Flying Doctor Service can be very helpful. Good knowledge of the land can be helpful if needed to attend an urgent situation. Knowing what services are available is of great assistance. Peer Workers engaged with these services and relationships can break down the stigma and discrimination about mental health issues and can connect the service and individuals to the community (NSW Health 2017).

Research from Across the Globe

There is growing research into the efficacy and impact of peer work in mental health services. Increasing evidence showing that peer work is not only effective and valuable to the people who access support, other staff, the Peer Workers themselves, families, and communities, it also delivers a good return on investment. Peer support has been shown to bring about significant reductions in hospital bed days, leading to financial savings well in excess of peer employment costs (Trachtenberg et al. 2013).

Chinman determined that "the effectiveness of peers added to traditional services and of peers delivering structured curricula was positive" (Chinman et al. 2014). This research found the beneficial effects for people receiving services included reduced inpatient service use, improved relationships with service providers, better engagement with care, higher levels of empowerment, higher levels of patient activation and higher levels of hopefulness for recovery.

The beneficial supports people report receiving from peers have driven research into trying to identify what those supports are and the mechanisms through which they are accessed or provided and how they deliver such positive results (Vayshenker et al. 2016).

Peer support is a rapidly growing feature of mental health services across the world including in the USA (Chinman et al. 2001), Canada (Rebeiro Gruhl et al. 2015), in the UK (Gillard et al. 2013), Australia (Lawn et al. 2008), and Asia (Fan et al. 2018; Tse et al. 2013).

The research has been so convincing that peer support is beneficial that in 2013 the World Health Organization (WHO) commented that peer support was essential to any comprehensive mental health system (WHO 2013) and technical training resources were developed, with support from across the World (Funk and Drew 2017).

Notable elements of peer support have been reported to include social support, emotional support, support with treatment, support with connecting to community resources, goal planning, teaching skills, sharing experience and inspiring hope (Gidugu et al. 2015; Lawn et al. 2008; Scanlan et al. 2017).

There is also evidence that consumers involved in peer support initiatives have higher levels of community integration (Repper and Carter 2011).

The benefits of peer work may best be demonstrated through the use of case studies.

Case Study 1 Far West Local Health District Mental Health Service

Far West Local Health District (LHD) Mental Health Service in remote New South Wales (NSW) covers a geographical area of 194,949 square kilometers and includes the traditional lands of the Barkandji/Paakantji, Wilyakali, Muthi, and Nyampa. It uniquely shares borders with three states (South Australia,

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Victoria and Queensland) and is closer to Melbourne and Adelaide than Sydney (1100 km away).

Far West NSW is the most sparsely populated region in NSW with 62% of its over 30,000 inhabitants living in the regional city of Broken Hill. The remainder of the population lives in agricultural towns and villages along the Murray River, on stations or in isolated communities of 80–800 people.

Of the total population, 91.1% are from an English speaking background. The region has the highest proportion of Aboriginal residents (12.7%) in NSW and many experience significant disadvantage. This population is relatively young, which reflects the lower life expectancy of Aboriginal people.

Director of Mental Health and Drug and Alcohol, Susan Daly: The Connections Project

Partnerships are particularly important in rural areas where services are few, so the LHD's first major peer work project, Connections, was with our partners, Mission Australia and GROW. GROW is a community-based organisation run by and for people with lived experience of mental illness. "Growers" share wisdom and knowledge to help each other overcome life's challenges and recover from mental ill health.

Connections is an out-of-hours social connection program, aimed at reducing loneliness, wholly staffed by Peer Workers employed by Mission Australia and supported by all three organisations. It runs each Thursday, Friday and Saturday evening plus every second Sunday.

People who attend Connections develop a monthly program of social activities with the Peer Workers; this includes local community activities like the movies, gym, art gallery openings and cafes.

In a rural area, attendance at community activities can be quite low (e.g., the local table tennis club consists of two people) and there's a risk they will simply stop running. By boosting attendance, Connections has a benefit for the community itself, as well as for participants.

We looked at the first 6 months' data for the five people who attended the most frequently. We found that, in the 6–7 months before Connections opened, these 5 people had used 549 acute mental health bed days and presented to the Emergency Department (ED) 16 times.

In the 6 months after Connections opened, their bed days had reduced to 195 and there were only 3 ED presentations. This is equivalent to approximately $760,000 in efficiency savings. This data supported our hopes that reducing loneliness through increasing social connection, using the remarkable and unique engagement skills of Peer Workers would reduce their need for health services.

But the data is just a part of it; the outcomes for some people have been life changing. For example, before Connections opened, one participant had spent almost 18 months continually in the hospital, rarely saw his family, used drugs

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and alcohol and was essentially homeless because he was very uncomfortable in his own home.

Within 6 months of attending Connections, he was settled at home, ran a poetry workshop for 14 people, became a Zumba regular, and started going to the gym (both with Connections and on his own). He stopped using drugs and alcohol and is now reconnected to his previously estranged daughter and grandchild. He doesn't come to Connections so often now, because he's too busy being a dad, a grandfather, writing poetry and going to the gym. This true connection with community, not reliance on a service, was a major aim of the project.

Peer Workers in the Far West are similar to Peer Workers everywhere despite their different backgrounds.

Stuart Leyh (Peer Worker) said, "I wanted to work in a people orientated field where I'm working with others, communicating with others as opposed to mining where I was previously."

Peter Daley (Peer Worker) captured the joy of peer work when he said, "I became a Peer Worker because it seemed a natural thing to do. I am motivated to help people be happier than what they are."

Those people that responded to me as a human being and that provided me with care, support and the inclination to feel safe, gave me the belief that I could do the same for others. Now, I would be diminishing my sense of self-worth if I wasn't a Peer Worker.

It's not about saving the world or saving other people; it's about making possible the minor changes and improvements in life that people can make for themselves.

When I heard about this job, I thought "I'm the bloke to do it." I wouldn't be doing anything else; as some said, "If you find the right job, you'll never work again."

Sam Jessett, Consumer Engagement Coordinator said, "All the good will and work in the world will not tell you more about the needs of the people we support than the voices of the people being supported. Ensuring these voices are heard on an organisational level and empowering Consumers to be a force in improvement and change organisationally is largely what I do, easy right! There are so few people who are lucky enough to combine their work and their passion."

Like other specialised professions, Peer Workers need professional supervision by seasoned, expert Peer Supervisors who have worked in similar services. While it may be necessary for their day-to-day support and supervision to be provided by a clinical supervisor, until a lived experience, Peer work manager is appointed, it is essential that they have professional external Peer supervision. This protects the role of peer work from colonisation by clinical practices, outlooks and language. It also

helps Peer Workers keep up with latest research, retain a vision of the big picture and gain new skills. An independent ear to hear the Peer Worker's concerns and help them find the right direction is invaluable.

Peer Workers need to be supported in rural and remote communities, just as they do in metropolitan areas. Regular connections to networks of Peer Workers and emerging Peer Worker peak bodies are perhaps even more important when the Peer Worker is from a rural or remote community. In rural areas, travel costs can be prohibitive, so face-to-face meetings and gatherings with peers are not always easy to maintain. Telephone and video conferencing, online peer work communities of practice and already existing and emerging social media groups help fill this gap. As peer work becomes more common, networks of Peer Workers from a number of different local organisations in rural communities are another method of supporting this growing workforce. Work has begun on establishing a National Peek Body for the Lived Experience Workforce.

Peer work can enable people to be less reliant on clinical interventions. Louise Byrne, a Lived Experience Academic from Townsville and Yale Fulbright Scholar, commented that there are many critical areas of peer work that are increasingly understood and represented in the literature, including the benefits of peer work. Yet, while research has proven the positive outcomes of peer work, there is still a need to define how the shared experiences, mutuality and reciprocity are making such remarkable differences in the lives of all stakeholders with lived experience. As Louise notes, "not all that encompasses good practice is contained in published research" (Byrne 2018).

Peer Workers Are Crucial to Multifaceted Services

Across a range of human service sectors, it is acknowledged that peer work is a means of individualised interaction that can prevent the escalation of distress and marginalisation. It promotes recovery, adjustment and inclusion by enhancing the participant's emotional, physical and spiritual well-being (Meagher and Naughton 2018).

Many services in the Community Managed Organisation (CMO) and public sectors in mental health have come to recognise that peer work and other lived experience positions are crucial elements to delivering high-quality multifaceted services which meet the needs of individuals, their families and the communities they serve. Private mental health services, however, are yet to realise the value of paid peer support (Priv. MH CCN 2014).

Some visionary services, like Flourish Australia and Southern New South Wales, Local Health District, Far West Local Health District, Mental Health and South Eastern NSW Primary Health Network which commissions services to employ Peer Workers, have recognised that Peer Workers strongly influence positive cultural change (Byrne et al. 2019). They have utilised designated lived experience roles to lead changes in design, culture, practice, research and reporting. Services which have employed Peer Workers and other designated lived experience roles at all levels

place people with lived experience at the front of services rather than only in the center. The paid Peer Workers and staff in other designated lived experience roles leading service change do so both from their own lived experience and that of the collective lived experience community.

Peer-Operated Services such as the Victorian Mental Illness Awareness Council (VMIAC) in Victoria, Brook RED in Queensland and the Flourish Australia Peer-Operated Service in Hervey Bay, Queensland are proof that services whose entire personnel are Peer Workers or people with lived experience, are the proof that Peer-Operated Services can be services of high quality and longevity.

Case Study 2 The Southern New South Wales Local Health District

The Southern New South Wales Local Health District (SNSWLHD) is part of the Public Health system in NSW and encompasses the Local Government Areas of Bega Valley, Bombala, Cooma-Monaro, Eurobodalla, Goulburn Mulwaree, Palerang, Queanbeyan, Snowy River, Upper Lachlan and Yass Valley. It covers an area of 44,534 sq./km with a population density of 4.5 residents per square km.

The travel distances between towns within SNSWLHD can be significant. Traveling from Bega to Goulburn, for example, is a nearly 4-hour trip via road one way, making return trips a 10+ hour expedition. Journeys throughout the LHD can be further lengthened by the Great Dividing Range which effectively divides the region in two. Areas within the region are prone to closure in winter due to frost and snow.

Senior Peer Worker/Consumer Advocate Robert (Butch) Young: 'Working as a Peer Worker in an acute mental health inpatient setting which services rural and remote areas has been a journey that has come with its challenges. However, the challenges are outweighed by the opportunity to influence my colleagues without lived experience and promote a journey of wellness for people with mental illness.

Being in a position to be able to influence positive cultural changes in the inpatient unit can change the outcomes of care for people with lived experience and their families and carers. This cultural change develops through being inquisitive and questioning staff at all levels about why they have been doing things in a certain way, and if it isn't working well for the consumers, then why not change work practices. Peer Workers challenge the status quo. That is part of our job.

When challenging status quo, it is important as a Peer Worker, to understand not only lived experience but the Mental Health Act and other legislations. Knowing these legislations enables Peer Workers to challenge practices, staff behaviors and situations with confidence and respect.

An example of the advocacy role I undertook in the Goulburn Inpatient Mental Health Unit is as a member of the Seclusion and Restraint Committee.

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As the peer work member of the multidisciplinary team, I review all seclusions and restraints within the unit. I work with staff to build their understanding of opportunities to provide early support and intervention for consumers, how to de-escalate vulnerable situations and to prevent incidents of seclusion and restraint.

Also, as a Peer Worker and member of the team in the Goulburn inpatient services, I form part of the Violence Prevention and Management Training Team. This supports clinical staff to understand the impact of performing a restraint or seclusion on a person that has been admitted. We talk about the trauma this causes and the long-term impact this can have on people and the way it negatively changes relationships with the staff, treatment, services, families and carers.

We discuss how to talk with people and how to provide options for non-contact interventions. This work has led to a major reduction in our seclusion and restraint figures and the subsequent reduction in trauma on all people involved including the workforce. Our unit now has some of the lowest seclusion rates in NSW public facilities. We aim to end seclusion and restraint in our service.

The impact of seclusion and restraint is a heavier burden in rural and remote areas because there are no other services to access. There is no choice, and so people become very afraid of having to return to the same service they were traumatised in previously. They often don't access the service until they are forced to because they are so afraid of being secluded and restrained again. It is a catch 22 situation. They feel damned if they do and damned if they don't.

Supporting a culture of understanding, the experience of an inpatient unit, especially a rural service, is part of the Peer Worker role. Being able to support staff to understand what it feels like to live with mental illness in a rural or remote community, the fear of being restrained, being isolated from contact with the outside world and the experience of going back into the community where "everyone knows everything" has made a big difference to the culture of our service.

Another major project we have been able to introduce is the ability for people in the inpatient unit to have access to their mobile devices. Through listening and supporting the voice of people in the inpatient setting, enabling clinical staff to be reassured about the possible risks, supporting and empowering people admitted to do the right thing within a shared environment, "rules" were worked out with and by the consumers as to what was acceptable and appropriate use of phones. These rules and the culture of respect and care for each other and all concerned have negated the risks.

People having access to their phones have helped them stay connected with their loved ones when they are a long way from home. Without this there would be little to no contact with their families and friends as the distances can

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be impossible for many people to negotiate because there is no public transport between many rural communities.

Their phones enable them to meet their responsibilities such as paying bills and reassuring children back home that things will get better.

All of this has also contributed to the decrease in seclusion and restraint, but more than this, it is humane.

Director of Mental Health Drug and Alcohol, Cancer, Renal, Palliative Care, and Breast Screen, Cherie Puckett: As the Director Mental Health Drug and Alcohol, leading and supporting the introduction of peer work and peer advocacy roles within Mental Health facilities is important. It is imperative to have a clear understanding of the how the positions will work as part of the team, how to support each individual, and recognizing the importance within the team. There is also advocacy responsibilities within the health care organization to ensure that the role is understood and the work that is done is recognized, acknowledged, and valued.

When analysing seclusion and restraint data and reviewing trends, a major factor discovered in this analysis was the difference the support of the Peer Worker made in the inpatient setting. '*When I looked back over our seclusion and restraint incidents to see if there was any common denominators supporting our low incidence of seclusion and restraint it became obvious, we had not had an occasion of seclusion and restraint when Butch, our senior Peer Worker was on duty.'*

While lived experience is an imperative of the Peer Worker role, it is not the only requirement in successfully recruiting to a Peer Worker position. Recruiting and retaining Peer Workers within the acute setting is often difficult as the experience of the persons lived experience can influence their desire to remain in the role.

It is particularly difficult in rural areas, as the person's experience is often within the unit they are expected to work and their colleagues may be people that provided their care when an inpatient. Ensuring that there are appropriate supports in place for a person through both leadership and supervision support is imperative.

In rural areas the demographic spread is significant, putting distances of hours between Peer Workers, within the peer work network. Due to this distance, it is important to support catch-ups, peer supervision, support and orientation through other Peer Workers and networking opportunities on a regular basis.

As a Director, building relationships and being accessible are important for Peer Workers just as it is for all staff. Peer Workers with lived experience articulate frequently their difficulty in trusting and have confidence within the system, associated with the long-term psychological impact of the system.

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This often restricts the Peer Worker's capacity to disclose issues with confidence when they arise.

Delivering care to people with mental illness across a large demographic region in rural areas of NSW has many challenges, but these challenges can be lessened by a clear and collaborative approach to care through the voices of those who use the services and the voices of the Peer Workers; *however service leaders and directors need to listen.'*

Practice Implications

Peer Workers are increasingly important members of mental health service teams.

Employing Peer Workers involves overcoming the existing workforce's low expectations and myths about Peer Workers and their abilities but opens up a whole new set of skills and talents in rural and remote communities that can be accessed to engage with and support people who feel isolated, distressed and hopeless.

Whatever the specific requirements, the basic ingredients of peer work is the same. When two minds and two hearts come together, as they do when a Peer Worker sits and deeply listens to a person's past traumas, current fears, despair, shame and lack of self-worth, it resonates deeply with both parties. When the moment is right and the Peer Worker carefully and purposefully shares their own, similar experiences, similar traumas, abuse and feelings with the person, they connect. They sit with the acknowledgement of each other's pain. The burden is shared. Hope for healing often begins at this time. The burden of "facing things alone" begins to diminish.

It is rare for people to experience such honesty. To share vulnerabilities like this in a professional relationship leads to a strong and binding connection, one that can become the foundation of a new future.

In the reciprocal sharing of mutual thoughts, feelings and experiences, new reason, meaning, wisdom and purpose can be explored. Through unpacking and reprocessing harmful thoughts, feelings and inner dialogue that is often preempted by trauma, a new narrative can begin. The close connection and reciprocity felt between the two peers build a healing relationship in an almost unbelievably short space of time.

The Peer Worker is adept at *not* being an expert over the people they are supporting. They encourage the person to find their own ways forward and to reframe the past. The Peer Worker gently champions the people to advocate for themselves; to find their voice; to talk with clinical staff, family and friends; to connect them with services; to support them in tribunal hearings; to explain how the service works; and to connect them with the community in which they live. The peer

relationship is one in which the Peer Worker slowly invites the person to become inquisitive about life again, to wonder at possibilities.

Authentic peer work is not about the Peer Worker, it is about the person they support. It utilises lived experience purposefully, so it can be a healing bridge between the people supported and those around them. The focus should be sharing, encouragement and experience rather than giving advice (Meagher and Naughton 2018). However, both the Peer Worker and the person being supported can benefit from their conversation and professional relationship, as each learns a new way of thinking about the self, their experiences and their humanity.

Peer Workers do benefit greatly from having meaningful employment, finding that their suffering was not in vain and being able to see that what happened to them, how they relate to their experience, and purposefully share it with others is valuable, unique and healing for a multitude of people. Although Peer Workers themselves can experience personal growth in the course of their work, the primary purpose of this important role must always be for the benefit of the people they support.

Peer work is not sympathetic; rather it is empathic. Experienced Peer Workers also know that what is left out of the conversation about their own lived experience can be as important as what is included. It is important that in sharing experiences, the Peer Worker deliberately includes information that will help and not hinder the person's recovery. They avoid causing vicarious trauma or making their own experience seem more challenging than that of the person they are supporting. Importantly, while reciprocity of experiences is the basis of the relationship, Peer Workers must not engage in reciprocal victimhood. It is their job to encourage people to acknowledge what has happened to them but also to look to their future with hope and healing.

Preparing the Workforce Culture to Accept and Value Peer Work

Workforce shortages in rural and remote communities challenge us to find new solutions to delivering supports for people with mental health issues, their families and carers. Peer Workers and other designated lived experience staff are a mostly untapped and underdeveloped resource waiting to be utilised to serve their local communities. This resource is not only beneficial to mental health services; it is beneficial across all human services.

Mental Health services in Australia are leading the way in the paid Peer Workforce. It is important for an organisation to value lived experience at all levels when developing an effective Peer Workforce. Flourish Australia a leading employer of Peer Workers in Australia does just that. As well as their strategy of "Why Not A Peer Worker?" in which they use affirmative action to employ Peer Workers, they also demonstrate their appreciation of the lived experience perspective by employing people with lived experience throughout the service, in advocacy, governance, executive roles and other senior management positions.

In addition, every policy, program, and significant decision are made in consultation with people with a mental health issue (Jackson and Fong 2017). This

embracing of lived experience of a mental health issue as a valuable organisational resource creates an atmosphere in which discussions can readily turn to increasing and improving the lived experience workforce.

This philosophical position translates into practical outcomes in rural and remote areas where Peer Workers and lived experience managers work in local communities delivering both center-based services and one on one support.

Case Study 3 Flourish Australia, Hervey Bay Peer-Operated Service

Chief Executive Officer, Mark Orr: 'Flourish Australia is a large not-for-profit, community managed organisation with expanding services spread over vast distances across New South Wales, Queensland and Victoria. Flourish Australia utilises affirmative action policies to employ people with a personal lived experience of mental health issues.

Over 50% of our almost 900 staff identify as having lived experience. Added to this are a large number of colleagues who are family members or carers of loved ones with a mental health issue.

In 2014, Flourish Australia instituted a strategy called "Why Not A Peer Worker?" (Jackson and Fong 2014). This strategy was driven by our General Manager of Inclusion, Fay Jackson and Tim Fong, our General Manager of Human Resources. It ensured that, for every new support role made available, it would be advertised as a Peer Worker role unless there was strong reason not to. It also enabled mental health workers who had a lived experience and the ability to be good Peer Workers to transition into a Peer Worker role.

Flourish Australia entered into peer work when the growing evidence base for the efficacy and value of peer work for people with mental health became evident.

The "Why Not A Peer Worker?" strategy has seen our peer work numbers grow from 20 to over 180 Peer Workers. The rate of this increase is tracked in the graph below' (Fig. 2).

'Flourish Australia is now seen as a leader in mental health peer work across Australia and internationally. Achieving these excellent results involved many robust conversations and years of effort which encompassed the development of our Embracing Inclusion Policy, other supporting policies, cultural change, affirmative action and organisational leadership across all levels including the Flourish Australia Board of Directors, executive members, managers and staff.

Flourish Australia believes valuing lived experience as a rich source of knowledge and capability is key to developing an effective Peer Workforce that supports people to achieve positive outcomes, recover and lead the lives they choose, connected to their communities and enjoying a sense of belonging, meaning and purpose.

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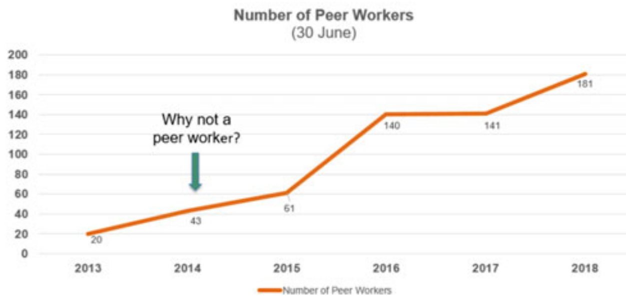

Fig. 2 Strategic goal – 50% of frontline workforce (Orr 2017)

While we utilise Peer Workers across all of our services, we have two Peer-Operated Services. One of these is in a small coastal town in Queensland. In order to have a true picture of the value of the Peer-Operated Service (POS) and peer work over all, Flourish Australia (previously known as RichmondPRA) commissioned Social Ventures Australia to gain understanding, measure and value the social and economic changes generated by the POS by undertaking a Social Return on Investment analysis. This analysis was called *Queensland Social Return on Investment (SROI) analysis of Flourish Australia's Peer-Operated Service in Hervey Bay* (SVA 2014). The information below pertains to this service and is the focus of this case study.

Flourish Australia's Peer-Operated Service (POS) provides recovery-oriented support to adults with severe and persistent mental health issues in the Hervey Bay area, Queensland. It is run entirely by Peer Workers and a Peer Manager who identify as having a lived experience of mental health issues and who purposefully use this lived experience to support the people accessing the service and each other. Individuals who attend the POS are referred to as "Peers."

The POS is made up of three services: (1) Resource Center, the "hub" of the POS where peers can attend one on one support sessions and group sessions and can socialise with other peers; (2) Warmline, a dedicated, non-crisis phone support service for peers who need support with their mental health recovery; and (3) Rest and Recovery House, short-term accommodation available for peers to take time-out from their current living arrangement. Peers voluntarily attend any or all of the services.

SROI is an internationally recognised methodology used to understand, measure and value the impact of a program or organisation. It places a

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monetary value on the impact (the benefit) of an activity and compares this with the cost, or investment required, to create that benefit.

The SROI methodology was used to assess the outcomes created in 1 year (2014) and the investment made to generate those outcomes. The analysis involved 24 consultations with stakeholders of the POS, including 11 peers, as well as a review of the program's historical data and past evaluations.

Key Findings

When the total investment in the POS in 2014 is compared to the total social and economic value created, the SROI ratio is 3.27:1. This means that for every $1 invested into the POS, approximately $3.27 of value was created.

In 2014, 141 peers engaged with the POS, with 40% of those engaging intensely (at least once a week). In total, activities generated approximately $2.1 M in present value for its stakeholders across a range of outcomes (using a discount rate of 7%).

An investment of $0.7 M (88% cash and 12% in-kind) was required during this period to fund the program. This equates to approximately $5 k for each peer who participated.

The largest portion of value created by the POS accrued to the peers ($1.6 M). 69% of this is attributable to social recovery (developing a larger and more diverse social network) and personal recovery (development of hope, self-determination, and identity).

The majority of the remaining value, $0.6 M, accrued to WB MH who experienced reduced pressure on their services due to lower peer admissions/readmissions and shorter lengths of stay at their health services.

Dr. Glen Adamson, the Wide Bay Mental Health Intervention Coordinator said, "I believe that these [peer support] services are the new evolution of psychiatry and although they are a new concept to mainstream treatment, they will be the 'norm' in the future."

The POS has had far reaching influence in other rural and metropolitan settings. It has influenced the Community Care Unit (CCU) in Bundaberg (Queensland) to include a model of Intentional Peer Support, and Flourish Australia was invited by Queensland Health to step in to support a service which had suddenly and dramatically closed because of another not-for-profit services financial predicament. This invitation was due to the respect that Flourish Australia, the POS and our large Peer Workforce have earned and enjoy.'

To be effective, peer work and lived experience roles cannot be "tacked onto the end" of service personnel and delivery in rural and remote communities. The people being employed into these positions need to be selected carefully and engaged in all aspects of service design, delivery and review, and they need to be valued. They are important roles through which to engage people who utilise services, families and

careers, along with other staff and stakeholders. They ensure a richer, more wholistic, visionary mental health services that meet the needs of the people accessing them. This can be more important in rural and remote communities where, due to resource and workforce constraints, new and innovative ways of delivering services need to be developed. This facilitates the required reform of traditional mental health supports, policies, procedures and work practices that must adapt if an organisation is to develop and grow a high-quality Peer Workforce.

Historically Slow Uptake of Peer Work

Ashamedly, there has been an historically slow uptake of Peer Workers and other designated lived experience roles in mental health services throughout Australia. However, this slow uptake is more prevalent in rural and remote areas. There may be many "reasons" for this some of which include (Byrne et al. 2017):

- The continuing dominance of the Biomedical model and its associated research base
- Stigmatising and discriminatory attitudes toward people with mental health issues
- Not valuing the wisdom of lived experience used deliberately to improve services and heal lives
- The "once a patient, always a patient" attitude and the subsequent positioning of Peer Workers as "lesser"
- Historically low number of published research papers about the efficacy and value of peer work that were "recognised" by the clinical community
- The relatively new emergence of lived experience research
- Perceived threat to nursing, other clinical positions and the power of their industrial bodies
- Lack of appropriate levels of designated funding for the Peer Workforce
- Lack of resources to support the employment and development of quality peer work
- Lack of career pathways

The reasons given above can no longer be justified.

People with mental health issues have the same human, legal and moral rights to be accepted in their communities and to engage in employment as any person. Peer Workers have proven their capability to fulfill the inherent duties in their position descriptions. They can work independently and as a part of a multidisciplinary team.

If designated funding is not available, conversion of unfilled positions into Peer Worker positions can solve under staffed services.

"Everyone Knows Everyone Here"

Unlike their city cousins, Peer Workers in rural and remote communities tend to "know everyone" and may well be related to many in the community. Lack of confidentiality is an important issue that can lead to people not seeking help when they need it. Boundaries are needed to support the Peer Worker when their friends and families need their support (Byrne et al. 2018).

Another reason services give for not employing Peer Workers pertains to the 'Peer Worker as patient' concern. This can be used as an excuse for not employing Peer Workers by managers who have been influenced by discriminating attitudes or who have not yet recognised the value of Lived Experience staff However, this can be a legitimate concern for both the service and the Peer Worker. Questions and statements such as "But what happens when they become unwell? What about their confidentiality?" and "They can't come into hospital and be a patient alongside the people they have been supporting!" are sometimes voiced.

These concerns can be overcome in a number of ways: The person can be supported in another service; they can receive services at home which may include face-to-face, tele or video health; they can have remote support from other Peer Workers; some rural Peer Workers who are appreciated and valued in their service have no issues with being supported in the service in which they work. This is usually the case when a plan is in place that clearly spells out the boundaries between being a patient and being a worker. It is important to recognise the hopeful and real possibility that the Peer Worker may not need to be hospitialised or use local mental health services again.

Evidence has shown that Peer Workers have better mental health and less relapses after their employment (Moran et al. 2011) (MH.org.UK) and particularly so in supportive environments.

Acceptance, understanding the value of lived experience to self, the value of using this in service of others, the benefits to local communities and the pride which comes from this experience can be difficult to imagine if you have been on the receiving end of stigma and discrimination in your community; however peer work acts as the bridge to achieve these positive attributes.

Ironically, destigmatising mental health and addressing discrimination in rural communities can be a process led by Peer Workers, and it can be some of the most valuable work they do. Peer Workers break down the barriers and help start conversations in all human and health services, schools, churches, the Country Women's Association, Men's sheds, Sale yards, Aboriginal health centers, Lands councils, pubs, clubs, the Stock and Station Agency, the GPs, the service clubs such as Rotary, Lions, Probus and others (Nat. Academies of Sc. 2016).

Ending discrimination and stigma is a whole of community endeavor. Research by Professor Patrick Corrigan et al. has shown that the best way to address these challenges is by featuring people who are open about their experiences of mental health issues and recovery and are leading contributing lives in local communities. This introduces to the community an alternative view of mental health and well-being (Corrigan et al. 2013).

Different Perspectives

Notably, while Flourish Australia believe that peer support provided by carers and family members to carers and family members is important, Flourish Australia's Peer Workforce does not include carers or family members who have had experience of caring for people with lived experience of mental health issues or unpaid volunteers. Nor does it include employees who hold a different position in the organisation who have a lived experience. An employee engaged as a "Peer Worker" with Flourish Australia is paid at an award rate just like any other employee and fulfills an important role integrated into mental health service teams (Jackson and Fong 2018).

Peer Workers are very capable of supporting family and carers if what they want is in keeping with what the person receiving treatment wants. However, if there is a difference of opinions between what the "patient" wants and what the family and carer wants, the most suitable supports for the patient is a Peer Worker and a family and Carer Worker for the families in crisis (NCCF 2010).

The contradictory points of view between a person receiving treatment and their family can be more acute in rural and remote areas where public "shame" runs deep. The person may be vehemently passionately about not taking strong psychotropic medications to "slow them down" because of the unwanted side effects; however, the family may feel desperate for this to happen.

The different standpoints are best served by staff who empathise with the respective party. A Peer Worker who has experienced being hospitalised against their will and treated with medications that have caused distressing long-term negative impacts to their bodies is unlikely to be able to 100% support a family wanting this for their family member who is rejecting such treatments.

This places all parties in compromised positions. It is unwise and potentially dangerous to all stakeholder's well-being to be compromised in these or similar conflicting circumstances. It is better to employ Peer Workers for the people accessing the services and family and carers workers for their families (ARAFMI 2011).

Concluding Comments and Recommendations

Rural and remote communities desperately need to decrease suicides and improve the services they offer to people at all stages. In order to do this, we must employ and value the Peer and lived experience workforce. This valuable workforce is an almost untapped resource waiting to be utilised in rural and remote communities. When Peer Workers are supported to liaise with the Peer Worker community and receive external professional supervision, they adhere to the principals and value of Peer support. If these principles and values, and the views and experiences of the lived experience workforce are respected, reformed services can be guaranteed.

Metaphorically speaking, Peer Workers are a seam of gold running through rural communities. Unlike mining, services just need to scratch the surface to find the gold which will bring the much needed resources to individuals, services and

communities. Research has shown the value of peer work in personal recovery for people receiving support, in saved bed days, costs to services and communities.

Denying the research and employment of Peer Workers at appropriate numbers and levels equates to rural and remote services which cannot claim that "least restrictive" or "best practices" are being offered and utilised services in these areas.

It is time for rural and remote communities and mental health services to recognise and employ peer work for the valuable resource it is. When Peer Workers are listened to about the changes needed in their service, where the problems lie and the possible solutions they pose are considered, respected and adopted, immense changes can take place in both the culture and outcomes of services.

Mental health reform in rural and remote communities is achievable by utilising the wisdom and experience of local Peer Workers. They are dedicated to their community. These "outstanding members of the community" know the land and its people. They use their lived experience to break down stigma and discrimination and connect services with the individual people, families and broader communities in their region. They form relationships which promote hope, healing, recovery, belonging, worth and contributing citizens. Their knowledge, transparency and pride contribute strongly toward developing thriving, healthy, rural and remote communities.

The positive effects Peer Worker and other designated lived experience roles have on services and communities cannot be understated. The openness, undisguised experiences, identities and values held by these roles must be nourished, supported and utilised to permeate the whole mental health system. When services open themselves up to this in rural and remote communities, deep healing of individuals, families and communities takes place, attitudes and cultures are reformed and everyone is a winner.

> *'All truth passes through three stages. In the first, it is ridiculed. Then it is opposed. And finally, it is accepted as self-evident.'* Attributed to Arthur Schopenhauer (1788–1860)

Take Home Messages

1. The efficacy and value of peer work has been established via research from across the globe.
2. Services need to employ and value considerable numbers of Peer Workers who are trained and supported.
3. Peer Workers are necessary to produce the best multifaceted services possible.
4. Services that do not offer readily available Peer Workers cannot rightfully claim they are offering recovery focused, best practice, least restrictive services.
5. Peer Workers positively change the culture of services and communities. They contribute greatly to services being more engaging for people who need support.

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