Australian Healthcare Associates

Australia's largest specialist health and community care consultancy

Evaluation of the Community Mental Health Intentional Peer Support Training and Consumer Operated Services

Final Report

June 2013

Acknowledgements

We would to thank all those who were involved in this Evaluation for their openness, co-operation and engagement. We would particularly like to thank the peers and peer workers. These people shared very personal information in order to convey the benefits of the program. All were passionate about the IPS approach and the positive gains that they had either experienced or witnessed as a result.

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Glossary and Acronyms

GLOSSARY AND ACRONYMS

Affective learning domain	One of three domains of learning described by Bloom (1964).[1] The domains are: Cognitive (knowledge), Psychomotor (skills, including interpersonal skills) and Affective (attitudes, values, beliefs)
AHA	Australian Healthcare Associates
AOD	Alcohol and Other Drugs
AQF	Australian Qualifications Framework
CALD	Culturally and Linguistically Diverse
COS	Consumer Operated Service
Department of Communities	Queensland Government Department of Communities, Disability and Community Care Services
Dual diagnosis	The co-morbid condition of a person having a mental ill and a substance abuse problem
Experiential delivery	A mode of training delivery that facilitates learning through individual and group-based activities including role playing and simulations. The experiential mode does not use lectures or provision of information.
Instructional design	Refers to how the learning experience is organised (based on analysis of learning needs and systematic development of learning materials).
IPS	Intentional Peer Support
Lived Experience (of mental illness)	A self-understanding of a phenomenon (in this case mental illness) through subjective experience.
MHSIP	Mental Health Statistics Improvement Program
PHaMS	Personal Helpers and Mentors Service
POP	Peer Outcomes Protocol
PSW	Peer Support Worker
Recovery	Refers to a person's improved capacity to lead a fulfilled life that is not dominated by mental illness and treatment. Recovery acknowledges that having a mental illness does not necessarily mean life long deterioration, and that people with mental illness should be recognised as whole, equal and contributing members of the community.[2]
RPL	Recognition of prior learning
RWO	Request for written offer
Service user	The term service user has been used in this report to differentiate those peers who use COS programs from those who are in IPS worker roles. Within the individual COS, terms such as consumers, peers, members and people with lived experience of mental illness are used.
Statistical Reports	Six-monthly output reports provided by COS programs to the Department
VET	Vocational education and training
WA	Western Australia
Warmlines	A 'warm', kind or friendly telephone support line provided to service users. In the Queensland COS context, warmlines are generally provided by IPS workers after hours or on weekends.

[1] B Bloom. *The taxonomy of educational objectives: Handbook II – The affective domain*. Masia, Krathwohl, 1964.
[2] Queensland Government, *Queensland Plan for Mental Health 2007-2017*, Queensland Health, Brisbane, 2008.

1. Executive Summary

1 EXECUTIVE SUMMARY

1.1 Background

The Intentional Peer Support (IPS) training program and the Consumer Operated Services (COS) program are initiatives of the Queensland Government Department of Communities, Disability and Community Care Services (Department of Communities). The aim of these programs is to promote the role of consumers in the delivery of mental health services and improve outcomes for people with mental illness. The core purpose of the IPS training program in Queensland during this period was to provide participants with a way of developing relationships that were effective, mutually enhancing and which enabled both people (or a group of people) in the relationship to grow and challenge each other. IPS is characterised as different from traditional relationships between service providers and service users, and promotes alternate ways for service users to think about their experiences.

IPS training was first provided in 2008 and the COS program was established in 2010. These initiatives are aligned to an international shift towards consumer empowerment in mental health and a concurrent focus on the potential for recovery for people with mental illness.

In 2012, Australian Healthcare Associates (AHA) was engaged by the Department of Communities to evaluate the IPS training program and the COS model. This report presents the findings of that evaluation.

1.2 Evaluation objectives

The evaluation objectives were to:

- Evaluate the effectiveness of the IPS training in terms of preparing peer workers in the peer support role and the extent to which it promotes and helps to build a peer workforce
- Describe the satisfaction of key stakeholders and any unintended outcomes of the IPS training and provide recommendations for enhancement where relevant
- Profile the people who receive support through the COS program
- Evaluate the effectiveness of the COS program by examining the processes employed to deliver the program
- Determine the type and range of outcomes that are being achieved for the respective target cohort and ascertain the extent to which improved outcomes are linked to the COS program.

1.3 Methods

The evaluation used a mixed methods evaluation approach involving a range of quantitative and qualitative data sources. There were four evaluation phases:

- Phase 1: Development of Evaluation Framework and Project Plan
- Phase 2: Evaluation of IPS Training
- Phase 3: Evaluation of COS Model
- Phase 4: Evaluation reporting

Information sources for the evaluation included:

- Survey of participants from the IPS training program including the Manager training program

- Consultations with IPS training providers and IPS training participants
- Survey of COS service users
- Analysis of six-monthly output reports provided by COS programs (Statistical Reports)
- Consultations with peer support workers who were employed by the COS program (this informed both the IPS and COS evaluation)
- Consultations with COS service users
- Consultations with key stakeholders from within the Queensland Government and the Queensland mental health service system (this informed both the IPS and COS evaluation)
- Review of the national and international literature, exploring peer support and consumer operated service models.

A number of challenges and limitations were encountered in conducting the evaluation. Key among these was the fact that:

- Existing training evaluation data was limited while the timespan of the training meant that issues of recall and loss to follow-up of the trainees applied.
- Template design errors, data entry errors, and inconsistent interpretations meant that data from the Statistical Reports provided limited insights into the COS program outputs.
- The accommodation component was only recently operational, thus making it difficult to fully assess the implications of this COS program.
- The quality of the interview data was potentially compromised by a small service user sample and the emotional impact of the shock death of one of the COS managers (Chapter 3).

The report separately presents the evaluation findings for the IPS training and the COS program.

The findings presented in this report are Part 1: Evaluation of the Intentional Peer Support and Manager Training and Part 2: Evaluation of the Consumer Operated Services Program

1.4 Summary of findings

Key findings identified in this report are summarised below.

Part 1: Evaluation of Intentional Peer Support and Manager Training

Implementation of IPS training in Queensland (Chapter 4)

- Although there has been significant investment in the Queensland mental health workforce, there is a lack of data available to measure if the investment has resulted in improved recruitment and retention rates.
- Training outside the AQF is not systematically moderated and validated which potentially erodes industry confidence in the qualification and disadvantages trainees who may not be getting valid, fair, reliable and flexible assessments.
- Because there is no mandatory qualification for community mental health workers, IPS workers are likely to continue to suffer from the perception that they are part of an unprofessionalised workforce. Consequently, they may experience the industrial issues related to pay scales and

occupational recognition that accompany a non-accredited worker group in the broader mental health workforce.

- The Shery Mead Consulting training packages are not accredited under the AQF. This potentially disadvantages workers with respect to career pathways and recognition of prior learning.
- Formalising competency and/or assessment procedures so they are transparent and reproducible would assist in building industry confidence in the IPS and Manager training courses.
- Accreditation of the IPS and Manager training under the AQF would not only assist in building the community mental health workforce but also increase industry and training participants' confidence. It would also reduce inconsistencies and variations between courses.
- The possibility of synergies between current planning discussions among Queensland IPS training program stakeholders on ways to expand the delivery of Shery Mead Consulting IPS training products by local IPS training providers, and advice available from the Australian Skills Quality Authority (ASQA), may be worth exploring.

Effectiveness of IPS training (Chapter 5)

- Course participation patterns indicate that the IPS courses may not always be adequate to equip workers for the IPS worker role.
- Inconsistent eligibility criteria for entry into courses means that some people are doing the one course multiple times and on occasion, people are doing courses without prerequisite knowledge.
- Some individuals are accessing the 5-day IPS Basic course as a means of continuing skills development
- A significant number of IPS trainees are not entering the IPS courses to become IPS workers. Some complete the course for personal growth or to assist them in their work outside the IPS setting.
- Despite the improvements in understanding achieved as a result of the training, specific gaps in role readiness remained.
- Although Co-supervision training assists in preparing IPS workers for this part of their role, there is still a need to improve this training to better prepare participants for this role.
- Providing IPS basic training in a 5-day block may not be ideal. Further research into the optimal delivery schedule may be warranted.
- There was no evidence provided that the IPS training has resulted in workforce growth. Rather, it appears there is an influence on retention of staff in the mental health community sector which includes some sideways movement in line with development of new skills and reallocation of funds.
- Inclusion of course participants with no intention of becoming IPS workers in the IPS 5-day courses makes it difficult to ascertain the influence of the course on retention or recruitment of staff to the IPS workforce.
- As the aim of the IPS training provision is to build an IPS workforce in Queensland, eligibility criteria need to be clarified and enforced to ensure the course is available to those most likely to become IPS workers.

- Levels of satisfaction with training were high and did not differ between USA and Australian training providers.

Effectiveness of Manager training (Chapter 6)

- Those participating in Manager training reported being motivated to do the training because they were interested in developing a peer workforce or better support an existing peer workforce. This signifies that the Manager training is reaching the specified target groups for this training.
- Although managers reported that overall, the Managers training was of assistance and improved their knowledge of IPS, a number of gaps were identified in the training that should be addressed to maximise the utility of the course in future.
- Managers raised several concerns with course participants not having a prior knowledge of IPS. This may suggest the need to:
  - Modify entry screening processes for the Manager training courses and/or stream trainees so that trainees in each course have comparable knowledge of IPS
  - Include a larger IPS component in the Manager training
  - Establish the 5-day IPS training as a prerequisite for entry into the Manager training.
- Manager training is reported to have had a significant impact on organisations in the areas of internal process (i.e. changes to how teams are structured, how supervision is conducted and series are delivered) and understanding of recovery.
- Organisational change related to IPS manager training is likely to have improved organisational readiness to effectively employ peer support workers.
- One third of manager training participants are not currently engaged as managers. While this may be accounted for by the inclusion of Co-ordinators in the promotional target group, an opportunity exists for the Department to maximise its future return on investment, by specifically targeting those managers who are in positions of designated responsibility for developing workforce and organisation.

Part 2: Evaluation of Consumer Operated Services Model

Implementation of the COS model in the Queensland context (Chapter 7)

- Recruiting staff to work in the IPS model is not problematic in itself; however, but it takes time for staff to develop the appropriate skills and confidence to practice the IPS approach effectively.
- The COS programs are meeting the COS governance objectives as outlined in the model framework.
- Service user participation in all aspects of service delivery is strong and in line with service delivery guidelines and frameworks.
- Record keeping and planning processes need to be strengthened to ensure transparency, consistency and practice quality.

- While service users have access to their documentation, they are not routinely provided with copies of their service delivery plans such as Mutuality Action Plans or recovery action plans, or the outcomes of joint IPS conversations.
- Further work to address the needs of potential service users from culturally and linguistically diverse backgrounds should be considered. The cultural appropriateness of the services for Aboriginal and Torres Strait Islander service users also warrants attention.
- Both COS programs have put local reference groups in place. These reference groups are constituted in line with the appropriate guidelines.
- Work is currently underway in the area of risk management. This work needs to be continued as a high priority and the desire to maintain an empowering approach that maintains the fine balance between dignity of risk for the individual and organisational risk management needs to be reconciled.
- While many of the COS managerial/administrative staff held relevant work-related qualifications, IPS workers were considerably less qualified. In some cases, IPS training was the only relevant work-related training that IPS workers had completed.

Effectiveness of the COS model: Service level perspectives (Chapter 8)

- COS programs are a key employer of IPS workers in Queensland, and as such, they are an important training ground that is helping to build the IPS workforce
- Selection procedures for training recipients are important as the work is challenging from a personal perspective for many workers and requires intense practice and self-reflection.
- Referrals into and out of COS programs are reported to be working well.
- There are few barriers and challenges to providing flexible and responsive services. Primarily they relate to transport issues and geographical location which is a function of the fact there are presently only two services available.
- Without exception, the COS programs were viewed positively by all stakeholders involved in the evaluation. Although the paradigm shift in care provision was acknowledged as an issue, those familiar with the services always reported positive interactions and results.
- Initially, the COS providers had to negotiate their position in the service system and raise awareness about what they offer. COS now fills a vital niche in the service system as one option amongst a spectrum of services.
- Tension remains between principles of IPS and the statutory approach to risk management that applies in all workplace settings throughout Australia.
- Risk management procedures are generally reactive and need to be strengthened to protect both the IPS workforce and service users i.e. in the absence of formalised risk management policies and procedures, risk management is undertaken through a reactive process whereby staff subjectively respond to risk situations without direction from pre-approved procedural guidelines..

COS Consumer Profile (Chapter 9)

- Inconsistencies and gaps in the data captured within the Statistical Reports completed by each COS provider meant that it is not possible to present an accurate picture of the demographic characteristics of COS service users, referral patterns or levels of service usage.

- There is a lack of clinical and program data available to support planning and evaluation of outputs, impacts and outcomes of the program.
- Without prioritisation of data collection, it is, and will continue to be difficult to substantiate claims of spectacular program outcomes that are regularly communicated anecdotally by program stakeholders.

Effectiveness of the COS model: Consumer level perspectives (Chapter 10)

- The majority of survey respondents attended the COS at least twice per week, and used a number of the services/activities on offer.
- Survey respondents reported high levels of satisfaction with the COS program.
- A number of factors contributed to the high levels of satisfaction of the COS users. In particular, service users valued the responsiveness of the COS, the time and understanding that IPS workers put into understanding them, and the hope that this engendered.
- COS users experienced a number of positive outcomes as a result of their participation in the COS. These included improvements in ability to manage daily life, better relationships, improved ability to manage emotions, improved social interaction and reductions in hospitalisations.
- Some concerns were expressed by an external stakeholder regarding what they perceived to be, on occasion, a negative attitude towards mainstream mental health services in the COS environment.
- COS users reported that their participation in the COS assisted with their progress towards recovery from mental illness.

1.5 Summation

There is no doubt that the IPS training and the COS service delivery initiatives are innovative and highly valued not only by the people working in or utilising the services but also by others who care for people with mental illnesses in community or clinical settings.

While the evaluation identified a number of issues that warrant attention, the achievements of the initiative to date provide an important foundation on which to build.

2. Introduction, Background and Policy Context

2 INTRODUCTION, BACKGROUND AND POLICY CONTEXT

This chapter introduces the *Evaluation of the Community Mental Health Intentional Peer Support Training and Consumer Operated Services*, and contextualises the evaluation within the Australian mental illness and mental health policy environments in which the training and services were delivered.

2.1 Introduction

In 2012, Australian Healthcare Associates (AHA) was engaged by the Queensland Department of Communities, Disability and Community Care Services to evaluate the Intentional Peer Support (IPS) training program and the Consumer Operated Services (COS) model.

IPS is a framework of peer practice that is not only used within Queensland's COS programs but also in other mental health settings in Australia and internationally. The key tenets of this peer support model are mutually supportive relationships that enable all parties to learn and grow, rather than one person needing to 'help' another.

COS refer to services that provide supportive peer relationships to people who may experience crises, and as a consequence, frequently present to after-hours mental health crisis teams or emergency departments. COS aim to deliver individualised, flexible and responsive services to assist service users to develop capacity for self-management of personal crises.

The evolution and theoretical underpinnings of IPS and COS models are described in the following sections. The implementation of the IPS and COS models in the Queensland context are described in detail in Chapter 4 and Chapter 6 respectively.

2.1.1 Evaluation objectives

The overall intent of this evaluation is to understand the extent to which the IPS training and COS program are achieving their intended aims. The following objectives underpin the evaluation:

1. Evaluate the effectiveness of the IPS training in terms of preparing peer workers in the peer support role and the extent to which it promotes and helps to build a peer workforce
2. Describe the satisfaction of key stakeholders and any unintended outcomes of the IPS training and provide recommendations for enhancement where relevant
3. Profile the people who receive support through the COS program
4. Evaluate the effectiveness of the COS program by examining the processes employed to deliver the program
5. Determine the type and range of outcomes that are being achieved for the respective target cohort and ascertain the extent to which improved outcomes are linked to the COS program.

2.2 Background

This section provides an overview of the origins of peer support and consumer operated services in the mental health context. A more detailed discussion is provided in Appendix A.

2.2.1 Peer Support in Mental Health

The evolution of peer support in mental health can best be understood within the historical context of the Mental Health Consumer Movement (also known as the Psychiatric survivors (or ex-patients) movement). The Mental Health Consumer Movement arose out of the civil rights movement of the late 1960s and early 1970s. It saw former psychiatric patients organise groups to fight for patients' rights and against forced treatment, stigma and discrimination, and set the scene for deinstitutionalisation of psychiatric care. The rights of patients to make informed decisions and to take active roles in their treatment underpinned this movement. Service users increasingly began forming groups to meet their needs and those of their peers who were returning to the community following deinstitutionalisation.[3]

Peer support has been described as 'a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.'[4] It should be noted that peer support as a concept is not unique to mental health. The idea of using peers who are "experts by experience" [5] has been used in a diverse range of settings including breast-feeding, breast cancer and substance use disorders such as drugs and alcohol.

In mental health services, peer support involves people with experiences of mental health problems supporting others with similar experiences. Based on an extensive review of the literature, Davidson and colleagues identified three main types of peer support:

- Naturally occurring (informal) peer support
- Peers participating in consumer or peer-run services (e.g. Consumer operated services)
- Mental health service users as providers within traditional clinical and rehabilitative services.[6]

Within these different settings, peer support is provided in either a paid or volunteer capacity.

The potential of peer support in the recovery context has been clearly articulated by Repper and Carter:

> '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'.[7]

[3] Substance Abuse and Mental Health Services Administration. *Consumer-Operated Services: The Evidence*. Rockville, US Department of Health and Human Services, 2011.
[4] Mead, S. (2003). Defining Peer Support. http://www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf Accessed 24/1/13.
[5] Anglicare Tasmania. E*xperts by Experience: Strengthening the mental health consumer voiced in Tasmania*. Social Action and Research Centre: Hobart, 2009.
[6] M Davidson, M Chinman, B Kloos, et al, Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence *Clinical Psychology Science and Practice,*1999, 6:165-187.
[7] J Repper and T Carter, A review of the literature on peer support in mental health services. *Journal of Mental Health*, 2011, 20(4), 392–411, p.400.

2.2.2 Consumer Operated Services

Consumer Operated Services (COS) represent a further evolution of the vision advocated by the Mental Health Consumer Movement described in Section 3.2. The philosophy that underpins the peer support model is also central to the COS model. This includes belief systems around recovery and empowerment, and an emphasis on reciprocal relationships, peer role models and a sense of one's inherent strengths and value.[8]

While consumer operated organisations may take different approaches to providing services, there are several consistent key elements:

- Consumer control: true consumer-operated organisations are autonomous and fully consumer controlled (with service users having majority control of the governing board and full authority for program administration and operation)
- Member-run services: COS programs provide opportunities for members to perform different roles within the organisation, including serving as paid or volunteer staff and as board members
- Participatory leadership: COS programs often try to establish participatory, non-hierarchical, and shared leadership structures that are responsive to the needs and preferences of participants
- Voluntary participation: participation in the COS is voluntary, with members choosing the amount and kind of program participation that suits their personal needs or preferences.[9]

COS programs may include a diverse range of activities and services, but often include the following:

- Providing mutual support
- Building the community (by providing participants with opportunities to develop new social and interpersonal networks and to become full members of an inclusive and accepting community)
- Providing services (such as safe shelters and assistance with other basic needs, such as housing and employment or education)
- Conducting advocacy activities (at both the level of the individual, and at the system level, to promote system change and social justice).[10]

It has been suggested that through PSWs and COS, the Mental Health Consumer Movement has succeeded in 'infusing the mental health workforce with people who are coping successfully with their own psychiatric disabilities [which] may not only provide direct effects on the level of individual service user outcomes, but may also affect the lingering stigma surrounding people with mental illness that continues to permeate the mental health system and the broader culture'.[11]

2.3 The Australian context

In this section, the prevalence and impact of mental illness in Australia is discussed. This is followed by a brief review of the policy response to mental illness that underpins the IPS and COS programs.

[8] Substance Abuse and Mental Health Services Administration. *Consumer-Operated Services: The Evidence*. Rockville, US Department of Health and Human Services, 2011.
[9] Substance Abuse and Mental Health Services Administration, 2011.
[10] Substance Abuse and Mental Health Services Administration, 2011.
[11] Davidson, Chinman, Kloos et al; 1999, p.182.

2.3.1 Prevalence and Impact of Mental Illness in Australia

Mental illness is an important public health concern in Australia. The term 'mental illness' covers a wide range of disorders and often has far reaching implication for individuals, families and society as a whole.[12] The prevalence of mental illness is high, with almost 45% of Australians aged 16-85 having experienced a mental disorder sometime in their lifetime.[13] Results of the 2007 *National Survey of Mental Health and Wellbeing* indicated that in the 12 month period prior to the survey:

- One in five (20%) Australians aged 16-85 experienced one or more of the common mental disorders (anxiety disorders, affective disorder, substance use disorders)
- One in seven (14.4%) Australians had an anxiety disorder
- One in twenty (6.2%) had an affective disorder; and
- One in twenty (5.1%) had a substance use disorder.[14]

The results also indicated differences by gender and age. Women were more likely to have experienced a mental illness in any given year and reported higher levels of anxiety disorder (17.9% compared to 10.8% for men). In contrast, men were twice as likely to have a substance use disorder (7.0% compared to 3.3% for women).[15] Prevalence of mental illness is greatest among 16-24 year olds, with a reported prevalence of more than one in four (26.4%) in any one year.[16]

The *Fourth National Mental Health Plan* reported that an estimated 3% of Australian adults have severe disorders. Of these, about 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.[17]

People experiencing mental illness and substance use disorders have markedly poorer psychological and physical health than the general population. Coghlan and colleagues, in a Western Australian (WA) study, found that the overall death rate of people with mental illness was 2.5 times higher than the general population of WA. The study found higher prevalence of heart disease, respiratory disorders, infectious diseases such as hepatitis C and Human Immunodeficiency Virus (HIV), injuries, iron deficiency anaemia and a much poorer prognosis once cancer was diagnosed.[18] The authors were also concerned that the data on hospitalisation rates suggested that people with mental illness do not receive the same level of medical treatment in hospital, based on need. In addition, suicide was a significant contributor to 'excess deaths' in people experiencing mental health issues with the greatest period of risk occurring in the first two weeks after discharge from inpatient care.[19]

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[12] Australian Institute of Health and Welfare, *Australia's Health 2012,* Australia's Health Series No.13. AIHW, Canberra, 2012.
[13] AIHW, *Australia's Health 2012.*
[14] Australian Bureau of Statistics. *2007 National Survey of Mental Health and Wellbeing*: Summary of Results. ABS, Canberra, 2008.
[15] T Slade, A Johnston, M Teesson et al, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, 2009.
[16] M Sawyer, F Arney, P Baghurst, et al, *The Mental Health of Young People in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2007.
[17] Department of Health and Ageing. *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009–2014*, DoHA, Canberra, 2009.
[18] R Coghlan, D Lawrence, D Holman et al, *Duty to care: Physical illness in people with mental illness*. University of Western Australia Department of Public Health and Department of Psychiatry, Perth, 2001.
[19] Coghlan et al 2001.

Poorer living conditions can be one of the impacts of mental illness, whilst a lack of secure accommodation can also contribute to poor mental health. People who reported being homeless in the 2007 *National Survey of Mental Health and Wellbeing* experienced mental health disorders at a rate two and a half times higher than for the general population.[20] The incidence of mental ill-health in prison populations is much higher than the general population with around 40% of prisoners experiencing mental illness and 10–20% affected by severe disorders.[21]

The symptoms of mental illness often make it more difficult to manage the demands of day-to-day life, including work, study and relationships. Those with mental illness also experience problems such as isolation, discrimination and stigma.[22] The *Fourth National Mental Health Plan* (2009 -2014) highlights low educational attainment and participation in the workforce as key problems for those experiencing mental illness.[23]

Mental illness also has an economic impact with 7.3% of all government health spending (across Australia) devoted to responding to mental ill health.[24] In addition, the government bears further costs via disability welfare payments, unemployment benefits and the direct costs of imprisonment. The cost of mental illness due to lost productivity is also substantial: it is estimated that mental illness in young men aged 12-25 years costs the Australian economy $3.27 billion per annum.[25] These figures illustrate that the human and economic costs of mental illness are substantial and borne across a range of sectors and institutions beyond the health sector.

2.3.2 Policy response to Mental Illness in Australia

Governments across Australia have committed to addressing the prevalence and impact of mental health problems. The key policy developments relevant to the implementation of the IPS and COS programs are:

- The Fourth National Mental Health Plan (Commonwealth)
- The National Mental Health Commission (Commonwealth)
- Queensland Plan for Mental Health.

Fourth National Mental Health Plan

The *Fourth National Mental Health Plan* (2009-2014)[26] describes a population health framework that considers the complex interplay of biological, social, psychological, environmental and economic factors that influence mental health. It advocates a whole of government approach, which includes a national effort across State/Territory governments as well as across a range of government portfolios beyond the health portfolio. The five priority areas for action are:

- Social inclusion and recovery (defined as 'a philosophy that emphasises the importance of hope, empowerment, choice, responsibility and citizenship... working to minimise any residual difficulty while maximising individual potential[27])

[20] Slade et al 2007.
[21] Slade et al 2007.
[22] AIHW, *Australia's Health 2012.*
[23] DoHA, *Fourth National Mental Health Plan,* 2009.
[24] AIHW, *Australia's Health 2012.*
[25] Ernst and Young, *Counting the cost: the impact of young men's mental health on the Australian economy,* Report for the Inspire Foundation. Inspire Foundation and Ernst and Young, 2012.
[26] Department of Health and Ageing. *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009–2014*, DoHA, 2009, Canberra.
[27] DoHA, *Fourth National Mental Health Plan*, 2009, p.26.

- Prevention and early intervention
- Service access, coordination and continuity of care
- Quality improvement and innovation; and
- Accountability – measuring and reporting progress.

National Mental Health Commission

Australia's first National Mental Health Commission was established on 1 January 2012 to report independently to the Prime Minister on Australia's efforts to promote mental health and to prevent mental illness and suicide. The Commission's vision is that all people in Australia the best possible mental health and wellbeing. A recovery orientation is evident in the title of the Commission's first 'Report Card' on Mental Health and Suicide Prevention – 'A Contributing Life'. While the Report Card does not make specific recommendations relating to peer support or consumer operated models of care, there is a strong focus on ensuring that people with mental health problems and their families have a voice in decision making about services that affect them, and that the lived experience of people with and recovering from mental illness is captured through regular surveys.[28]

Queensland Plan for Mental Health

The *Queensland Plan for Mental Health 2007-2017*[29] (the Plan) outlines priorities for the reform and development of mental health care and improving mental health service delivery in Queensland. Consistent with the *Fourth National Mental Health Plan*, the Plan recognises that a whole-of-government, whole-of-community approach is needed to reduce the prevalence and impact of mental health problems and mental illness. The Plan aims to develop a coordinated approach that provides a full range of services that:

- Promote mental health and wellbeing
- Where possible prevent mental health problems and mental illness
- Reduce the impact of mental illness on individuals, their families and the community
- Promote recovery and build resilience
- Enable people who live with a mental illness to participate meaningfully in society.

The delivery of recovery-oriented services is central to the Plan. Recovery defined in the Plan as 'a person's improved capacity to lead a fulfilled life that is not dominated by illness and treatment'.[30] The focus of recovery is on enabling people to experience improved quality of life and higher levels of functioning despite their illness.

The Plan also emphasises the active role of service users, families and carers in all aspects of the mental health system. In this context, $35.64 million was allocated over four years (2007-2011) to purchase a range of accommodation and personal support services including additional places for consumer operated crisis and respite services. The goals, service model and implementation plan for the Consumer Operated Services Program have been articulated in Disability Services Queensland's *Overview of Future Directions: Consumer Operated Services.*[31]

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[28] Australian Government National Mental Health Commission. *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* NMHC, Sydney, 2012.
[29] Queensland Government, *Queensland Plan for Mental Health 2007-2017*, Queensland Health, Brisbane, 2008.
[30] Queensland Government, Queensland Plan for Mental Health 2007-2017, 2008, p.2.
[31] Queensland Government, Disability Services Queensland. *Overview of future directions: Consumer Operated Services Program*, Queensland Government, Brisbane, 2009.

2. Introduction, Background and Policy Context

The following Chapter 3, details the evaluation methodology

3. Methods

3 METHODS

In this chapter, details are provided of the methods used to conduct the Evaluation of the Community Mental Health Intentional Peer Support (IPS) Training and Consumer Operated Services (COS). Details are provided under the following headings:

1. Approach
2. Phase 1: Development of Evaluation Framework and Project Plan
3. Phase 2: IPS Training – Evaluation
4. Phase 3: COS – Evaluation
5. Phase 4: Overall Evaluation – Report.
6. Caveats and Limitations.

3.1 Approach

A mixed methods evaluation approach involving a combination of quantitative and qualitative data sources was used to conduct the evaluation. This approach comprised four phases as listed above.

While the evaluation of the IPS training and the COS represented two separate components, considerable overlap occurred. This is because many of those working in the COS setting had completed IPS/Manager training. Consequently, consultations with these trained workers in the COS evaluation also contributed to the training evaluation, particularly in terms of assessing the applicability of the training in the workforce context and ascertaining the extent to which the training contributed to building of a skilled workforce.

3.2 Phase 1: Development of Evaluation Framework and Project Plan

The Evaluation Framework was designed to align with the evaluation objectives. It provides details of the evaluation questions and data collection strategy, consultation methods and tools. The Framework was informed by an initial meeting with the Queensland Government Department of Communities in February 2012 and a review of the data/documentation subsequently provided. The Project Plan was finalised in April 2012.

Phase 1 identified some discrepancies between the information provided as part of the data/document review process and the details provided in the Queensland Government 'Request for Written Offer' (RWO) which had implications for how the Evaluation Framework and Project Plan were operationalised. These discrepancies included:

- The number of participants who completed training (n=197) was almost double the number specified in the RWO (n=100)
- A broader range of training courses had been delivered to December 2011 than was indicated in the RWO. It emerged that in addition to the 5-day IPS Basic training and 2-day Manager training, the following courses had been delivered in the review period: IPS Co-supervision training, a one-day training course for managers and an IPS Train the Trainer in Teaching Training 5 day course. Furthermore, the number of training providers was increased from two (Sheryl Mead Consulting and Brook RED) to three, with Community Focus (a mental health NGO in the Sunshine Coast) identified as the third provider

- The Department's presupposition that consent obtained from training participants at the time of registering for IPS/Manager training would negate the need for ethics approval for this Evaluation, was found to be inaccurate. Consequently, the ethics application had to be expanded to cover the training evaluation; which was not envisaged during the initial briefing meeting.

The implications of these discrepancies on the operationalisation of the evaluation framework were threefold. First, submission of the application for ethics approval was delayed so that details of the IPS Training Evaluation could be included. Second, the survey of training participants became more complex than originally anticipated, which had follow-on implications for the selection of trainees for consultation purposes. Third, the scheduling of phases was impacted while awaiting ethics approval.

Initially, it had been envisaged that Phases 2 and 3 would occur sequentially, with Phase 2 being conducted while ethics approval to consult with COS staff and service users was obtained. The requirement to secure ethics approval for Phase 2, coupled with a later delay seeking a variation to ethics following a revision to methods in Phase 3 (see Section 3.4 for details) and the transfer of the project from the Queensland Government Department of Communities to Queensland Health meant that Phase 2 was delayed. The time gap between phases was compressed as a result and overlap between phases occurred.

An ethics application was submitted to the Metro South Health Service District Human Research Ethics Committee on 20 May 2012 and approval was received on 26 June 2012.

3.3 Phase 2: IPS Training - Evaluation

This section describes the methods used to conduct the IPS Training evaluation under the following headings:

1. Evaluation questions and data sources
2. Data collection strategy and consultation methods
3. Survey response rates
4. Consultations and interviews
5. Data analysis.

3.3.1 Evaluation questions and data sources

The key evaluation questions and data sources, developed as part of the Evaluation Plan to address the IPS Training evaluation, are itemised in the following *Table 3-1*.

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Table 3-1: Key Evaluation Questions – Evaluation of IPS Training

Evaluation Objective	Evaluation Questions	Data Source
Evaluate the effectiveness of the IPS training in terms of: ▪ preparing peer workers in the peer support role, and ▪ the extent to which it promotes and helps to build a peer workforce	▪ What is the training model? ▪ Has it been modified for the Australian context? ▪ What is the mode of delivery? ▪ What are the learning objectives and key competencies? ▪ Who did the training target? ▪ Was the training adequate and effective? - knowledge change (recovery and provision of peer support) - attitudinal change - behavioural change ▪ Origins and motivations of participants ▪ Does the training provide managers with information on building a peer workforce? ▪ Are participants remaining in the Peer worker role? ▪ Does the IPS training prepare people for the Peer worker role? ▪ Are there any areas where the training needs to be further enhanced?	▪ Consultation with training providers (Shery Mead Consulting) ▪ Online survey of those who completed the IPS, Train the Trainer Teacher training and Co-Supervision training ▪ Online survey of those who completed the Manager training ▪ Consultations with a sample of participants who have completed the training ▪ Review of existing training data held by Department ▪ Review of documentation related to training programs
Describe the satisfaction of key stakeholders and any unintended outcomes of the IPS training and provide recommendations for enhancement where relevant	▪ Were the learning objectives met? ▪ Were participants able to translate the training into practice? ▪ Did participants identify difficulties in the field that could be addressed in the training? ▪ Do stakeholders perceive any differences in the training provided by locally trained providers and that provided by Shery Mead Consulting? ▪ Have there been any unintended consequences (positive and negative) of the IPS training? ▪ What features of the IPS training work/do not work effectively and efficiently? (overall, and from the perspective of those working in COS) ▪ Do the training objectives fit with the Department's view of recovery and Peer Support?	▪ Review of training evaluation data ▪ Online surveys (as listed above) ▪ Consultation with Department ▪ Consultations with sample of training participants

3.3.2 Data collection strategy and consultation methods

To address the range of evaluation questions listed above, a mixed methods data collection strategy was used. This strategy included consultations with each of the key stakeholder groups as well as targeted data collection using a customised survey instrument. A summary is provided in *Table 3-2*.

Table 3-2: Data Collection Strategy– Evaluation of IPS Training

Consultation	Target
▪ Group interview(s) with managers who completed training (non-COS)	5
▪ Group interviews(s) with 10 Peer workers who completed training	10
▪ Interviews(s) with participants who have completed Train the Trainer Teacher training (Group of 3-6 who work in Brook RED, plus telephone interviews with 3 non-COS others)	3-6 at Brook RED 3 non-COS
▪ Interview(s) with participants who have completed Co-supervision training (n=3)	3
▪ Consultation with IPS training provider (Shery Mead Consulting)	2
Targeted data collection	**Target**
▪ Survey of people who have participated in the IPS and manager training to date	Total trainees: 222 (expected response rate = 20%)

3.3.3 Survey response rates

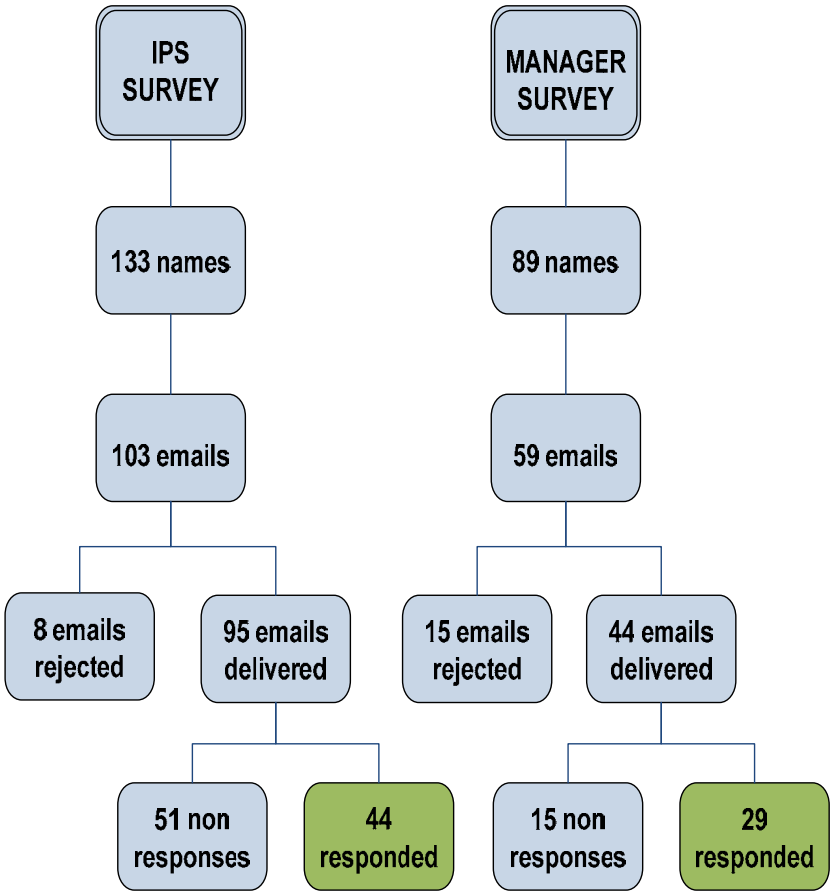
Two online surveys were developed – one for those who undertook some form of IPS training (Appendix B) and one of those who completed manager training (Appendix C). A list of former trainees was compiled by the Department of Communities, comprising 133 potential IPS training survey recipients and 89 manager survey recipients. Individual email addresses could not be sourced for all trainees on this list. In situations where only organisational affiliations were known, these organisations were contacted and in many cases agreement was secured for a nominated individual to forward the survey-related email(s) to former trainee(s) who were based in their organisation.

A summary of the survey population and response rate is provided in *Figure 3.1*.

The online survey was circulated by email on 12 July 2012, to 103 people who had completed IPS training and 59 people who had completed manager training for whom email addresses were available (Figure X). A number of these emails were subsequently rejected, signifying that these email addresses were either inaccurate or no longer valid. Prior to closing the survey in August 2012, two reminders were sent to optimise response rates.

A total of 44 (of 95) IPS trainees and 29 (of 44) managers completed the survey, thereby yielding a response rate of 46% and 66% respectively based on the number of surveys delivered. This response rate exceeded the expected 20% response rate targeted in *Table 3-2*.

Figure 3-1: Survey response rates



Survey respondents were also asked to indicate whether they were willing to be contacted for further consultation. Consent was provided by 32 (73% of 44) IPS survey respondents and by 15 (52% of 29) manager survey respondents. Interviews were scheduled with 14 (44% of 33) IPS survey respondents and 10 (67% of 15) of the manager survey respondents.

3.3.4 Consultations and interviews

A series of consultations were held with training participants, including:

- A focus group was arranged with six managers from non-COS in December 2012. Two cancelled on the day, and four participated
- Interviews were held with COS managers who had completed the Manager training
- Interviews were held with Brook RED staff and two trainers from Community Focus (one of whom had done the original Train the Trainer). These interviews covered IPS Basic training, Co-Supervision and Train the Trainer Teacher training, as appropriate.

3.3.5 Data analysis

Survey responses were analysed using SPSS version 21 and a range of descriptive statistics produced.

A thematic analysis was undertaken of data generated from the face-to-face and telephone consultations to identify key themes and issues and to better understand the experiences of training

participants. The thematic analysis was conducted using Grounded Theory, a technique that uses a constant comparative method of coding and recoding.[32,33]

3.4 Phase 3: COS - Evaluation

This section describes the methods used to conduct the COS evaluation, under the following headings:

1. Key Evaluation questions and data sources
2. Data collection strategy and consultation methods
3. Data analysis.

3.4.1 Evaluation questions and data sources

The key evaluation questions and data sources developed as part of the Project Plan to address the COS evaluation are itemised in *Table 3-3*. It is important to note that the evaluation focussed on the COS program model overall, rather than assessing the individual service providers who participated in the evaluation. For this reason, responses provided by IPS workers and service users are not identified by the COS program to which they apply. In some cases, however, individual COS organisations are identified for illustrative purposes only.

Table 3-3: Key Evaluation Questions - COS Program

Evaluation Objective	Evaluation Questions	Data Source proposed in Project Plan
Profile the people who receive support through the COS program	▪ Demographic characteristics ▪ Type and duration of support ▪ Outcomes	▪ Review of existing COS data from Department ▪ Consumer profile data from COS
Evaluate the effectiveness of the COS program by examining the processes employed to deliver the program	▪ What are the core components of the COS program? (including Service philosophy and model) ▪ What were the original objectives of the COS program? How do the current COS programs meet these? ▪ How well do the processes employed by the COS programs align with the processes outlined in the Department's COS Service Model Guidelines ▪ What stage of development do the COS programs perceive themselves to be at? ▪ What types of assistance are provided by the COS ▪ What is the organisational structure ▪ Number of workers (voluntary vs paid) ▪ Profile of workers: – lived experience of mental illness or not	▪ Review of policy documents ▪ Consultations with COS managers ▪ Consultations with peer workers at COS ▪ Consultations with COS IPS workers who have completed Co-supervision training

[32] J Saldana, *The coding manual for qualitative researchers*, Sage, USA, 2009.
[33] E DePoy & LGitlin, *Introduction to research: understanding and applying multiple strategies.* (2nd *Edition*), Mosby, St Louis, 1988.

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Evaluation Objective	Evaluation Questions	Data Source proposed in Project Plan
	- training undertaken - other relevant work experience. ▪ Process outcomes: - was the program implemented against the guidelines? e.g. target group, duration of support, active participation etc ▪ Identify achievements and obstacles ▪ Does the COS operate in a manner that supports the wellbeing of the PSW? ▪ Is there adequate and accessible supervision for PSWs? ▪ Consider start up issues vs longer term 'systemic' issues ▪ Identify obstacles that may be within the control of the COS and obstacles that are further out of reach. E.g. quality of partnerships with services, funding, etc. ▪ Implementation of risk management and quality assurance mechanisms ('do not harm' etc) ▪ Have any complaints been made? ▪ Linkages with other services providers and impact of relationship on these providers	
Determine the type and range of outcomes that are being achieved for the respective target cohort and ascertain the extent to which improved outcomes are linked to the COS program.	▪ What outcomes have been achieved by the target cohort? ▪ Did the consumer 'progress' towards recovery? ▪ Were there any unintended consequences? ▪ To what extent can these outcomes changes be linked to the COS program?	▪ Consumer snapshot data ▪ Changes in Recovery Assessment Survey (RAS) scores between entry and exit ▪ Consultations with COS managers ▪ Consultation with service users ▪ Consultation with Peer workers

While the evaluation questions remained unchanged throughout the evaluation project, changes were made to data collection strategy and consultation methods as outlined in Section 3.4.2 below.

3.4.2 Data collection strategy and consultation methods

The original data collection strategy and consultation methods identified in the Project Plan were developed prior to consulting with the COS service providers at the briefing held on 3 August 2012. At the briefing, the evaluation team presented details of the proposed data collection strategy and consultation methods, including the use of the changes in Recovery Assessment Survey (RAS) scores

between entry and exit as a measure of service user outcomes[34]. In the discussion that followed, two major issues emerged that impacted the data collection strategy that could be used in relation to COS service users:

- Contrary to expectations from the service model documentation review, it emerged that the COS did not operate on the basis of defined entry and exit points. Rather, service users' use of services was fluid, with some attending regularly (daily, weekly, monthly) while others attended intermittently on an 'as needed' basis depending on their circumstances at the time.
- Although COS programs operated with in a recovery philosophy, some of the language of recovery was often seen to be at odds with that of the peer support model that underpinned the COS operation. Terms such as 'goal setting' and measuring 'progress towards goals' were seen to be too aligned with traditional relationships between service providers and mental health service users. Because the COS promote alternate ways for service users to think about their experiences of mental illness, and the mental health service system, use of IPS-specific language was preferred.

Implications for proposed data collection strategy and consultation methods

The feedback provided by the COS service providers had a number of implications for the Evaluation, particularly in relation to the targeted data collection proposed in the Project Plan (refer *Table 3-4*).

Table 3-4: COS Evaluation – Data collection strategy proposed in the Project Plan

Consultation	Targeted data collection
▪ Profile of IPS workers in each COS ▪ Interview with manager in each COS ▪ Focus groups with IPS workers in each COS ▪ Interviews with IPS workers who have completed Co-Supervision training in each COS ▪ Telephone interviews with 2-3 service providers that the COS works with	▪ Changes in Recovery Assessment Survey (RAS) scores between program entry and exit ▪ Each COS to complete a proforma Client Profile detailing age, gender, diagnosis, cultural background etc of each service user who has used the service since its commencement ▪ Each COS to provide a snap shot of service users who have exited the program over the last 3 months detailing the type of assistance required and the outcomes achieved

Two main issues were identified with the above data collection method. First, the absence of clear entry and exit points made it impossible to:

- Conduct pre and post administration of the RAS over a 2 to 3 month period at each of the COS sites; or
- Construct a snap shot of service users who had exited over a 3 month period.

This was because service user follow-up could not be assured and sample size/representation was likely to be compromised as a result.

[34] In February 2010, the Australian Mental Health Outcomes and Classification Network (AMHOCN) published a review of available recovery measures, including instruments designed to measure individuals' recovery.[34] This included the RAS, a validated tool designed to assess various aspects of recovery from the perspective of the consumer, with a particular emphasis on hope and self-determination. The RAS was ranked in the AMHOCN review as being among the four best suited instruments for measuring individuals' recovery in the Australian public sector mental health services context.

Second, the RAS tool was deemed unsuitable. The phrasing of statements in the RAS was assessed by the COS service providers as being too goal-focused and therefore deemed inappropriate for use with their service users.

To address these issues and concerns, the proposed targeted data collection strategy was modified as follows:

- The RAS was replaced by a one month snap shot (cross sectional) survey period using a new tool (Appendix D) that consisted of a combination of selected Peer Outcomes Protocol (POP)35 modules, and questions taken from other sources such as the Brook RED Centre satisfaction survey (a modified form the Mental Health Statistics Improvement Program (MHSIP)) 36 and a number of anchoring questions related to service user demographics and service usage characteristics.
- Existing statistical reports produced by each COS for the Department as part of their regular reporting requirements replaced the proposed Service user Profile.

As both the POP and MHSIP instruments were developed in the USA, some modifications were required to the phrasing of selected questions used in the cross-sectional survey to render them appropriate to the Australian context. To ensure compatibility with the terminology/language used at Brook RED and FSG-PEARL, draft versions of the cross-sectional survey were circulated to service providers at each COS for feedback prior to implementation.

This revised approach facilitated data collection for all people who attended the COS across the different programs and activities during a one-month period (November 2012). It also minimised the impost on COS staff as the survey was completed by COS participants and distributed and collected by staff. It also became clear that some COS service users would need assistance to complete the survey, thus increasing the time staff would need to be available to assist with the survey implementation.

To optimise participation, service users had the option of submitting their completed survey in a sealed box located at each COS or by means of a pre-paid envelope provided. A total of 32 surveys were completed and returned, 21 from Brook RED and 11 from FSG-PEARL.

Site visits were made to both COS sites in December 2012 where consultations were conducted with managers, staff, peer workers and peers.

Telephone interviews were also conducted with a total of seven service providers that the COS works with.

3.4.3 Data Analysis

A thematic analysis was undertaken of data generated from the face-to-face and telephone consultations to identify key themes and issues and to better understand how the COS model operated

[35] The POP is a validated instrument designed to measure service and programmatic outcomes of self-help, peer support, and consumer operated programs in mental health. It is comprised of seven modules including: demographics, service use, employment, community life, quality of life, well-being, and program satisfaction. The protocol is structured so that modules can be selected or omitted depending on the needs of particular contexts/programs. Reference: J. Campbell, JA Cook. JA Jonikas and K Einspahr (2004) University of Illinois at Chicago add website Accessed 10/8/2012.

[36] The Brook RED satisfaction survey was a modified form the Mental Health Statistics Improvement Program(MHSIP). The MHSIP is a consumer survey consisting of 36 items and five domains: access, quality/appropriateness, outcomes, participation and general satisfaction http://www.mhsip.org/MHSIP_Adult_Survey.pdf Accessed 10/8/2012.

and the appropriateness of the IPS training for working in the COS environment. The thematic analysis was conducted using Grounded Theory, a technique that uses a constant comparative method of coding and recoding.[37,38]

3.5 Phase 4: Overall Evaluation - Report

In Phase 4, the findings from Phases 2 and 3 were synthesised and Draft and Final Reports produced.

3.6 Caveats and Limitations

The key caveats and limitations that apply to this Evaluation Report are summarised by Phase below.

3.6.1 Phase 2: IPS Training Evaluation

Key caveats and limitations that apply to the training evaluation fall into two categories:

- Timespan of the evaluation
- Data-related issues.

The training evaluation covered all IPS training conducted between 2008 and 2011. This timespan introduces a strong retrospective element to the evaluation and raises issues of recall and loss to follow-up of the trainees involved. Recall issues are likely to be most acute among those trainees who undertook training in the early years and may influence the clarity of the responses provided. Mobility in terms of job, residential and email addresses during the evaluation timeframe meant that some trainees were lost to follow-up. Contact details were either unavailable or inaccurate for 38 of the 133 (29%) of those who completed the IPS training and 45/89 (51%) of those who completed manager training (refer Figure 3-1). Nonetheless, a good response rate was achieved (46% and 66% for IPS and Manager survey recipients respectively).

While some limited training evaluation data was provided by the Department of Communities, this was insufficient to meet the needs of the evaluation.

Despite these limitations, we are confident that the results are likely to be reflective of the IPS-trained population as a whole, as information obtained in the consultations reinforced the findings from the survey results.

3.6.2 Phase 3: COS Model Evaluation

The key caveats and limitations that apply to the COS evaluation fall into three categories:

- Data-related issues
- Timeframe of study – accommodation component in early days
- Implications of the sudden death of the Brook RED COS manager.

[37] J Saldana, *The coding manual for qualitative researchers*, Sage, USA, 2009.
[38] E DePoy & L Gitlin, *Introduction to research: understanding and applying multiple strategies.* (2nd *Edition*), Mosby, St Louis, 1988.

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The proposed usage of existing Statistical Reports proved to be problematic because of errors in the template design, data entry errors, inconsistent interpretations and uncertainty regarding whether the data captured for each reporting period related to new service users only, or to both new and ongoing (see Section 9.1 for further details)

The small service user sample (interviews and survey participants) raises issues as to the generalisability of the finding. Furthermore, issues of service user literacy and impaired cognitive ability may also need to be considered in the interpretation of survey and consultation findings.

The timeframe of the study meant that the accommodation component of the COS programs were not long established. This is particularly true in the case of FSG-PEARL where the accommodation services did not become active until the July-December 2012 reporting period. Consequently, the full operational implications of the accommodation service may not yet be apparent in this formative stage of the program.

The sudden death of Jude Bugeja, Manager of the Brook RED COS, had several implications for the evaluation largely because the scheduled site visit occurred on the morning following Jude's death. Service users and staff were understandably upset by the sad news that had been announced only hours earlier. While staff explicitly chose to complete the consultations as planned, some of the service users scheduled for interview did not feel able to do so. For those staff and service users who did participate in the consultations, the shock of the death may have compromised clarity of their responses.

Jude's death also meant that the Brook RED manager's perspective is absent from this evaluation. Although many of the manager questions were subsequently addressed by the Brook RED Co-ordinator, Tyneal Hodges, the breadth of insight provided is likely to have been reduced.

Despite the caveats and limitations, we are confident that the Evaluation of the COS model reflects the innovation and high regard with which the program is held by the community involved.

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The following Chapters 4 to 10 detail the evaluation findings, as follows:

Part 1: Evaluation of Intentional Peer Support and manager training

4. Implementation of IPS training in Queensland
5. Findings: Effectiveness of IPS training
6. Findings: Effectiveness of manager training

Part 2: Evaluation of Consumer Operated Services model

7. Implementation of the COS model in the Queensland context
8. Effectiveness of COS model: Service level perspectives
9. Consumer Operated Services: Consumer profile
10. Effectiveness of Consumer Operated Services: Consumer level perspectives.

Part 1: Evaluation of Intentional Peer Support and Manager Training

4. Implementation of IPS training in Queensland

4 IMPLEMENTATION OF IPS TRAINING IN QUEENSLAND

This chapter outlines the implementation of the IPS training model in Queensland. Implementation is addressed in the context of the Queensland Government initiatives to develop a mental health peer workforce since 2007-2008 and the broader Queensland/Australian industrial education and training framework. In line with the scope of this evaluation, the focus of this chapter relates to IPS training held between 2008 and December 2011.

Data sources used in this chapter include:

- Queensland Government policy planning documents for mental health
- Australian Vocational Education and Training policy and training documents
- Interviews with representatives of Department of Communities/Health, December 2012
- Department of Communities/Health IPS training program promotional material
- AHA focus group held with Managers of non-COS community mental health NGOs in Queensland, who attended IPS Manager training between September 2008 and February 2011.
- AHA interview held with Shery Mead Consulting in June 2012 and website of Shery Mead Consulting www.intentionalpeersupport.org
- Shery Mead Consulting instructional design material
- Interviews with Community Focus and Brook RED, local IPS training providers, December 2012
- Interview with COS managers, December 2012.

This chapter is presented under the following headings:

1. Queensland Government initiatives to develop a mental health peer workforce
2. The origins of the IPS model in Queensland
3. Implementation of the IPS training program in Queensland (2008-2011)
4. Accredited mental health peer worker training in Australia
5. IPS training and Australian Qualifications Framework (AQF)
6. IPS training program quality assurance in Queensland
7. Recent developments in IPS training program development in Queensland (2012-2013)
8. Summary and implications of findings.

4.1 Queensland Government initiatives to develop a mental health peer workforce

Since 2007-2008 the Queensland Government has made significant investment in strategies to enhance the skills and knowledge of the community mental health workforce and improve workforce recruitment and retention rates. This investment has encompassed enhancing the recovery orientation of Queensland vocational education and training (VET) providers which provide relevant qualifications

to the community mental health workforce, but to date has stopped short of mandating a minimum VET qualification for Queensland community mental health support or peer support workers.[39]

Key Finding: Although there has been significant investment in the Queensland mental health workforce, there is a lack of data available to measure if the investment has resulted in improved recruitment and retention rates.

In *Supporting Recovery, Mental Health Community Service Plan 2011-2017*, the Department of Communities noted the Queensland Government allocation of one million dollars in 2010-2011 to support professional development of the community service workforce, including the community mental health workforce, through the Community Services Skilling Plan (the Skilling Plan)[40]. The purpose of the Skilling Plan 2012 was to develop a capable, skilled workforce which enhances service delivery across the community services continuum. Strategies to achieve this included linking community service workers to VET qualifications and grants, providing up-skilling programs for homelessness, youth, youth justice and child protection sector staff, plus mentoring programs for specific cohorts such as Aboriginal and Torres Strait Islander communities.[41]

In *Supporting Recovery,* the Department of Communities also outlined strategies to develop the community mental health workforce specifically, with a focus on peer support workers and the workforce needs of services in rural and remote areas, during 2011 to 2013.[42] Other actions planned for this period included:

- Implementation of mental health skills based training programs for front line mental health service delivery staff
- Continuation of strategies from 2007-2008 to:
  - ensure a recovery-orientation among VET providers of mental health qualifications
  - provide scholarships for community mental health staff to up-skill
  - provide and evaluate recovery-oriented leadership programs for mental health leaders in government and NGO organisations, including people with a lived experience of mental illness and their carers.[43]

Supporting Recovery also pledged Government action to continue the work of 2011-2013 and further develop the community mental health including the peer support workforce from 2013. Pledged actions included:

[39] Priority 3.6 A Valued Workforce, Supporting Recovery, Mental Health Community Service Plan 2011-2017, Department of Communities, reports on the Government's delivery on commitments made in the QLD Plan for Mental Health 2007 – 2017, under Priority Three Participation in the Community.
[40] Ibid. 3.6 A Valued Workforce
[41] QLD Department of Education, Training and Employment at http://training.qld.gov.au/information/skilling-plans/community-services/overview.html accessed 6-2-2013. The 2012 Skilling Plan built on both the Community Services Skilling Plan of 2011 and the Disability Services Skilling Plan.
[42] Priority 3.6 A Valued Workforce, Supporting Recovery, Mental Health Community Service Plan 2011-2017, Department of Communities, reports on the Government's delivery on commitments made in the QLD Plan for Mental Health 2007 – 2017, under Priority Three Participation in the Community.
[43] Ibid

- Incorporate Aboriginal and Torres Strait Islander and multicultural perspectives into all education and training programs targeted to the mental health community sector, including peer support training.
- Promote employment in the mental health community sector to new graduates and support new graduate staff through induction, cross-agency professional supervision, and study and peer support groups
- Investigate the feasibility of a minimum qualification for employment in the community mental health sector
- Support innovation in mental health education and training, including the development of undergraduate mental health programs and learning pathways which recognise prior learning.

4.2 Origins of the IPS training model in Queensland

The Department of Communities commenced planning for training of service users in 2007-2008, in consultation with the Brook RED Centre, which was the first organisation chosen to develop a consumer operated service (COS) in Queensland. The Department of Communities, Brook RED and the operator of the second COS program in Queensland (FSG Australia) agreed that while it was possible to recruit staff with lived experience of mental illness, or even with peer worker experience, it was not possible to establish a COS without training its new workforce.

The Department of Communities chose Shery Mead Consulting to develop the peer workforce of its COS and other Queensland mental health organisations. The Intentional Peer Support (IPS) model was developed by Shery Mead approximately fifteen years ago.[44] Research conducted by the Department of Communities indicated that outcomes for service users of Shery Mead IPS training programs and centres in the USA and New Zealand closely aligned with the Queensland proposal to develop a non-clinical COS program, "run by service users for service users".

4.3 Implementation of the IPS training program in Queensland (2008 - 2011)

4.3.1 Target groups

The Department of Communities determined that the key target groups for IPS training program participation were volunteers or staff already employed in consumer operated services, who self-identified as having a lived experience of mental illness. Where places in courses were available, the Department of Communities accepted peer workers from non-consumer operated services. These participants worked in:

- Queensland Government funded community mental health NGOs
- Organisations funded by the Commonwealth for the Personal Helpers and Mentors Scheme (PHaMS)
- Mental health consumer consultants in Queensland Health funded service organisations.

Other than the requirements to be working in the mental health service system, and self-identify as having a lived experience of mental illness, the prior learning of participants was not screened before training participation. Some participants however, had participated in NGO internally provided, non-AQF accredited mental health peer worker training prior to their participation in these training courses.

[44] www.intentionalpeersupport.org (website of Shery Mead Consulting) accessed 7-1-2013

4.3.2 Course selection

The selection of specific courses from the suite of Shery Mead training products were aligned with the developmental stage of service delivery of the COS programs. The *Overview of Future Directions* paper noted that in investigating the development of a potential mental health peer support model for Queensland, a number of peer support services were overviewed and that most shared the characteristic of a developmental approach to service delivery.[45]

All the IPS courses offered in Queensland by the Department of Communities/Health retained Shery Mead's copyright, and the same integrity of design and content as those offered in other parts of the world.[46]

Like the overseas services reviewed by the Queensland Government, both Brook RED and FSG Australia commenced COS program operations with non-residential services before developing retreat / residential crisis prevention services. As such the training courses provided prior to 2012 reflect the initial organisational learning needs of the COS to develop an IPS-informed workforce, capable of conducting IPS relationships with service users in COS day programs.

4.3.3 Training schedule

The first training course was offered in August 2008, in Brisbane. Courses were offered in the Sunshine Coast area from June 2010 and in the Hervey Bay area by early in 2011.

Table 4-1 provides details of the training program schedule in Queensland between 2008 and December 2011, plus brief overviews of each course, as described in the Department of Communities' promotional literature or as clarified with Shery Mead Consulting.[47,48]

Table 4-1 also demonstrates how provision of the IPS Basic 5 day training course during this time expanded from delivery solely by Shery Mead Consulting to include Brook RED and Community Focus. Community Focus is a community mental health NGO located in Maroochydore, Sunshine Coast, Queensland. Staff from both Community Focus and Brook RED participated in the IPS Train the Trainer Teachers Training 5 day course held February 2010 in Brisbane, which allowed them to subsequently provide the IPS Basic 5 day training.

Table 4-1: Queensland IPS Training Program, 2008 to December 2011

QLD IPS Training Program - 2008 – December 2011		
Date	Location	Provider
IPS Basic 5 day training course: Covers the basics of Intentional Peer Support and offers participants an opportunity to learn more about the IPS framework, the practice and basic evaluation using co-supervision.		
August 2008	Brisbane	Shery Mead Consulting

[45] Overview of Future Directions, Consumer Operated Services Program, November 2008, Updated October 2009, Queensland Government Disability Services
[46] Department of Health IPS Training program course promotional brochure for courses scheduled for 2012, notes, *"All courses are copyrighted by Shery Mead."*
[47] Department of Communities' IPS Training program course promotional literature for courses scheduled between August 2008 and December 2011
[48] AHA consultation with training designers/providers, Shery Mead and Chris Hansen, May 2012

4. Implementation of IPS training in Queensland

QLD IPS Training Program - 2008 – December 2011		
Date	Location	Provider
February 2009	Brisbane	Shery Mead Consulting
March 2010	Sunshine Coast	Shery Mead Consulting
June 2010	Brisbane	Brook Red
June 2010 to August 2011	Sunshine Coast	Community Focus
January 2011	Sunshine Coast	Brook Red
March 2011	Hervey Bay	Shery Mead Consulting
April to June 2011	Sunshine Coast	Community Focus
September 2011	Brisbane	Brook Red
September 2011	Brisbane	Brook Red
September to November 2011	Sunshine Coast	Community Focus
Co-supervision 2 day course: Within the IPS model, the process of co-supervision aims to keep IPS worker peer relationships on track. Covers developing a co-supervision relationship, creating a learning environment and practising co-supervision skills for self and others.		
February 2009	Brisbane	Shery Mead Consulting
March 2011	Sunshine Coast	Shery Mead Consulting
IPS Train the Trainer Teachers Training 5 day course: Training for trainers to provide, through co-facilitation, the 5 day IPS Basic 5 day training course.		
February 2010	Brisbane	Shery Mead Consulting
Managers course: Training for Managers or Coordinators of NGO Mental Health services who have or are interested in developing a peer workforce. Provides an overview of IPS and how to create peer friendly work environments.		
September 2008 (one day only)	Brisbane	Shery Mead Consulting
February 2009 (two day)	Brisbane	Shery Mead Consulting
February 2011 (two day)	Brisbane	Shery Mead Consulting
February 2011 (two day)	Hervey Bay	Shery Mead Consulting

4.3.4 Instructional design

The core purpose of the IPS training program in Queensland during this period was to provide participants with a way of developing relationships that were effective, mutually enhancing and which enabled both people (or a group of people) in the relationship to grow and challenge each other.[49],[50] Training in IPS involved learning how to practise four key skills, or tasks, namely:

- Connection
- Worldview

[49] AHA consultation with training designers/providers, Shery Mead and Chris Hansen, May 2012
[50] Intentional Peer Support: An Alternative Approach, IPS Training Manual. Shery Mead, NSW, 2005/2007/2008

- Mutuality
- Moving towards.[51, 52, 53]

Understanding and practising these four key skills required, or was enhanced by, a lived experience of mental illness and consumer experience of the mental health service system. That is, IPS is characterised as different from traditional relationships between service providers and service users, and promotes alternate ways for service users to think about their experiences.[54] As such, 'learning IPS' also involved learning about:

- What makes IPS different
- Listening with intention
- Challenging old roles
- Understanding trauma worldview and trauma re-enactment
- Working towards shared responsibility and shared power
- Creating a vision
- Using supervision as a tool to maintain values in action.[55]

Instructional design[56] refers to how the learning experience or process is organised. The curriculum and support materials used in the IPS training program in Queensland between 2008 and December 2011 were provided to AHA,[57] and their intended use discussed with Shery Mead Consulting. The IPS training program design is summarised in *Table 4-2*.

Table 4-2: Summary IPS Training Program design in Queensland, 2008 to December 2011

Learning component	Target group or Pre-requisites	Key classroom resource(s)	Classroom assessment	Reaction to learning evaluation	Ongoing learning
Core training program courses					
IPS Basic 5 day training course (IPS Basic)	Paid/unpaid peer workers (lived experience of mental health issues)	Pre-course self-assessment IPS Manual	Optional action planning Post course self-assessment	Daily (verbal) End of course (written)	IPS Manual review Action Plans for next year *Since June 2011:* Competencies as self-reflection
2 day Co-supervisors course	Completion of the IPS Basic	Power point handout Role plays	No	Daily (verbal) End of course (written)	

[51] Ibid
[52] AHA consultation with training designers/providers, Shery Mead and Chris Hansen, June 2012
[53] QLD Department of Health Promotional material for Advanced IPS training course 2 days, 2012.
[54] AHA consultation with training designers/providers, Shery Mead and Chris Hansen, May 2012
[55] www.intentionalpeersupport.org (website of Shery Mead Consulting) accessed 7-1-2013
[56] The term Instructional design is defined at www.instructionaldesign.org (accessed 15-1-2013) as, "The process by which instruction is improved through the analysis of learning needs and systematic development of learning materials."
[57] Instructional Design materials included: Managers Handout 2011; Facilitators Training Handout 2010; Train the Trainer Manual 2011; IPS Core Competencies Condensed; IPS Core Competencies Full Version; Co-supervision handout Aus 2012; 5 Day IPS Training Information sheet V4; Intentional Peer Support Flyer 2011; Application form 5 Day IPS; Intentional Peer Support: An Alternative Approach, IPS Training Manual, Shery Mead, 2005/2007/2008

4. Implementation of IPS training in Queensland

Learning component	Target group or Pre-requisites	Key classroom resource(s)	Classroom assessment	Reaction to learning evaluation	Ongoing learning
IPS Train the Trainer Teachers training course					
IPS Train the Trainer Teachers 5 day training course	Completion of: -IPS Basic -IPS Basic Manual exercises -some IPS Basic Manual reading references -co-supervision meetings *Since Feb 2010:* -applicant screening	Train the Facilitator in IPS Manual	IPS Self-assessment tool	Review of course learning objectives, during and at end of course *Since February 2010:* Individualised evaluation process whereby participants receive advice/ approval on their suitability to provide future IPS training, from Shery Mead Consulting	
Managers training course					
Managers of NGO mental health services 2 day course	Interest in developing or have developed a peer workforce.	Powerpoint handout Reading materials	Optional NGO self-assessment and planning	Daily (verbal) End of course (written)	*Since June 2011:* Competencies for use as performance review tool with staff

More detailed analysis of the instructional design information sources revealed:

- A predominant use of experiential[58] delivery modes, which require the trainer to be skilled in group facilitation, is prioritised across all courses. Use of role play, role play debriefing and a facilitated, non-lecture delivery style where the trainer role models the values underpinning the course content were strong, as is appropriate to the primarily affective learning domain with which this training program is concerned.[59]
- The IPS Basic five day training course is the core of the training program design, with completion of this course a pre-requisite for peer worker participation in subsequent courses.
- The IPS Train the Trainer Teachers training course was only delivered once in Queensland. Shery Mead Consulting advised AHA that their delivery of this course did not result in its learning objectives being met. In particular, at the end of the course not all participants could successfully deliver training to adult learners or role model IPS while facilitating.

[58] The term experiential delivery refers to a mode of training delivery which encompasses role playing, debrief of role plays, simulations, individual and group based activities, and facilitation of learning. Lecturing or provision of information are not features of this delivery mode. Source: Wilson, A. L., 1993, The Promise of Situated Cognition, in An Update on Adult Learning Theory, Merriam S., (ed), Jossey Bass, San Francisco, pp 71 – 79.

[59] The Taxonomy of Educational Objectives: Handbook II The Affective Domain. Bloom B, Masia, Krathwohl, 1964. Other learning domains discussed by Bloom, et al are: cognitive (knowledge) and psychomotor (skills, including interpersonal)

As a result of delivering this course, Shery Mead Consulting have not yet delivered it again in Queensland, and have delivered it less often globally. They have also introduced an application screening process which affects who can participate in the training, and incorporated an end of course individualised evaluation process whereby participants receive advice/ approval on their future IPS training program provision suitability, from Shery Mead Consulting.

- Assessment of participant learning in the Queensland IPS training program is informal and not enforced by Shery Mead Consulting. However homework and ways for participants to apply learning from and beyond the classroom is encouraged.

  Between 2008 and December 2011 Shery Mead Consulting introduced another means of encouraging application of learning from the classroom, into the IPS training program design, via use of course competencies (Appendix E), in both Queensland and elsewhere.

  The course competencies were developed in June 2011 in the USA and target the behaviours participants should adopt when practising IPS. The course competencies are not time-bound, nor yet validated, but the IPS training program design indicates participants should be competent in these behaviours within a year of attending an IPS Basic five day training course.[60,61]

  The competencies are also integrated into the co-supervision training and emphasised in the managers' course as a tool for reviewing peer work performance. At the time of interview with Shery Mead Consulting, introduction of behavioural competencies into Train the Trainer Teachers courses was yet to be decided.

- The IPS course competencies in use are:
  - Demonstrate the intention of learning as opposed to the intention of helping
  - Focus on the relationship (rather than individual) and how it is working for both people
  - Have awareness of own intentions (e.g.: agendas, assumptions)
  - Value and validate others and demonstrate mutual empathy
  - Use language that describes things as they are experienced; uses language that is free of medical jargon, assumptions, judgements, generalisations and characterisations
  - Understand how a person's past experiences impacts who they are, how they think, and how they relate
  - Invite conversation that shifts from a problem focus to a creating focus
  - Give and receive difficult messages with awareness of other worldviews as well as one's own
  - Sit with discomfort and negotiate fear, anger, and conflict
  - Attend and fully participate in co-supervision and have the desire and ability to self-reflect.[62]

[60]Training designers/providers advised during consultation that the course competencies are in development with the Human Resources Research Institute (http://www.hsri.org), but have not yet been validated.
[61] The IPS Basic 5 day training course design requires participants to develop a personal and co-supervision focus plan for the year following attendance at the training.
[62] Intentional Peer Support Core Competencies – Full Version. Revised December 29, 2011.

4.4 Accredited mental health peer worker training in Australia

4.4.1 The Australian Quality Framework

In Australia, education and training which leads to qualifications for use in the workforce, or accredited training, is a shared responsibility of all Commonwealth, State and Territory governments. Education, training and employment ministers collectively own and are responsible for the Australian Quality Framework (AQF).[63] The AQF was first introduced in 1995 (revised 2011) and is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector (higher education, vocational education and training (VET), and schools) into a single comprehensive national qualifications framework.

The framework also underpins the national regulatory and quality assurance arrangements for education and training, including those that guide the accrediting authorities and institutions providing education and training. The accreditation of AQF qualifications, the authorisation of organisations to issue them, and the ongoing quality assurance of qualifications and issuing organisations is legislated within Australian jurisdictions.

The many other AQF stakeholders include industry and its representative bodies, unions, professional associations and licensing authorities and governments. Ultimately, students, graduates and employers, both Australian and international, benefit from the quality qualifications that are built on the requirements of the AQF. The AQF is also responsible for policies covering transfers between institutions and recognition of prior learning (RPL) credits.[64]

4.4.2 Vocational Educational Training (VET) Quality Framework

VET providers can offer qualifications at the following levels if they are registered as training providers (RTOs) through the Australian Government's Australian Skills Quality Authority:

- Certificates I, II, III and IV
- Diploma
- Advanced Diploma
- Vocational Graduate Certificate
- Vocational Graduate Diploma.

Verification of AQF qualifications, and the organisations authorised to issue them, is through the AQF register. Currently, approximately 5,000 RTOs are registered.[65]

All RTOs must comply with standards set out in the VET Quality Framework. For example, RTOs must have defined strategies and procedures in place to ensure assessment of participants for qualification, including RPL, is systematically moderated and validated.[66] Moderation involves trainers/assessors working in collaboration to review their assessment process and outcomes, including validating their assessment methods and tools. Moderation ensures that the outcomes of qualifications or units of competency are consistent across all RTOs, which helps to ensure industry confidence in its workforce

[63] http://www.aqf.edu.au Accessed 1 February 2013
[64] Ibid
[65] http://www.asqa.gov.au/about-vet/about-rtos/about-rtos.html Accessed 1 February 2013
[66] Ibid.

and the VET system. Moderation also ensures that assessments of learners are valid, fair, reliable and flexible.[67]

Key Finding: Training outside the AQF is not systematically moderated and validated which potentially erodes industry confidence in the qualification and disadvantages trainees who may not be getting valid, fair, reliable and flexible assessments.

RTOs can apply for national and state and territory funding to deliver vocational education and training.[68]

4.4.3 Mental Health Peer training in Australia: The Community Services Training Package

National Industry Skills Councils are funded by the Australian Government to develop and maintain VET Training Packages, in consultation with the relevant industry. The Community Services and Health Industry Skills Council is responsible for the Community Services Training Package and the Health Training Package. A hallmark of Australian Training Package design is training/ career pathways through qualification levels.[69] As an individual moves up through VET training pathways access to industry or career or employment pathways which support, reinforce and reward the learning initiative becomes important.

The Community Services Training Package (2008) includes a Certificate IV in Mental Health Peer Work (CHC42912). While this Package was available to RTOs from 2008, the Certificate IV in Mental Health Peer Work qualification only commenced development in 2010. It was endorsed and released for RTOs to access on 20 April 2012.[70]

This qualification descriptor is:

> *Consumer workers and carer workers who are employed within the mental health sector in government, public, private or community managed services. This qualification is specific to workers who have lived experience of mental health problems as either consumer or carer and who work in mental health services in roles that support consumer peers or carer peers. Occupational titles may include:*
>
> - *Consumer consultant, consumer representative, peer support worker, peer mentor, youth peer worker, carer consultant, carer representative, Aboriginal peer worker, participation coordinator, family advocate.*[71]

Fifteen units of competency must be selected for award of this qualification. Of the 15 units, six are deemed core units to earn the qualification, and therefore are compulsory. A number of rules apply to how the remaining nine elective units must be chosen. These rules and elective competency unit options are outlined in Appendix F.

[67] http://www.tpatwork.com/Back-2-Basics/Delivery-basics/Assessment-and-moderation.aspx Accessed 1 February 2013
[68] http://www.asqa.gov.au/about-vet/about-rtos/about-rtos.html Options for specific Registered Training Organisations to apply for funding from these three sources may be affected by their scope of registration and the number of states and/or territory in which they operate.
[69] Community Services & Health Industry Skills Council https://www.cshisc.com.au/index.php?option=com_content&task=section&id=6&Itemid=123
[70] Community Services and Health Industry Skills Council, Personal correspondence, 4 June 2013.
[71] http://training.gov.au Accessed 19-12-2013 and 4-1-2013

4. Implementation of IPS training in Queensland

Achievement of any Certificate IV qualification in VET indicates that the worker may function independently in the workplace. Individuals need to demonstrate consistency of performance over time to be assessed as competent. Particular Certificate IV units of competency may be recommended as pre-requisites for individuals who wish to focus on specific qualifications at Diploma level, and the requirement to be working in a relevant work role is very likely.[72]

Two Australian RTOs currently have the qualification or units of the CHC42912 Certificate IV in Mental Health Peer Work on their scope of registration. None of the IPS training program stakeholders interviewed or surveyed by AHA for this evaluation indicated that they had earnt this qualification to date. The RTOs are:

- GP Links Wide Bay Ltd, trading as Health Industry Training Queensland
- Minister for Employment, Higher Education and Skills, trading as TAFE SA Adelaide South Institute.[73]

4.5 IPS training and Australian Qualifications Framework (AQF)

The training designed and provided by Shery Mead Consulting in Queensland was not accredited within the Australian Qualifications Framework (AQF). Although the Department of Communities was familiar with VET sector processes through its work to deliver on commitments made in the Queensland Plan for Mental Health 2007-2017, consultations with key Department stakeholders indicated that detailed consideration of an AQF-endorsed community mental health peer support workforce was not a high priority for the Department of Communities in 2007-2008 because of the process involved in securing AQF-endorsement for the IPS training. Nevertheless access by this workforce to career pathways, recognition of prior learning (RPL) and accredited qualifications were considered an option for the future.

Key Finding: No mandatory qualification for community mental health workers means that the sector will continue to suffer from the perception of an unprofessionalised workforce and experience the industrial issues related to pay scales and occupational recognition that accompany a non-accredited worker group in the broader mental health workforce.

Key Finding: The Shery Mead Consulting training packages are not accredited under the AQF. This potentially disadvantages workers with respect to career pathways and recognition of prior learning.

4.6 IPS training program quality assurance in Queensland

4.6.1 Role of the Department of Communities/Health

Since 2008 to date, the Department of Communities/Health has not taken a role in monitoring the quality or the consistency of training design and delivery by either Shery Mead Consulting or local IPS training providers. Instead, responsibility for any moderation of assessment processes or quality control of training design and delivery has been referred to Shery Mead Consulting.

[72] www.cshisc.com.au Accessed 4-1-2013
[73] http://training.gov.au Accessed 19-12-2013 and 4-1-2013

4.6.2 Trainer-lead initiatives

As noted, Shery Mead Consulting does not operate within the AQF. AHA found no evidence that Shery Mead Consulting has utilised any moderation process to ensure the assessment of learners within the IPS training program in Queensland was valid, fair, reliable or flexible.

Key examples of difference among local IPS training providers in regard to the IPS 5 day Basic course included:

- In consultation with Shery Mead Consulting, Community Focus first trialled spreading course delivery of the IPS Basic 5 day course over a number of months, from mid-2010. Community Focus has continued this practice since then, in order to better accommodate participant application of learning over time.
- Community Focus has formalised its participant assessment requirements, by introducing a written pre-course checklist, plus setting expectations about course attendance and assessment task completion based on the course competencies. When Community Focus course participants have not sufficiently completed assessment tasks, they have been invited to repeat the training until competency is assessed as met.
- Brook RED reported using the core competencies to encourage participant self-reflection and foster reflective IPS practice, rather than "giving marks", or assessing learner competency in the same way as Community Focus does.
- Brook RED has introduced an Expression of Interest screening mechanism into selection of participants for this training. (So far no one who has applied has been excluded).

Key Finding: Formalising competency and/or assessment procedures so they are transparent and reproducible would assist industry confidence in the IPS and Manager training courses.

Also as noted, since 2011 the Department of Health and Shery Mead Consulting have scheduled IPS training courses which require participants to have completed pre-requisites. This is particularly so for those participants who wish to join the IPS Train the Trainer Teachers Training Course.[74] While the emergence of a learning pathway through the IPS training program may be of benefit to some IPS training program participants, the criteria used to select participants for this course is not clear. In comparison, the AQF sets out clear policies around learner transfers between institutions and RPL.[75] Such transparency underpins the principle which informs Australian training package design, namely to foster career pathways for all learners through qualification levels.[76]

Given these findings on inconsistencies and variation, consideration of ways learners may benefit from integration of the IPS training program in Queensland into the Australian accredited training system may be warranted.

[74] As noted at *Table 5-5: Indicative Queensland IPS Training Program content in 2013*, to be eligible to join the IPS Train the Trainer Teachers Training 5 day course, participants will need to have: completed the Facilitators Course 3 days; implemented learning from the Facilitators course in their agencies over time; completed an application process

[75] http://www.aqf.edu.au

[76] Community Services & Health Industry Skills Council https://www.cshisc.com.au/index.php?option=com_content&task=section&id=6&Itemid=123

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Key Finding: Ensuring the IPS and Managers training becomes accredited under the AQF would assist in building the community mental health workforce through industry and training participant confidence. It would also reduce inconsistencies and variations between courses.

4.6.3 The Australian Skills Quality Authority

The Australian Skills Quality Authority (ASQA)[77] is the national regulator for Australia's vocational education and training sector, and ensures nationally approved quality standards are met. ASQA provides information on ways to integrate non-accredited courses into the AQF[78]. For example, possible ways to integrate may include Shery Mead Consulting partnering with Australian RTO(s).

In any consideration of how to integrate the IPS training program in Queensland into the Australian accredited training context, it may also be useful to consider ways to harness:

- The existing CHC42912 Certificate IV in Mental Health Peer Work qualification.
- The Queensland RTO which already has the CHC42912 on its scope of registration (GP Links Wide Bay Ltd, trading as Health Industry Training Queensland)
- FSG Australia's status as an RTO, with the Certificates III and IV in Disabilities plus the Certificate IV in Mental Health already on its scope of registration[79], plus its commitment to,
  - "…partner with other RTO agencies to deliver nationally recognised training and qualifications to further increase the learning opportunities of our staff. Our continual focus is on offering pathways for our employees…"[80].

Key Finding: Synergies between current planning discussions among Queensland IPS training program stakeholders on ways to expand the delivery of Shery Mead Consulting IPS training products by local IPS training providers, and advice available from the Australian Skills Quality Authority (ASQA), may also be worth exploring.

4.7 Recent developments in IPS training program development in Queensland (2012-2013)

After December 2011 the IPS training program in Queensland remained unaccredited. It also continued to develop in line with the developmental needs of the COS. For example, as each COS introduced the retreat/ residential component of their service in late 2011 and 2012 respectively, COS service providers expressed disquiet over their capacity to manage risk in the context of retreat / respite residential services' implementation. The concern was addressed via the Department of Health scheduling and promoting a two day IPS Crisis Work course from the Shery Mead Consulting suite of training products, which was delivered by Shery Mead Consulting.

[77] The ASQA website is www.asqa.gov.au
[78] See www.asqa.gov.au for full details.
[79] www.fsg.org.au/whatwedo/training-employment accessed 06-02-2013.
[80] Ibid

4. Implementation of IPS training in Queensland

Table 4-3 provides an indication of the content of IPS courses offered in Queensland during 2012, with descriptions of each course taken from the Department of Health promotional literature.[81] Additional information provided in the promotional literature, about target participants for each course, has also been included. This target participant information:

- Reinforces the way in which specific Shery Mead Consulting training products were aligned with the developmental stage of service delivery of the COS programs
- Demonstrates an emerging workforce need for up skilling in IPS, once a graduate of the IPS Basic 5 day training course has had time to assimilate their learning in the workplace
- Outlines more stringent entry requirements of participants for the IPS Train the Trainer Teachers Training 5 day course, in comparison to the 2010 IPS Train the Trainer Teachers Training 5 day course
- Indicates a developing learning pathway within the IPS training program in Queensland for the cohort of learners who progress to the IPS Train the Trainer Teachers Training 5 day course.

Table 4-4: Indicative Queensland IPS Training Program content in 2012

QLD IPS Training Program courses 2012
Crisis work 2 day training course:
This training is intended for peer workers who are, or will be, working in the residential components (retreats) of the COS services
Peer Run Crisis Programs are springing up all over the USA, and other countries. While there seems to be a direct correlation between decreased admission to hospitals and increased use of these programs, it is important to also measure success in terms of what's gained rather than just keeping people out of the hospital. This training will focus on crisis as a time to connect, to maintain mutuality and to build a culture of healing between members of the respite community. We will practice challenging scenarios as well as learn how to proactively interview potential guests.
Advanced IPS training course 2 days:
COS programs need to prioritise workers to attend this training according to their length of experience practising IPS.
This training offers participants a more in-depth skill building into the practices of Intentional Peer Support (connection, worldview, mutuality and moving towards). It focuses on difficult situations (e.g. conflict, self-harm, suicide, intense feelings and behaviour) and also on real life situations that participants bring to the workshop. COS programs need to prioritise workers to attend this training according to their length of experience practising IPS.
Facilitators Training course 3 days:
This course is subject to a selection process and applicants will be asked to complete a short questionnaire. Participants can progress to future 5-day Trainers' Training in IPS (**IPS Train the Trainer Teachers Training 5 day course**) after having implemented their learnings from this training in their agencies over a period of time, as well as completing the application process for the Trainers' Training.
This training offers advanced IPS practitioners the opportunity to develop their content knowledge of

[81] Department of Health IPS Training program course promotional brochure for courses scheduled for 2012.

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QLD IPS Training Program courses 2012
IPS while also learning skills aimed at facilitating small groups and one to one training. Some of these skills include: understanding group dynamics, difficult situations, working with a wide range of participants etc.

Both Brook RED and FSG advised AHA that they now regularly provide training in IPS internally within their own respective organisations. For example in late 2012 FSG commenced a major, still current, initiative to deliver training in IPS for non-IPS managers of FSG's community mental health programs and to their senior executive FSG staff. Both organisations reported that their internal training delivery was conducted with the knowledge and approval of Shery Mead Consulting.

Brook RED has also recently delivered manager training courses externally, to Queensland non-government organisations, on behalf of or in conjunction with Shery Mead Consulting.

Both organisations reported to AHA on their discussions with the Department of Health about how this local IPS training activity is set to increase in 2013, in the context of a planned visit by Shery Mead Consulting to Queensland to deliver an IPS Train the Trainer Teachers Training 5 day course, as well as other IPS courses, in March 2013. Discussion points regarding an increase in delivery of Shery Mead Consulting training products by local IPS training providers in Queensland among the key IPS training program stakeholders have included:

- Brook RED developing an IPS not for profit 'training hub', where IPS course content, trainer expertise and course materials can be further developed and produced
- An expansion in IPS training delivery by Brook RED to external Queensland parties
- The role of the Department of Health in providing funds for IPS training program expansion and 'training hub' development
- Consultation with Shery Mead Consulting on plans for IPS training program expansion and 'training hub' development
- FSG Australia providing some form of administrative function in regard to IPS training program and 'training hub' development funding.

In late December 2012 however the Department of Health advised AHA that this planning was on hold, due to the sudden death of Jude Bujega, General Manager at Brook RED, and because of internal government administration changes related to the way in which community mental health non-government organisations are contracted. Prior to the hold, no time frame had been set for transition from Shery Mead Consulting training provision to local training provision.

The following *Table 4-5* provides an indication of IPS course planning for 2013 by the Department of Health, before the hold. Information about the content of these courses was summarised by AHA from the Department of Health's 2012 IPS training program course promotional brochure and brochures prior to 2012.

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Table 4-5: Indicative Queensland IPS Training Program content in 2013

QLD IPS Training Program - Planned course 2013		
Date	Provider	IPS Course
March 2013	Shery Mead Consulting	IPS Train the Trainer Teachers Training 5 day course: To be eligible participants will need to have: ▪ Completed the Facilitators Course 3 days ▪ Implemented learning from the Facilitators course in their agencies over time ▪ Completed an application process
TBC	Shery Mead Consulting	Co-Supervision 2 day course: Within the IPS model, the process of co-supervision aims to keep IPS worker peer relationships on track. Covers developing a co-supervision relationship, creating a learning environment and practising co-supervision skills for self and others

4.8 Summary and implications of findings

There has been significant investment in the Queensland mental health workforce, however there is a lack of data available to measure if the investment has resulted in improved recruitment and retention rates. These data issues are highlighted repeatedly in subsequent chapters of this report.

The fact that there is no mandatory qualification for community mental health workers means that the sector will continue to suffer from the perception of an unprofessionalised workforce and experience the industrial issues related to pay scales and occupational recognition that accompany a non-accredited worker group in the broader mental health workforce.

The Shery Mead Consulting training packages are not accredited with the AQF, which potentially disadvantages workers with respect to career pathways and recognition of prior learning. Training outside the AQF is not systematically moderated and validated which potentially erodes industry confidence in the qualification and disadvantages trainees who may not be getting valid, fair, reliable and flexible assessments. Formalising competency and/or assessment procedures so they are transparent and reproducible would assist industry confidence in the IPS and manager training courses.

Ensuring the IPS and managers training becomes accredited under the AQF would assist in building the community mental health workforce through industry and training participant confidence. It would also result in decreased inconsistency and variation between courses. Synergies between current planning discussions among Queensland IPS training program stakeholders on ways to expand the delivery of Shery Mead Consulting IPS training products by local IPS training providers, and advice available from the Australian Skills Quality Authority (ASQA), may also be worth exploring.

5 FINDINGS: EFFECTIVENESS OF IPS TRAINING

In this chapter, the effectiveness of the IPS training is assessed using two main data sources:

- Training survey
- Consultations with those who completed IPS training.

As outlined in Chapter 4, IPS training between 2008 and December 2011 took three different forms, namely:

- 5-day IPS Basic training
- 2-day Co-supervision training
- 5-day Train the Trainer Teachers training.

For the purposes of clarity, 'IPS training' is used as a collective term to include the three different forms of the training. 'Manager training' is the collective term to describe the one or two day training delivered specifically to managers. The effectiveness of the IPS training is considered in this chapter, the effectiveness of the manager training is discussed in Chapter 6.

Findings are presented in this chapter under the following headings:

1. Profile of survey respondents
2. Effectiveness of IPS training in preparing peer workers in the peer support role
3. Additional IPS topics suggested
4. Effectiveness of IPS training in promoting and helping to build a peer workforce
5. Satisfaction with IPS training
6. Satisfaction with Co-supervision training
7. Satisfaction with Train the Trainer Teachers Training
8. Summary and implications of findings.

5.1 Profile of survey respondents

The IPS training survey was distributed to 97 IPS training participants with a response rate of 47% (46 perticipants). The training survey requested information from IPS training recipients on several aspects of the training and their views on how the training prepared them for work in the peer support workforce. Demographic characteristics were also captured thus making it possible to generate a profile of the IPS training recipients. This section presents demographic details of the survey respondents. In addition, the survey elicited information about what motivated respondents to undertake IPS training and their level of previous experience in peer support roles.

The profile of survey respondents is shown in *Table 5-1*.

5. Findings: Effectiveness of IPS training

Table 5-1: Profile of survey respondents

Characteristic	Respondents n= 46
Gender	
Male	15 (33%)
Female	41 (67%)
Age	
18-29 years	7 (15%)
30-39 years	9 (20%)
40-49 years	17 (37%)
50-59 years	11 (24%)
60+years	2 (4%)
Background	
Aboriginal and Torres Strait Islander	1 (2%)
Culturally and Linguistically Diverse (CALD)	2 (4%)
Lived experience of mental illness	46 (100%)

Three of the 46 IPS survey respondents were managers. To ensure completeness of the IPS survey analyses, the responses of these three managers in relation to the IPS training have been included in the IPS survey figures. Their responses to questions relating to the manager training are included in the appropriate sections in Chapter 6.

More than one-third of all respondents were female and aged over 30 years. Very few were of Aboriginal and or Torres Strait Islander or CALD background. All 46 respondents had a lived experience of mental illness.

It should be noted that some respondents did not complete all sections of the survey. As a result, the total number of responses identified in the sections that follow may not match the total number of respondents indicated in *Table 5.1*, because of missing values.

Survey responses were obtained across the full range of IPS courses delivered between 2008 and 2011 (*Table 5-2*).

Table 5-2: Number of respondents by course

When provided	Course details	Training provider	Respondents n=46
August 2008	5 Day IPS Basic training	Shery Mead Consulting	7
Feb 2009	5 Day IPS Basic training	Shery Mead Consulting	8
Mar 2010	5 Day IPS Basic training	Shery Mead Consulting	10
June 2010	5 Day IPS Basic training	Brook RED	8
June-Aug 2010	5 Day IPS Basic training	Community Focus	2

5. Findings: Effectiveness of IPS training

When provided	Course details	Training provider	Respondents n=46
Jan 2011	5 Day IPS training (to PEARL)	Brook RED	4
Mar 2011	5 Day IPS training	Shery Mead Consulting	8
April – Jun 2011	Community Focus staff	Community Focus	2
Sept 2011	Brook RED Staff	Brook RED	7
Sept 2011	FSG staff	Brook RED	4
Sept-Nov 2011	Community Focus	Community Focus	2
Feb 2009	2 Day Co-supervision training	Shery Mead Consulting	8
March 2011	2 Day Co-supervision training	Shery Mead Consulting	9
Feb 2010	5-day Train the Trainer Teachers training	Shery Mead Consulting	5
Total*	14 courses	3 providers	84

* The number of respondents by course exceeds the total number of respondents because some respondents undertook multiple IPS courses.

Further analysis of attendance patterns revealed that some respondents undertook the same course multiple times. Two respondents completed the 5-day IPS training course with Shery Mead Consulting twice and one did so on three occasions. One of these same respondents then went on to do the 5-day IPS training course with Brook RED trainers twice more and another respondent did so three times more. One of these same respondents subsequently did both of the Co-supervision courses delivered by Shery Mead Consulting. Another two respondents completed the 5-day IPS training course with Shery Mead Consulting and then later did the 5-day IPS training course with Community Focus.

These findings from the survey are consistent with what peer workers who had completed IPS training reported during the consultations. As one peer worker stated: "*The first time you do the training it leads to a personal journey. The second time it's about applying it to working with others and practicing*."

This duplication of course attendance raises two key issues. First, the fact that some respondents undertook the same course multiple times raises the question of whether the initial training is adequate to equip participants for the IPS worker role.

Second, the effectiveness of the course eligibility criteria is called into question if the same applicants can undertake the same course on multiple occasions. This is of particular concern in the case of courses delivered by Shery Mead Consulting as these courses are funded by the Department and access to these external providers is limited. 'Double-dipping' by trainees means that the pool of individuals who can receive training is restricted, thus raising the question of whether the current course eligibility criteria ensures the most appropriate use of training resources. This issue is less acute in organisations such as Brook RED where additional training is provided in-house to their own staff. Consultations with Brook RED peer workers indicated that undertaking multiple IPS courses was common practice as it serviced as both a refresher course and professional development opportunities for the staff involved.

It also emerged that one respondent reported having completed the Co-supervision course without having completed the prerequisite 5-day IPS training course. This anomaly also suggests that the processes for establishing eligibility for courses could be improved.

Key Finding: Course participation patterns indicate that the IPS courses may not always be adequate to equip workers for the IPS worker role.

Key Finding: Inconsistent eligibility criteria for entry into courses means that some people are doing the one course multiple times and on occasion, people are doing courses without prerequisite knowledge.

Key Finding: Some individuals are accessing the 5-day base IPS course as a means of continuing skills development. An alternative to utilisation of the basic course may warrant consideration.

Motivation for undertaking training

The main reasons cited for doing the IPS training are shown in *Table 5-3*. The majority of respondents were self-motivated, with only eight respondents (18%) indicating that the impetus for course attendance came from their manager. The most frequently cited reason for undertaking IPS training (12 respondents, 27%) was seeking to assist other service users towards recovery. A desire to become a peer support worker and being interested in finding out more about the peer support role each accounted for eight (18%) responses. All four respondents who provided 'other' responses reported being already employed in a peer/consumer role and therefore, the survey response options provided did not apply in their case.

Table 5-3: Reasons for undertaking IPS training

Reasons for undertaking IPS training	Respondents n=44
I wanted to become a Peer Support Worker	8 (18%)
I was interested in finding out more about the PSW role	8 (18%)
I wanted to assist other service users towards recovery	12 (27%)
I wanted to do it for my personal or self-development	2 (5%)
I wanted to work within the mental health sector	2 (5%)
My manager suggested I do the training	8 (18%)
Other	4 (9%)

Peer work prior to training

Of the survey respondents who provided information about peer roles prior to undertaking IPS training, more than half (24 of 44, 55%) indicated that they had worked as a Peer support worker. Of the 15 respondents who provided duration details, time in the role (prior to IPS training) ranged from one to 10 years.

5. Findings: Effectiveness of IPS training

Of the 24 respondents who had been employed as Peer support workers prior to undertaking IPS training, eight (33%) had been employed by Personal Helpers and Mentors (PHaMS) services (Table 5-4). Queensland Health and other non-government community mental health services were also key employers, each accounting for 21% of the previously employed peer workers (Table 5-4).

Table 5-4: Services where IPS training participants were employed

Services where IPS training participants were employed	Number (%)
Funded under the Consumer Operated Service Program	3 (13%)
Consumer-run services (other)	2 (8%)
Personal Helpers and Mentors (PHaMS)	8 (33%)
Queensland Health	5 (21%)
Other non-government community mental health service	5 (21%)
Other	1 (4%)

In most cases, these previous roles were part-time (19 of 22, 86%) and paid (21 of 24, 86%).

Compliance with Department of Communities target participant guidelines

The Department of Communities guidelines indicate that the key target groups for IPS training were volunteers or staff already employed in COS (Chapter 4) who self-identified as having a lived experience of mental illness. Where places were available in course, workers from non-COS could be accepted. While all respondents matched the lived experience criteria (*Table 5-1*), only 20 of 44 (45%) respondents reported not being employed as a Peer support worker (paid or volunteer) prior to undertaking training and hence did not meet the target criteria set by the Department.

Given that survey respondents included those who undertook training from 2008, the prominence of non-COS staff in Table 5-4 is likely to reflect the fact that the new COS services did not have adequate staff to fill the courses, so staff from PHaMS, QLD Health and other NGOs were recruited.

Consultations with Brook RED and Community Focus indicated that the Department of Communities/Health' definition of target participants had been expanded to include service users. This meant that service users attended IPS training for the purpose of personal growth rather than with the intent of joining the IPS workforce as the course was intended.

Key Finding: A significant number of IPS trainees are not entering the IPS courses to become IPS workers. Some complete the course for personal growth or to assist them in their work outside the IPS setting.

5.2 Effectiveness of IPS training in preparing peer workers in the peer support role

Effectiveness of the IPS training was reviewed from two perspectives:

- Understanding of IPS
- Preparedness for IPS role.

5. Findings: Effectiveness of IPS training

5.2.1 Understanding of IPS

For the majority of respondents, the IPS training resulted in substantial improvements in their understanding of what IPS involved (*Figure 5-1*). Respondents were asked to rank their understanding prior to training using a five point scale with 1 indicating very little understanding and 5 a strong understanding. Prior to training, only 11% ranked their understanding as either a 4 or 5, signifying low overall levels of understanding. Following training, this figure had risen to 78% indicating that respondents had a much stronger understanding of IPS after training.

Figure 5-1: Level of understanding of IPS before training

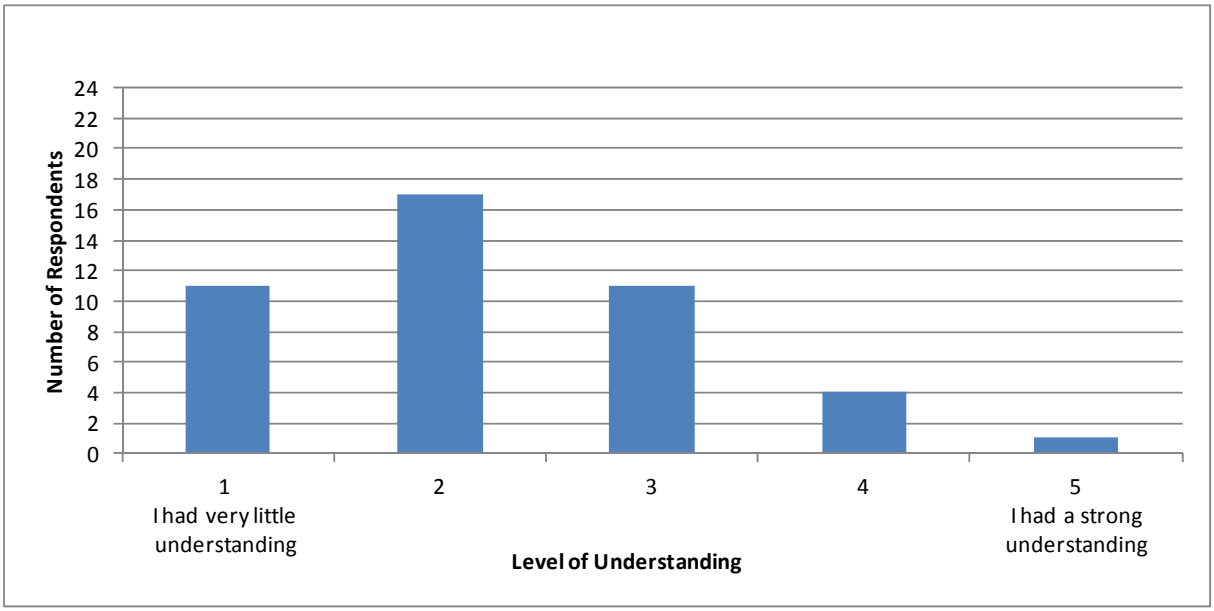
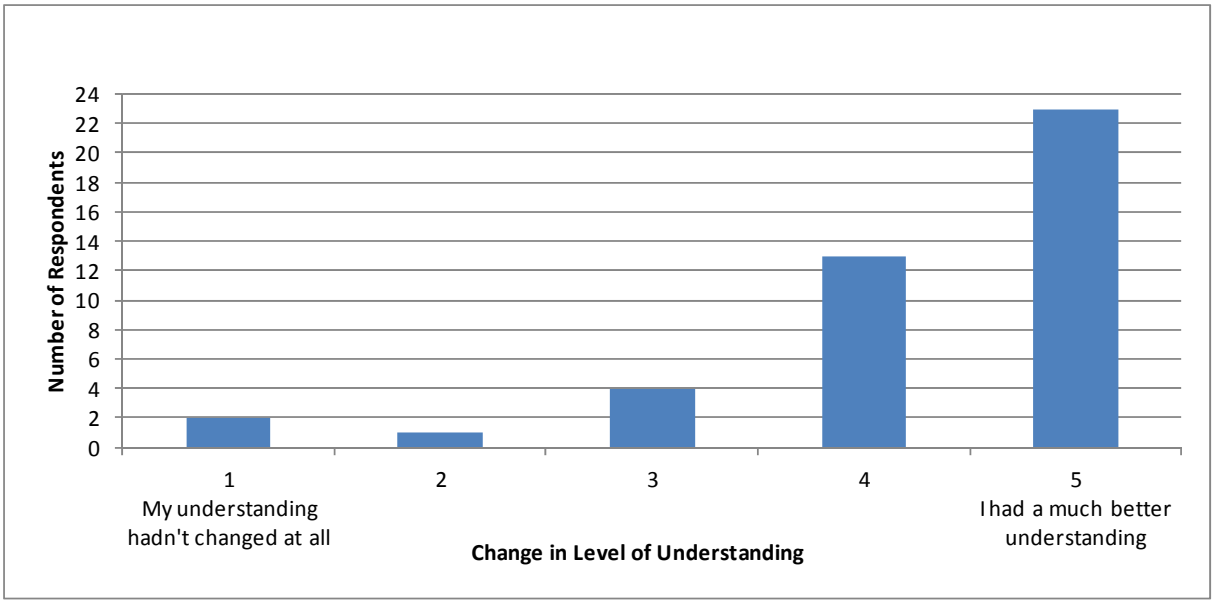


Figure 5-2: Level of understanding of IPS after training



Seven of the 43 respondents who provided both pre and post-training responses had a post-training rating of three or less. This however, did not signify major incongruence between pre and post ratings.

Two of these seven respondents indicated no change in understanding post-training (rating 1). Given that their pre-training understanding was strong (rating 5), it is not surprising therefore that minimal change ensued. For the remaining five respondents with post-training ratings less than three, these scores nonetheless indicated improved understanding albeit on a less dramatic scale than the other respondents overall.

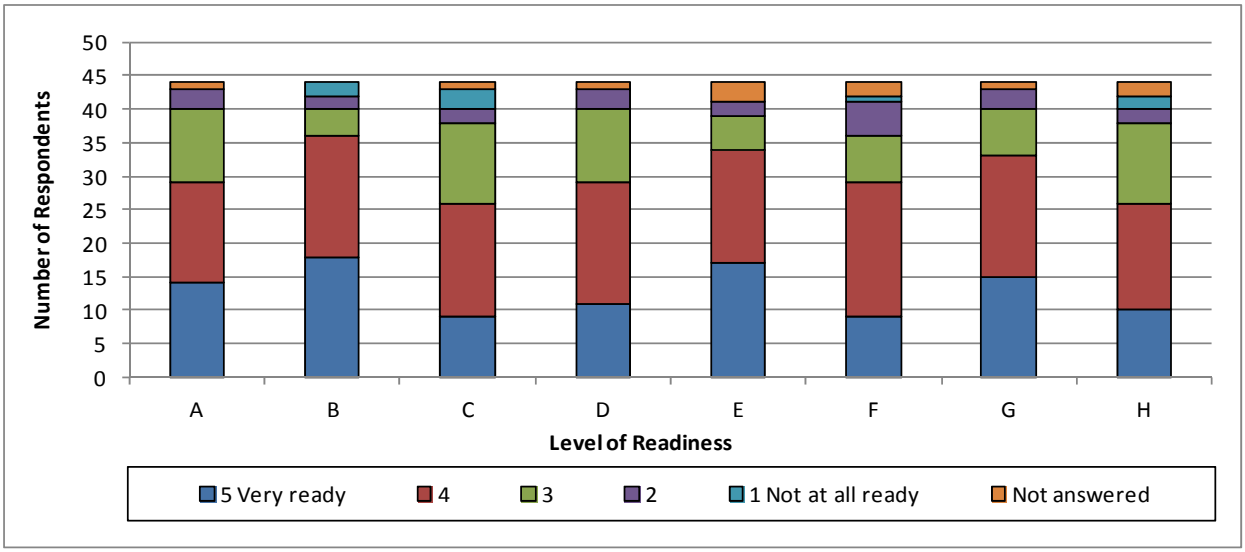
5.2.2 Preparedness for IPS role

The majority of respondents (72%) positively affirmed that the training was effective in preparing them for the Peer support role, ranking their levels of agreement as either a four or five (*Figure 5-3*: Level of readiness for Peer support role). The remaining 28% (11 of 43) ranked the training poorly in terms of preparing them for their Peer support role (rank scores of three or less). Further analysis yielded no clear association between these poor responses and the pattern of responses to the post training changes in their understanding of IPS, with a mix of those who achieved a much better understanding and those who did not, reporting scores of three or less in terms of how well the training prepared them the Peer worker role.

When asked to assess their readiness to undertake each of the eight key domains of the IPS role after completing the IPS training, high levels of readiness were evident overall with more than half rating their responses by domain as either a 4 or 5 (very ready) (*Figure 5-3*). Nonetheless, a considerable proportion awarded a rating 3, signifying a neutral response, and in four of the eight domains (*Doing first contact, Setting boundaries, Being safe in peer relationships and Self-care*) rating 1 (not at all ready) were reported.

Key Finding: Despite the increases in understanding achieved as a result of the training (Section 5.2.1) and that respondents reported that the training was effective in preparing them for the Peer support role, specific gaps remained in role readiness by domain.

Figure 5-3: Level of readiness for Peer support role



Level of Readiness

At the end of the IPS training, how ready were you to:

A. Do "first contact"?

B. Listen Differently?
C. Develop trauma-informed, mutually responsible relationships?
D. Set boundaries?
E. Be safe in peer relationships?
F. Manage conflict?
G. Self-care?
H. Participate in co-supervision?

Surprisingly, further analysis indicated that readiness to participate in co-supervision was not contingent on having completed the 2 day co-supervision training. Of the 14 respondents who completed co-supervision training, one felt they were not at all ready (rating 1) and three others were neutral (rating 3) in their assessment of their readiness to undertake co-supervision. While 10 of 14 who undertook co-supervision training rated their readiness as 4 or 5, 16 of the 28 respondents who had not undertaken co-supervision training rated their readiness as 4 or 5. Overall, therefore 71% of people who had undertaken co-supervision training were ready or very ready, compared with 57% of those who had not undertaken co-supervision training. This suggests that although co-supervision training helps with this domain, it was not as effective as it might have been.

Key Finding: Although Co-supervision training assists in preparing IPS workers for this part of their role, there is still a need to improve this training to better prepare participants for this role.

Consultations with peer workers who had completed IPS training provided some insights into this apparent incongruence between training effectiveness and role readiness. The need to practice course learnings over time was a key theme in these consultations with peer workers reporting that "*There is not enough opportunity during the course for practice.*" The IPS course *"is not a* stand-alone. *You need to apply it in practice, and shape and mould it over time, with experience and co-supervision."* It is for this reason that the Community Focus trainers indicated that they spread course delivery of the IPS Basic 5 day course over a number of months in order to better accommodate participant application of learning over time.

This peer viewpoint was supported by consultations with COS managers. As one manager stated: *"Five days IPS doesn't prepare a workforce. You need on the ground experience. It was never designed to build a workforce, it's for anyone."*

In an online interview provided on their website[82], training developer Shery Mead acknowledges the limitations of providing IPS training in a 5-day block advocating that "*in the best of all possible worlds would be better once a week over many weeks, because it's a whole new way of thinking for people...five days (intensive) is tiring for them...because we travel to do this, we have to do it in five days."*

Key Finding: Providing IPS basic training in a 5-day block may not be ideal. Further research into the optimal delivery schedule may be warranted.

[82] www.intentionalpeersupport.org Accessed 11 February 2013.

5. Findings: Effectiveness of IPS training

5.3 Additional IPS topics suggested

Respondents were given the opportunity to suggest additional topics that they would like to have included in the IPS training. Nine responses were received, with suggestions including:

> *"Clear differentiation between workers' responsibilities (duty of care in terms of workplace health and safety) and IPS."*
>
> *"Crisis training."*
>
> *"Information on what are moderate to severe mental health issues."*
>
> *"How to better talk about our personal relationships i.e. families."*
>
> *"Start with 3 principles to set values/motives/intent before going into the 'how to' of 4 tasks.""*
>
> *"Manage conflict."*
>
> *"More entry level communication skills - the 'how to' of the meta theory of IPS."*
>
> *"More on self-care, conflict within the staff/management."*

A number of other responses that did not directly relate to the question were included by survey respondents. Three of these additional responses related to the mode of delivery and one addressed training availability in general. These responses are listed below:

> *"I felt that this training was inadequate and did not feel that the execution of the course was as professional as it could/should have been. Very basic"*
>
> *"More focus on learning about positive experiences that we've learnt from"*
>
> *"Realistic role plays"*
>
> *"More available training in Australia"*

5.4 Effectiveness of IPS training in promoting and helping to build a peer workforce

The effectiveness of IPS training in promoting and building a peer workforce is assessed in this section from four perspectives:

1. Work role readiness
2. Application of training
3. Workforce participation
4. Increased training capacity in Queensland.

5.4.1 Work role readiness

For the majority of respondents, the IPS training resulted in considerable learning. Most (39 of 44, 89%) had no peer support training prior to undertaking the IPS training. Amongst the five respondents who did have previous peer support training, this training comprised in-service training (4 of 5) and mental

health recovery orientation training (1 of 5). Slightly more than one-third (16 of 44, 36%) had undertaken other training in relation to recovery with several respondents remarking that the recovery training had been very clinically oriented.

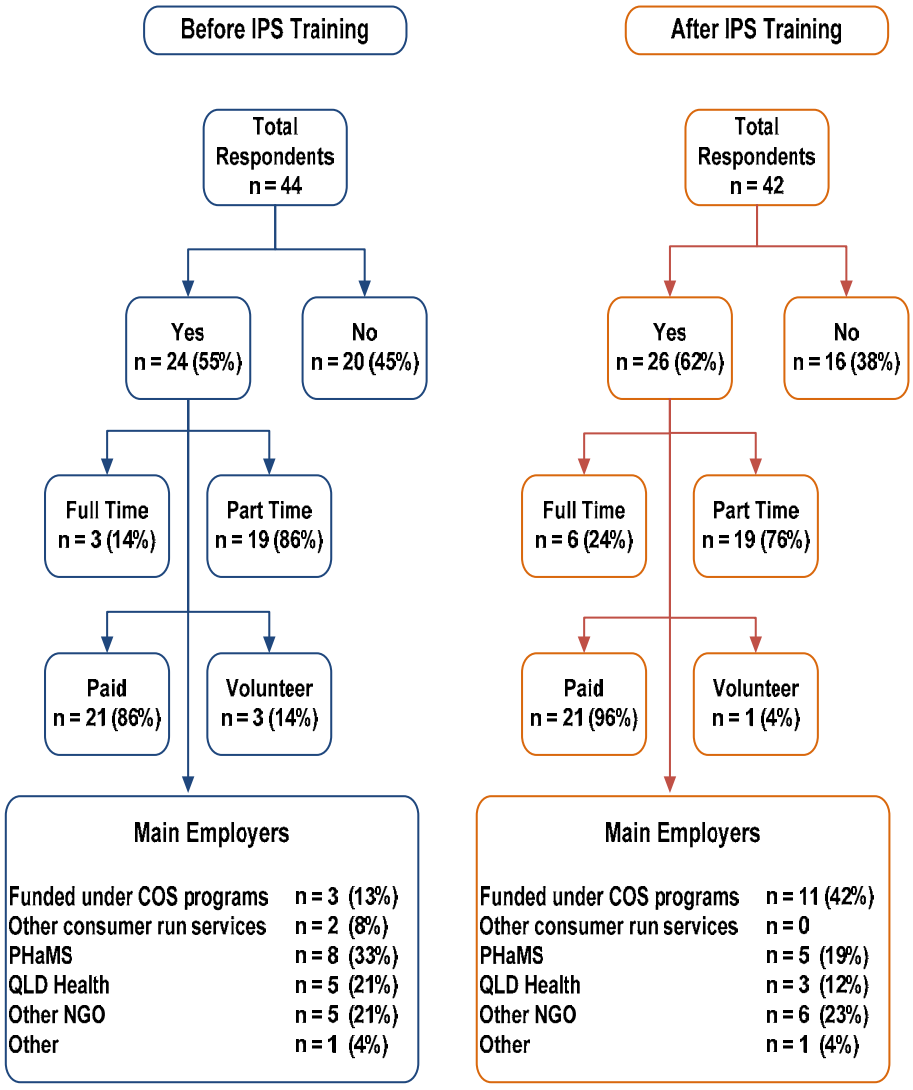
5.4.2 Application of training

All 26 respondents who were currently working in a peer support role indicated that they had been able to apply their IPS training in their role. Relationship building, particularly in terms of listening differently, building connections and achieving mutuality, were listed as the key areas in which they had applied the training. More generally, respondents indicated that the training had not only yielded benefits in peer/workplace contexts but also in their personal relationships, developing life skills and confidence-building generally.

5.4.3 Workforce participation

The workforce participation profile of respondents pre and post IPS training is shown in the following *Figure 5.4*.

Figure 5-4: Workforce participation before and after IPS training



5. Findings: Effectiveness of IPS training

Figure 5-4 shows that while completion of the IPS training resulted in only a small increase in the number of respondents who were currently working as peer workers (from 24 of 44, to 26 of 42), a considerable shift occurred in where respondents were employed following training. PHaMS not only ceased to be the main employer of those who worked as peer workers but the number of respondents working in PHaMS also declined. This corresponded with a clear shift in numbers employed at organisations funded under the COS program (from three to 11).

Despite these shifts in employer proportions, the overall picture is of workforce retention rather than workforce growth within the Queensland mental health service. This situation is further endorsed by the fact that overall, 31 of 39 respondents (80%) who undertook IPS training were currently working in the mental health sector albeit not always as peer support workers thus contributing to the overall development of the mental health workforce in Queensland.

Key Finding: There was no evidence provided that the IPS training has resulted in workforce growth. Rather, it appears there is an influence on retention of staff in the mental health community sector which includes some sideways movement in line with new skills and reallocation of funds.

The employment status of those employed as Peer workers both pre and post training was largely part-time and paid.

Respondents who were not working in an IPS role

To understand the success of a program, it is important to explore why it appears to work for some and not others.[83] For this reason, an analysis was undertaken of those respondents who completed IPS training but who were not currently working as IPS workers (n=16). It transpired that only 5 of 16 (46%) had intended to work as an IPS worker at the time of undertaking training; 11 of 16 (69%) had not. This finding is in line with earlier statements made during consultations (Section 5.1) that training participants included those interested in personal growth, not just those who were currently working or intending to join the IPS workforce as the course was intended.

Key Finding: Inclusion of course participants with no intention of becoming IPS workers in the IPS 5-day courses makes it difficult to ascertain the influence of the course on retention or recruitment of staff to the IPS workforce.

Three of the five respondents who were initially motivated to undertake training to become IPS workers provided reasons why they were not in a peer role at the time of the survey. Two reported taking up positions (one as a COS manager, the other in a senior consumer role) that enabled them to apply their IPS training without working in the specific role of IPS worker. The third respondent indicated that they '*didn't want to talk about .. [their] experience any more so became a support worker without a peer element*', a rationale that not only highlights the differences between support worker and IPS roles but also points to the personal burden placed on peers involved in the IPS model of service delivery that was raised in Chapter 2 and is further explored in Appendix A (Literature review). The demands of the

[83] S Funnell and P Rogers. *Purposeful Program Theory: Effective use of theories of change and logic models*. Jossey–Bass, San Francisco, 2011.

IPS worker role, and the need for effective support for those undertaking these roles, are also discussed in the context of service-level outcomes in Chapter 7.

Those training participants currently engaged in IPS roles also highlighted the difficulties inherent in the IPS role: "*Practising IPS takes a certain type of person. People need to be ready. You have to be very 'raw and open'. You need to respond not react – this is challenging. It's about learning to challenge one another and accept challenges."*

The topic of the specific challenges of the IPS role arose during the consultations with managers. Acknowledging that people who do the IPS training cannot cope with the ongoing requirement to self-disclose as an IPS worker, some managers reported that they provide these staff with alternative employment as mental health support workers.

Six of the 11 respondents who had not intended to become IPS workers when they undertook training listed their motivation for undertaking the IPS training. Interest in finding out more about the IPS role emerged as the main reason (3 of 6) cited. Wanting to assist other consumer towards recovery, a desire to work in the mental health sector and the suggestion coming from the manager made up the remainder of responses given.

Discussions with the training developers, Shery Mead Consulting, indicated that a trainee's decision not to become an IPS worker following training did not necessarily signify a negative outcome of the training. Instead, the view was that trainees may achieve a level of self-actualisation as a result of the training that leads them to the realisation that IPS work is not the optimum career choice for them. Such realisation was seen by Shery Mead Consulting as a positive outcome in itself as it indicated self-discovery.

The extent to which a desire for self-discovery underpinned the rationale of those respondents who undertook the training without any intention of becoming an IPS is unclear. However, given that the purpose of the IPS training is to build a peer workforce, it may be prudent to add aspirational questions to the applicant intake process to ensure that those who apply for and are accepted into the IPS training are those who are most likely to pursue a career as an IPS worker in Queensland. Those who are interested in IPS training purely for the communication and relational benefits it offers are absorbing valuable training resources without contributing to the development of the peer workforce.

Key Finding: As the aim of the IPS training provision is to build an IPS workforce in Queensland, eligibility criteria need to be clarified and enforced to ensure the course is available to those most likely to become IPS workers.

5.4.4 Increased training capacity in Queensland

The IPS training has resulted in an increase in the number of IPS courses being delivered by Australian-based trainers (*Table 5-5*). From 2008-2009, all IPS training was provided by US-based Shery Mead Consulting. From 2010 onwards, the number of courses provided by local trainers such as Brook RED and Community Focus grew. Investment in IPS training has therefore not only had a direct impact on the development of the peer workforce in Queensland but has also increased training capacity. This simultaneously reduces dependency on external providers and offers the potential for organisations such as Brook RED to become income generating, thus presenting an additional return on the Department's investment in IPS training.

Table 5-6: Number of IPS training courses delivered

Year	Training provider			Total
	Shery Mead Consulting	Brook RED	Community Focus	
2008	1	-	-	1
2009	2	-	-	2
2010	2	1	1	4
2011	2	3	2	7
Total	7	4	3	14

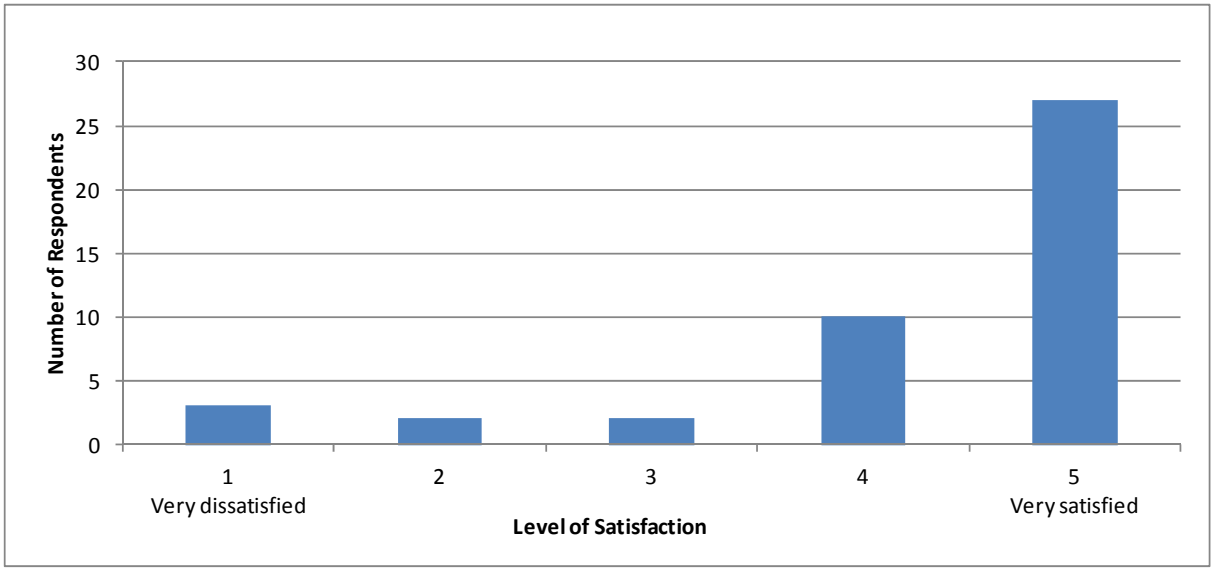
Importantly, as the following section illustrates, levels of satisfaction did not differ between those respondents trained by Shery Mead Consulting and the local providers. This suggests that the calibre of training provided by the Australian-based providers was comparable to that provided by Shery Mead Consulting.

5.5 Satisfaction with IPS training

5.5.1 Satisfaction with training delivery

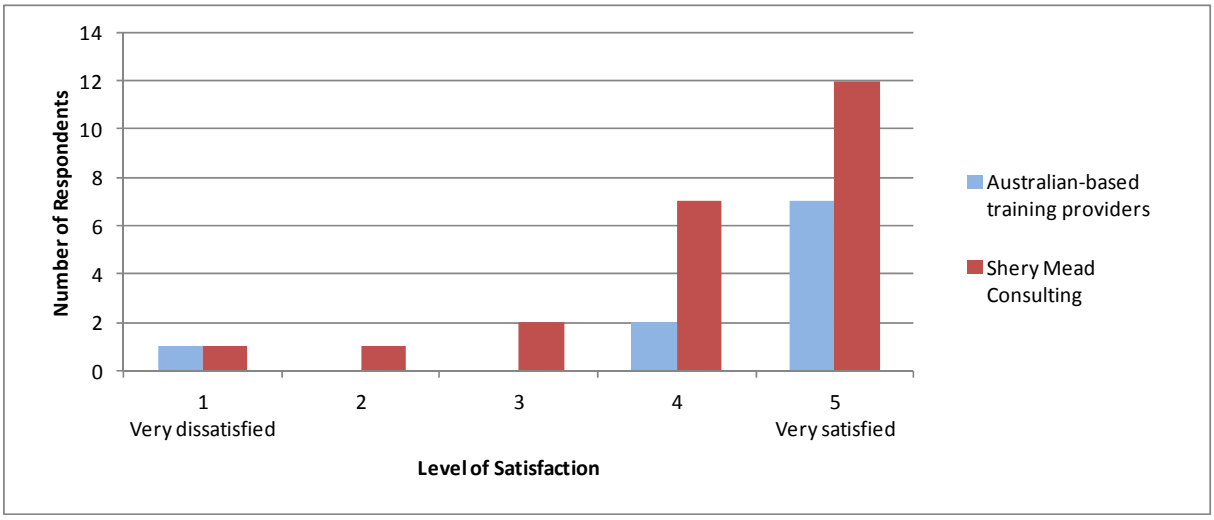
Overall, high levels of satisfaction were evident regarding training delivery. Using a five point rating system where 1 indicated very dissatisfied and 5 indicated very satisfied, 37 of 44 respondents (84%) rated their satisfaction as either 4 or 5 (*Figure 5-5*). Five respondents (11%) reported dissatisfaction (rank 1 or 2) and two others were neutral. This suggests that the training was not delivered in a manner that met the expectations of some respondents.

Figure 5-5: Satisfaction with IPS training delivery



Levels of satisfaction with how the training was delivered did not differ substantially between those who completed their training with Shery Mead Consulting and the Australian-based trainers (*Figure 5-6*). This suggests that consistently high levels of delivery were attained across training providers.

Figure 5-6: Comparison of satisfaction ratings by training provider



Key Finding: Levels of satisfaction with training were high and did not differ between USA and Australian training providers.

5.5.2 Suggestions for improving training delivery

In the survey, 16 respondents (36%) made suggestions to improve the IPS training delivery. Given that survey was completed some time after respondents had completed the training, the suggestions and assessments are therefore likely to be more reflective than those that would be captured through 'happy sheets' completed at the end of a training session.

These suggestions included:

- Reformatting the course timetable.

  Five consecutive days was considered to be too exhausting and did not allow adequate time for participants to absorb the material delivered

  "Maybe break up the 5 day training so there is more time to mull over the homework and let it sink in'."

  "Five straight days full time was exhausting - splitting it as Wed, Thurs, Fri, Mon, Tues would be better."
- More role plays and hands-on learning.
- More on how to implement the skills learned
- Inclusion of an organisational readiness kit for organisations to take on IPS workers
- Manual to be made available in advance so that participants can read it before undertaking training
- Refresher courses at least once per year
- Reduced reliance on the training manual, particularly by the Brook RED trainers

"I think a more free flowing information system would be much better than two people reading from a book."

"…not so much done through the text books...."

- Availability of additional resources such as videos and evaluation tools
- Screening of applicants to ensure applicant is working in a mental health context. This would ensure trainees would get the most from the training
- Ensuring trainees are aware that training alone will not ensure readiness for the IPS role; experience is also essential.

Many of these suggestions were reinforced during consultations with IPS workers. In particular, the five consecutive days of training was an issue:

> *"They tried to pack too much into five days. It was too intensive – you needed more time to absorb the information (all of which was very useful)."*
>
> *"It would be good to break it up – 1 day a week over 5 weeks."*
>
> *"By Friday my brain was nuked."*

Additional suggestions/comments raised during these consultations included:

> *"The prerequisite reading was too much; training days were big days. Lots of homework"*
>
> *"The practical 'how' is missing from the IPS training. You need to move on from telling the story to the 'how' to move towards recovery. Conversations are good but a person may need help with 'action'."*
>
> *"Practical bits missing: 'how do you connect to the community?', 'if get stuck in the story how do you get to the next step?', 'what do you used to prompt conversations (e.g. life cards)?"*
>
> *"Not everyone is auditory."*
>
> *"'Booster' sessions would be good"*
>
> *"The course could be Australianised - include Australian examples or phrases."*

5.5.3 Best features

Respondents listed the following as being the best features of the IPS training:

- Role play
- Practical exercises
- Group participation and presentations
- Networking opportunities
- Listening differently and sharing

- The modelling of IPS during training i.e. training was provided on the basis of mutuality and was not a lecture.

These comments mirror findings in Section 4.3 that experiential modes of delivery are effective for this course. The experiential component has the advantage that literacy levels of a group are less problematic. It also indicates that the IPS would not be suitable for online delivery.

5.6 Satisfaction with Co-supervision training

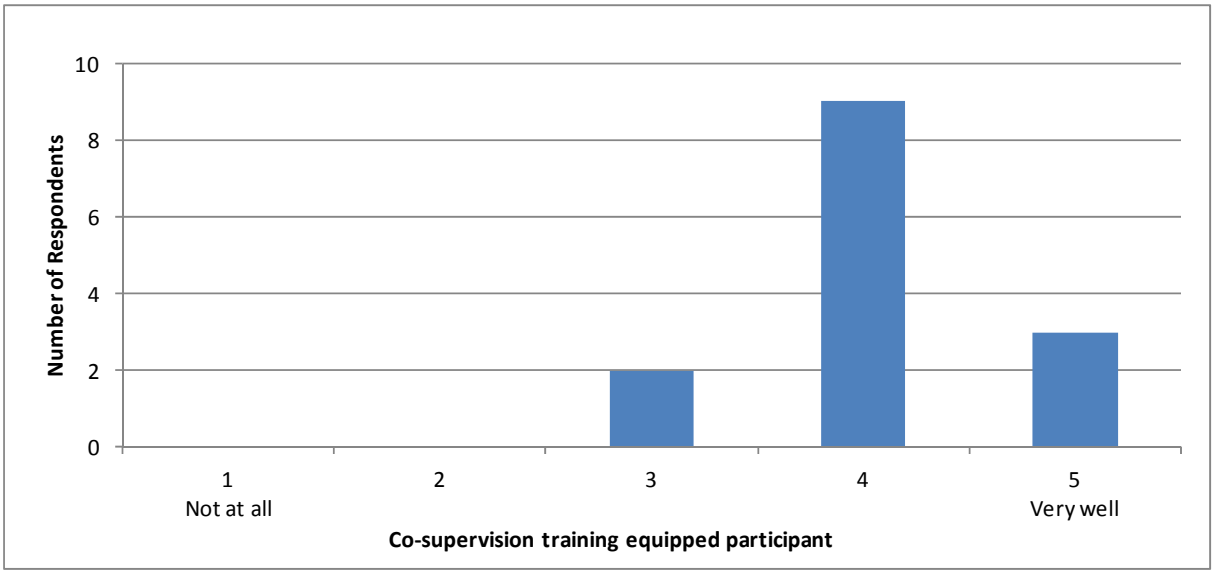
A total of 16 respondents undertook co-supervision training. One respondent completed the course twice.

Satisfaction with how the co-supervision training was delivered was very high with most respondents (9 of 12) selecting a value of 5 (very satisfied) to rank training delivery and the remainder (3 of 12) selecting 4.

Ten respondents indicated that they were undertaking co-supervision in their role at the time of completing the survey. Of the remaining three, two provided reasons why they were not currently undertaking co-supervision. One was not working as a peer worker while the other had not had an opportunity to practice co-supervision despite being in a peer role.

Overall, respondents' assessment of the extent to which the Co-supervision training equipped them to undertake co-supervision was positive (*Figure 5-7*). None applied a rating of either 1 or 2 to their assessment (1 being Not at all), responses were spread over values 3 to 5. Most, (9 of 14) opted for value 4 and only three rated their assessment as a 5. This indicates that some shortfalls may exist between the skills presented in the training course and respondents' ability to apply these skills in the work place.

Figure 5-7: Extent that Co-supervision training equipped participants for role



Respondents provided only three suggestions for improvements to the Co-supervision training which most likely reiterates their almost unanimous positive view of the course for equipping them to undertake co-supervision.

> *"More time to absorb these incredibly valuable ideas."*
>
> *"Differentiating Performance Management as opposed to practice of IPS."*
>
> *"Clear structures to take back to workplace – a list to know if it is not working."*

During consultations with those who had completed Co-supervision training indicated that "having a gap [from IPS Basic training] before doing Co-supervision was good."

5.7 Satisfaction with Train the Trainer Teachers Training

Ten respondents had undertaken the 5-day Train the Trainer Teachers Training run in 2010. Anecdotal evidence from the trainee consultants indicates that this number could be the full complement of participants who undertook the training in 2010.

Of these, only two had prior experience in training delivery: one had formal qualifications in education and workplace training while the other had experience of training in a tertiary setting.

Three of those who completed the Train the Trainer in Teachers Training were working as a trainer at the time of completing the survey. One other respondent indicated that they did have an opportunity to deliver training but was not currently doing so, while another had never facilitated/co-facilitated training following the course.

Only five respondents ranked the course in terms of how well it equipped them to undertake an IPS training role. Three of these ranked the course a 3 (neutral) while the other two ranked the course a 2 (disagree). This therefore suggests that some shortfalls may exist between the objectives of the training course and respondents' ability to apply the skills they learned in the training context. It should be noted however, that the numbers of respondents in this section are small hence the reliability of the findings may be an issue.

This viewpoint was reiterated during consultations with those who completed the Train the Trainer Teachers Training. While some felt that "The course equipped me well to become a facilitator", others added that:

> *"The course was good on content, but there was not so much on how to teach – so not enough for someone who didn't have experience in delivering training to a group of adult learners"*
>
> *"The resources provided are sufficient if you have a training background. Young facilitators should co-facilitate."*
>
> *"At the beginning we were very wooden … highly reliant on the manual"*
>
> *"Confidence is a major barrier for Train the Trainer"*
>
> *"To be a good trainer you need to be well-versed in IPS, have lived experience, have confidence and group facilitation skills."*

5. Findings: Effectiveness of IPS training

Consultations with Shery Mead Consulting also indicated that not all those who completed the Train the Trainer Teachers Training in 2010 were ready to deliver training. They pointed out that "not all participants could successfully deliver training to adult learners or role model IPS while facilitating."

When asked to identify any gaps in training, only two survey respondents provided a response. In both cases, the gaps related to facilitation skills. In particular, skills around how to address diversity in the training audience and how to adapt training to the needs of those participating in the training were key requirements.

The following suggestions for course improvement were made by respondents:

- *Continuous improvement and modules to keep relevance of practice. Need to still be practising IPS*
- *Provision of refresher, resources and accreditation*
- *Ongoing requalification/re-evaluation of trainers to assess their capability and to hone skills*.

Consultations with those who had completed the Train the Trainer Teachers Training yielded a number of additional suggestions, particularly in relation to risk management training, as follows:

> "*There need more content about risk management. Chris and Shery come from a different context, where there are more options available for managing someone in crisis than there are in Australia."*
>
> *"We don't want bad outcomes that impact our workers. I don't want my staff exposed to someone hurting themselves."*
>
> "*Once someone has a paid position other factors come in, such as employer responsibilities. There are ethical, legal and moral obligations with the shift from peer to worker. There are benefits to doing IPS but people close their eyes to the difficult bits. Inappropriate relationships are a problem. This wrecks the trust."*

5.8 Summary and implications of findings

A significant number of IPS trainees are not entering the IPS courses to become IPS workers. Some complete the course for personal growth or to assist them in their work outside the IPS setting. Additionally, some individuals are accessing the base IPS course as a means of continuing skills development. An alternative to utilisation of the basic course may warrant consideration. Also, it appears that providing IPS basic training in a 5 day block may not be ideal. Further research into the optimal delivery schedule may be warranted.

As the aim of the IPS training provision is to build an IPS workforce in Queensland, eligibility criteria need to be clarified and enforced to ensure the course is available to those most likely to become IPS workers. Training people with no intention of becoming IPS workers in the IPS 5 day courses makes it difficult to ascertain the influence of the course on retention or recruitment of staff to the IPS workforce. However, there was no evidence that the IPS training has resulted in workforce growth. Rather, it appears there is an influence on retention of staff in the mental health community sector which includes some sideways movement in line with new skills and reallocation of funds.

Inconsistent eligibility criteria for entry into courses means that some people are doing the one course multiple times and on occasion, people are doing courses without prerequisite knowledge. Some

individuals are accessing the base IPS course as a means of continuing skills development. An alternative to utilisation of the basic course may warrant consideration

Course participation patterns indicate that the IPS courses may not always be adequate to equip workers for the IPS worker role. Despite the increases in understanding achieved as a result of the training and respondents reporting that the training was effective in preparing them for the Peer support role, specific gaps remained in role readiness by domain.

Although Co-supervision training assists in preparing IPS workers for this part of their role, there is still a need to improve this training to better prepare participants for this role.

Providing IPS basic training in a 5-day block may not be ideal. Further research into the optimal delivery schedule may be warranted.

Levels of satisfaction with training were high and did not differ between USA and Australian lead training providers.

6 FINDINGS: EFFECTIVENESS OF MANAGER TRAINING

In this chapter, the effectiveness of the manager training is assessed using two main data sources:

- Responses to managers training survey
- Consultations with those who completed manager training during the period from 2008 to end of 2011.

This chapter focuses on the effectiveness of the manager training only and includes both the one and two day training courses which were delivered by Shery Mead Consulting during this period.

Department of Communities promotional material (Appendix G) for these courses indicated that:

- The target audience was "managers or co-ordinators of NGO mental health services who have or are interested in developing a peer workforce."
- The course was designed to "provide an overview of IPS and how to create peer friendly environments."

Findings are presented in the chapter under the following headings:

1. Profile of survey respondents
2. Motivation for under taking training
3. Effectiveness of manager training in preparing managers for the manager role
4. Satisfaction with Manager training
5. Effectiveness of manager training in promoting and helping to build a peer workforce
6. Summary and implications of findings.

6.1 Profile of survey respondents

The manager training survey was distributed to 44 training participants and a response rate of 66% (29 of 44) was achieved. The training survey requested information from manager training recipients on several aspects of the training and their views on how the training prepared them for managerial work in the peer support environment. Demographic characteristics were also captured thus making it possible to construct a profile of the people who undertook manager training. In addition, the survey elicited information about what motivated respondents to undertake manager training and their level of previous experience in the peer support environment.

The profile of survey respondents is shown in *Table 6-1*.

Table 6-1: Profile of manager training survey respondents

Characteristic	Manager training n=29
Gender	
Male	8 (28%)
Female	21 (72%)
Age	
18-29 years	2 (7%)

6. Findings: Effectiveness of Manager Training

Characteristic	Manager training n=29
30-39 years	9 (31%)
40-49 years	12 (41%)
50-59 years	4 (14%)
60+years	2 (7%)
Background	
Aboriginal and Torres Strait Islander	1 (3%)
Culturally and Linguistically Diverse (CALD)	3 (9%)
Lived experience of mental illness	
Yes	12 (41%)
No	17 (59%)

The majority of respondents were female (72%) and most were over 40 years of age (62%). Very few were of Aboriginal/Torres Strait Islander or CALD background. The majority, (59%) did not have a lived experience of mental illness.

It should be noted that some respondents did not complete all sections of the survey. As a result, the total number of responses reported in the sections that follow may not match the total number of respondents indicated in *Table 6-1* because of missing values.

The distribution of respondents by course is shown in *Table 6-2*. Participants from all four manager courses delivered between 2008 and 2011 were represented in the survey responses.

Table 6-2: Number of respondents by course

Year	Course	Trainer	Respondents n=29
Sept 2008	1-day	Shery Mead Consulting	4
Feb 2009	2-day	Shery Mead Consulting	5
Feb 2011 (Brisbane)	2-day	Shery Mead Consulting	12
Feb 2011 (Hervey Bay)	2-day	Shery Mead Consulting	8

Further analysis of attendance patterns revealed that, unlike the IPS training (Section 5.1), none of the respondents had undertaken the course multiple times.

6.2 Motivation for undertaking training

The main reasons cited for doing the manager training are shown in *Table 6-3*. Respondents were almost equally split between those interested in developing a peer workforce and those wanting to better support their existing peer workforce (45% in each case).

6. Findings: Effectiveness of Manager Training

Table 6-3: Number of respondents by course

Reason	Respondents n=29
My organisation was interested in developing a peer workforce	13 (45%)
My organisation was interested in better supporting our peer support workforce	13 (45%)
I was interested in finding out more about how to build a peer support workforce	3 (10%)

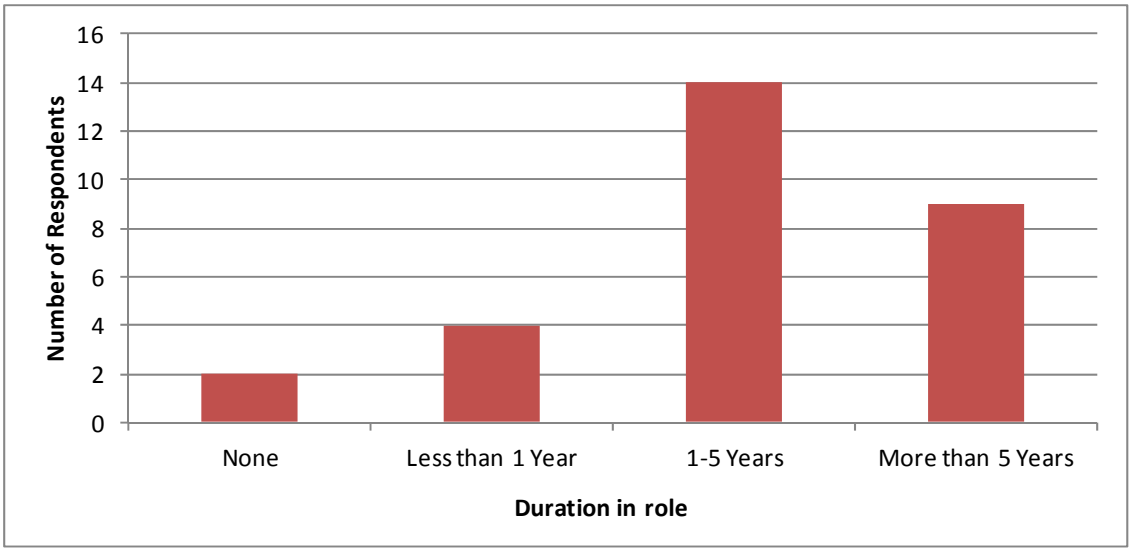
Key Finding: Those participating in IPS manager training reported being motivated to do the training because they were interested in developing a peer workforce or better support an existing peer workforce. This signifies that the Manager training is reaching the specified target groups for this training.

Management experience prior to training

Review of the management course training material, led to the hypothesis that course participants would need some understanding/experience of managing a workforce before considering the particular needs of a peer support workforce. Accordingly, a number of questions were included in the manager survey to ascertain the level of prior management experience among training participants.

Most managers (93%) had some management experience prior to undertaking the manager training (*Figure 6-1*). Almost half (48%) had 1 to 5 years' experience and a further 31% reported more than five years experience.

Figure 6-1: Duration of management experience prior to undertaking manager training



6.3 Effectiveness of manager training in preparing managers for the manager role

Effectiveness of the manager training is reviewed from two perspectives:

6. Findings: Effectiveness of Manager Training

1. Changes in understanding of IPS
2. Meeting managers' training needs.

6.3.1 Changes in understanding

For the majority of respondents, the manager training resulted in substantial improvements in their understanding of what IPS involved. Respondents were asked to rate their understanding prior to training using a five point scale with 1 indicating very little understanding and 5 a strong understanding. Prior to training, only 5 of 28 (18%) rated their understanding as either a 4 or 5, signifying low overall levels of understanding (*Figure 6-3*). Following training, this figure rose to 86% indicating that respondents had a much stronger understanding of IPS as a result of the training (*Figure 6-2*).

Figure 6-3: Level of understanding of IPS prior to manager training

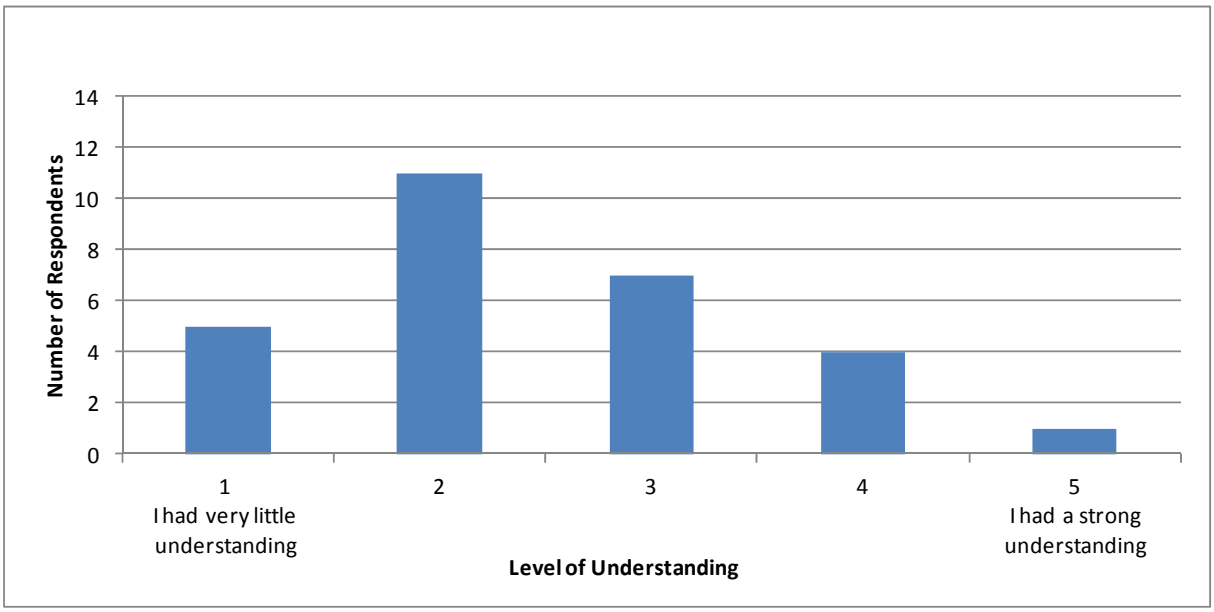
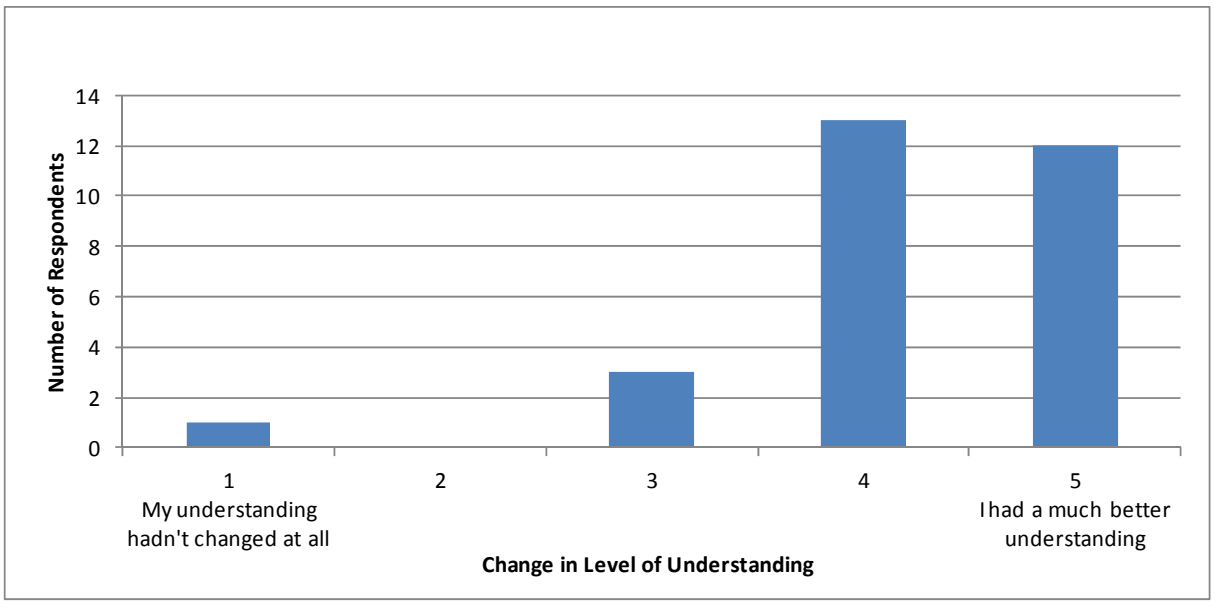


Figure 6-4: Level of understanding of IPS after manager training



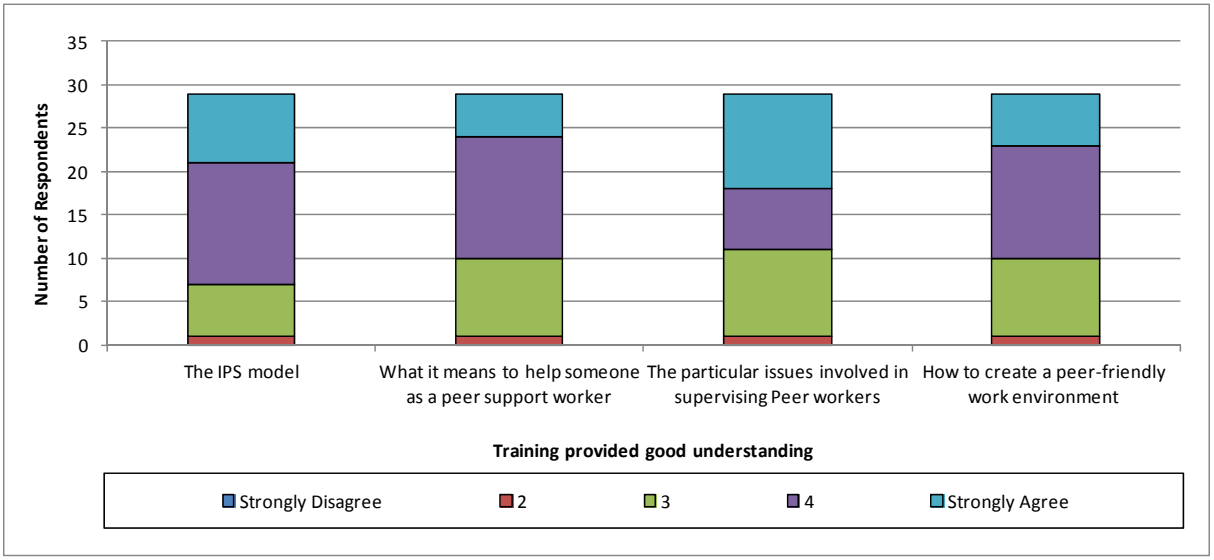
One respondent indicated that their understanding of IPS had not changed at all as a result of the training. This respondent had a strong understanding of IPS prior to undertaking the manager training (rate score 5), hence their score 1 rating (my understanding hadn't changed at all) is not surprising and does not reflect negatively on the training provided.

Consultations with non-COS managers affirmed the role that the manager training had played in developing a peer workforce in their organisation:

> "*The training was valuable. The concept seemed new and we weren't using it in any of the other mental health services that we had, so we were struggling at first in how to use it in our current workforce, although we wanted to use it. The training blew away the misconceptions we had and gave us a strong, underpinning on:*
>
> - *How to engage peers in the organisation and as part of the team.*
> - *Recruitment polices'*
> - *How to work with other staff / existing staff when bringing in peer workers*
>
> *It was fantastic as we were struggling with some of these things. Some of these leaders have gone on to do this peer support training as part of their personal and professional development.*"
>
> *"The training helped. It opened my eyes about the person going on the journey for themselves."*

Respondents' assessment of the extent to which the manager training had provided them with a good understanding of specific elements of managing a peer workforce is shown in *Figure 6-5*. Despite overall strong levels of agreement, the spread of responses indicates that some respondents still had gaps in their understanding. This was most pronounced in relation to *the particular issues involved in supervising peer workers*, *what it means to help someone as a peer support worker*, and *how to create a peer-friendly work environment* where more than a third of respondents rated the training as a 2 or 3.

Figure 6-6: Level understanding of specific elements of managing a peer workforce



6. Findings: Effectiveness of Manager Training

Through the consultations with non-COS managers, these specific issues of managing a peer workforce and integrating IPS workers into an existing workforce were also raised:

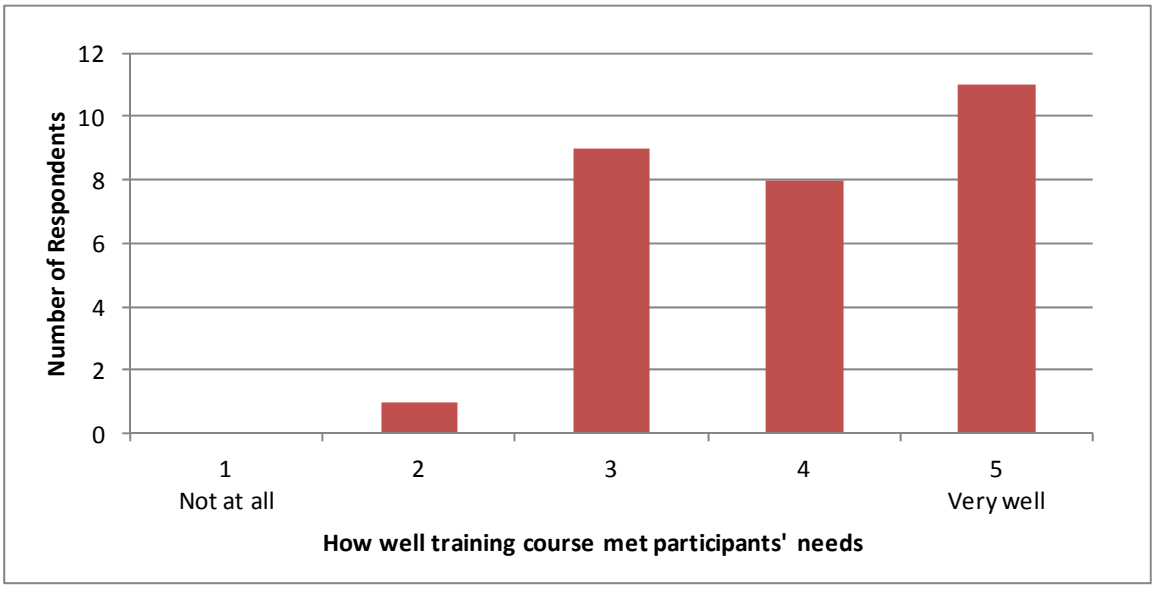
> *"We didn't want the PS position to be the phone answerer. We wanted them to work with the team, so we provided the new worker with an induction and the staff with an explanation. The team weren't the problem. It was HR the problem as there was concern about recruiting people with a mental illness. The health and safety of the new worker was their concern. Some thought that work stress would cause a relapse, but they found mental illness was not so different from any other illness. Sending the….managers to the training also helped with integration. We then spent a whole day working out recruiting and selection issues which helped integration in the long term."*

Key Finding: Although managers reported that overall, the Managers training was of assistance and improved their knowledge of IPS, a number of gaps were identified in the training that should be addressed to maximise the utility of the course in future.

6.3.2 Meeting managers' training needs

Given the mixed responses identified in *Figure 6-6* it is not surprising that managers' assessment of how well the training course met their needs was also mixed (*Figure 6-7*). Again, one-third of respondents rated the course as a 2 or 3, signifying perceived deficiencies in the training relative to their specific needs. As outlined in Section 6.3.1, issues around introducing IPS workers into an established workforce was deemed a training need and may account for the low ratings here.

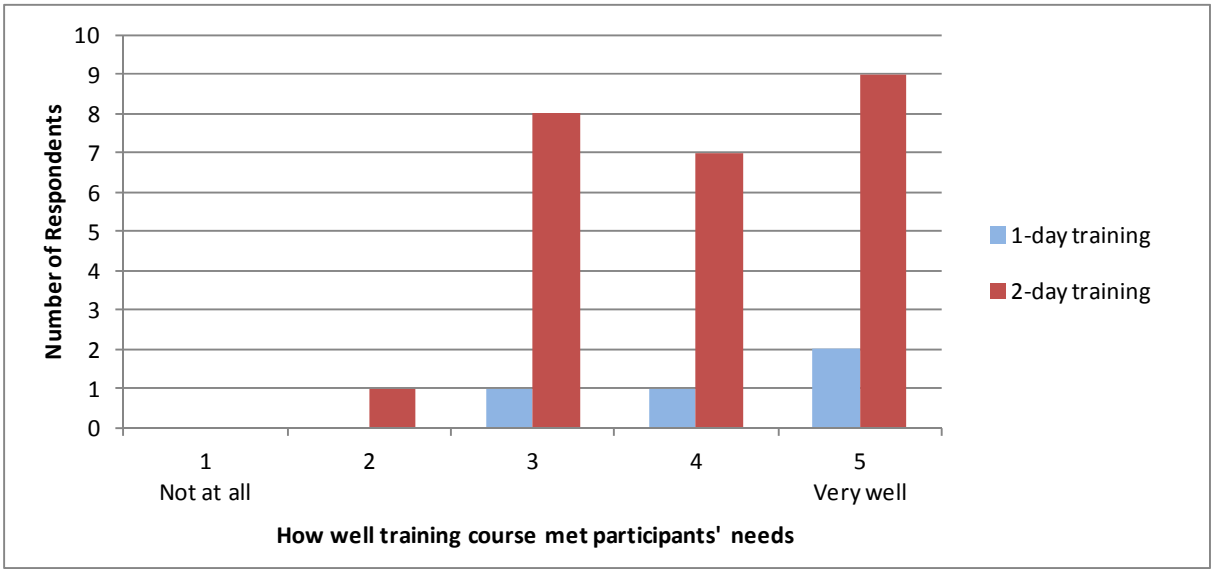
Figure 6-7: Extent to which manager training met managers' training needs



As outlined in Section 4.3, the format of the manager training course had changed in response to participant feedback following the first course in 2008. As a result, the one-day manager training course was expanded to become a two day course. To ascertain whether managers' assessments differed by

training duration, responses by those who undertook the one-day training and those who undertook the two-day training were compared (*Figure 6-8*).

Figure 6-9: Extent to which manager training met managers' training needs, by duration of training

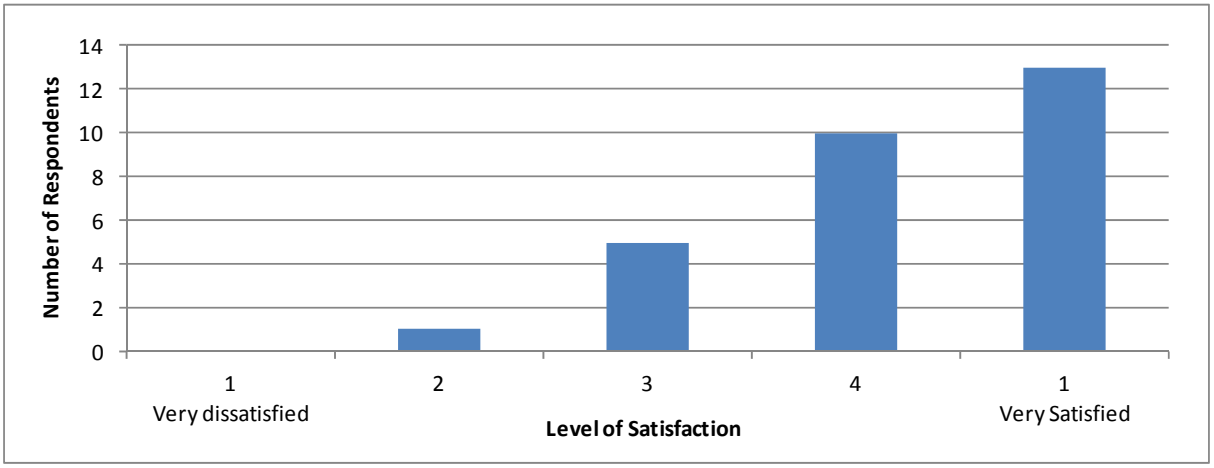


The distribution of responses in *Figure 6-9*, shows the levels of met/unmet need differed little by course duration. Given the small number of respondents that had completed the one-day training course, however, the representativeness of these findings may be limited.

6.4 Satisfaction with Manager training

High levels of satisfaction with training delivery were evident (*Figure 6-10*). More than three quarters of all respondents (23 of 29, 79%) rated their level of satisfaction as 4 or 5, with 5 (very satisfied) being the category chosen by almost half (45%) of all survey respondents.

Figure 6-10: Satisfaction with Manager training



6. Findings: Effectiveness of Manager Training

6.4.1 Topics not covered

Four respondents listed topics they felt were not covered in the manager training. These topics were:

> *"Alternative peer support models."*
>
> *"Greater information on integrating peer workers into teams with other types of staff."*
>
> *"More time spent on all aspects of peer workforces from recruiting to supporting, developing to performance management."*

Implementing these suggestions would require that course participants have a good grasp of routine human resource management and this may not be entirely best addressed as part of the IPS training but may signify alternate unmet training needs.

6.4.2 Suggestions to improve training

Seven respondents (24%) made suggestions to improve the training. These suggestions are listed below:

> *"More opportunities for Sherry [sic] to train more of our workforce and also the opportunity to have Sherry available for feedback on the progress we have made"*
>
> *"Maybe include some IPS training [in the Manager training]*
>
> *"Request [training evaluation] survey earlier"*
>
> *"Managers that attended hadn't an understanding of IPS and therefore struggled to understand what this would mean as a manager of an organisation "*
>
> *"The managers training would have been able to focus on the role of managing an IPS workforce rather than people trying to understand IPS."*
>
> *"At times could have been more succinct and engaging."*
>
> *"Longer timeframe and clearer indication of who it was targeted at (i.e. we mistakenly thought it was IPS workers in management; as opposed to non-IPS workers managing an IPS peer workforce)."*
>
> *"If there was potential to offer case studies of where IPS model was integrated within a large organisation that would be great."*

Respondents' claims regarding differences in understanding between course participants is supported by the fact that only 4 of 29 respondents had undertaken any peer support training prior to doing the manager training and that knowledge of IPS was generally low (Section 7.3.1).

Consultations with non-COS managers highlighted a number of additional suggestions for improving the training. These included:

6. Findings: Effectiveness of Manager Training

"More hands-on practical tools to set up an IPSW role or program."

"More insight into IPS itself. "

"More focus on how a PWS would work within an established program."

"Bring an IPSW worker in to talk about how they integrated the role into an existing workforce."

"Longer course as the current format was too short"

Key Finding: Several of the issues raised related to course participants not having a prior knowledge of IPS. This may suggest the need to:

- Modify entry screening processes for the manager training courses and/or streaming trainees so that trainees in each course have comparable knowledge of IPS
- Include a larger IPS component in the manager training
- Establish the 5-day IPS training as a prerequisite for entry into the manager training.

6.5 Effectiveness of manager training in promoting and helping to build a peer workforce

The effectiveness of manager training in promoting and building a peer workforce is assessed in this section from three perspectives:

- Application of training
- Organisational impact
- Workforce participation.

6.5.1 Application of training

Twenty-four of the 28 respondents (86%) reported that they had been able to apply their training in the workforce. This application took several forms including:

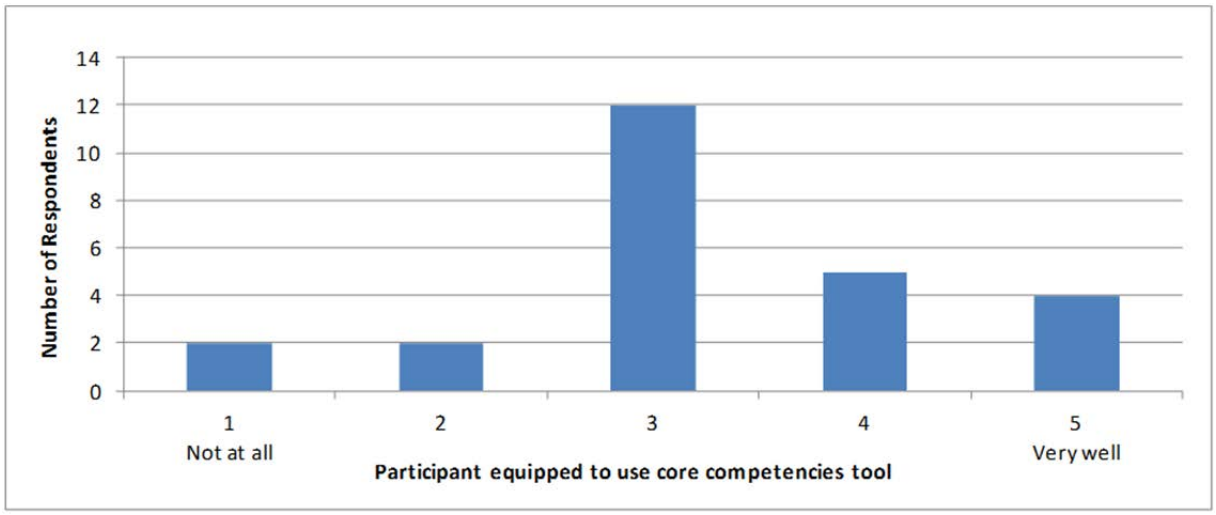
- Developing peer support programs
- Developing/reviewing position descriptions and approaches to management
- Employing and supervising peer support workforce
- Modelling IPS to other co-ordinators and managers in the service
- Liaising with others in their network that use peer support workers and sharing the knowledge with them
- Informed approach to workforce planning and development
- Used the handouts obtained in the course to increase the understanding of the elected members of the consumer committee
- Using the IPS model to better work through issues within the workplace
- Working with a larger team of peer workers.

Use of the IPS Core Competencies tool in the workplace

As noted in Section 4.3, a draft set of IPS course competencies were developed by Shery Mead Consulting and the Human Resources Research Institute in the USA, in June 2011.[84] The course competencies target the behaviours participants should adopt when practising IPS. These competencies are not time-bound, nor yet validated, but the IPS training program design indicates that participants should be competent in these behaviours within a year of attending an IPS Basic five day training course.[85] The competencies are also integrated into the Co-supervision training course and are emphasised in the manager's course as a tool for reviewing peer work performance.[86]

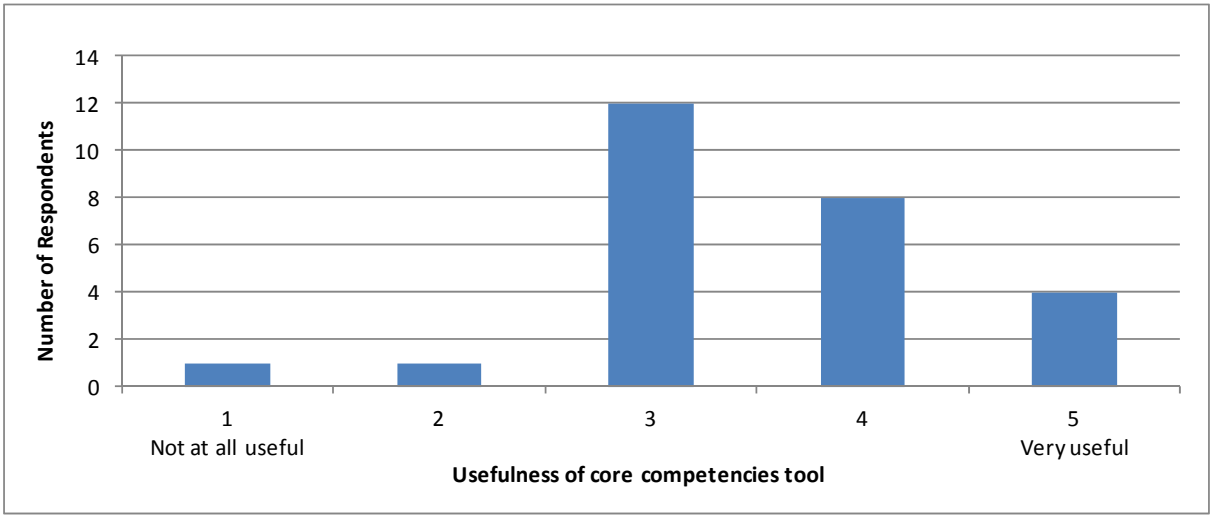
Inconsistencies were evident between the number of respondents who reported using the IPS Core Competencies tool (Appendix E) and the number who provided feedback on training and the utility of the tool in the workplace. Only 7 of 28 had used the Core Competencies tool with peer workers yet 25 and 26 respondents reported on the training and the tool's usage in the workplace respectively (*Figure 6-11*). This suggests that the respondents were confused about the core competencies tool and/or its use in practice.

Figure 6-11: Extent Manager training equipped Managers to use ISP Core Competencies tool in workplace



[84] The website of the Human Resources Research Institute is http://www.hsri.org
[85] AHA interview with Shery Mead Consulting June 2012
[86] Ibid

Figure 6-12: Usefulness of IPS Core Competencies tool in assessing Peer workers' skills on the job



Amongst those who reported using the IPS Core Competencies in the workplace, the key uses cited included

- Co-supervision
- Formal supervision
- Program review and development
- All aspects of staff management.

6.5.2 Organisational impact of training

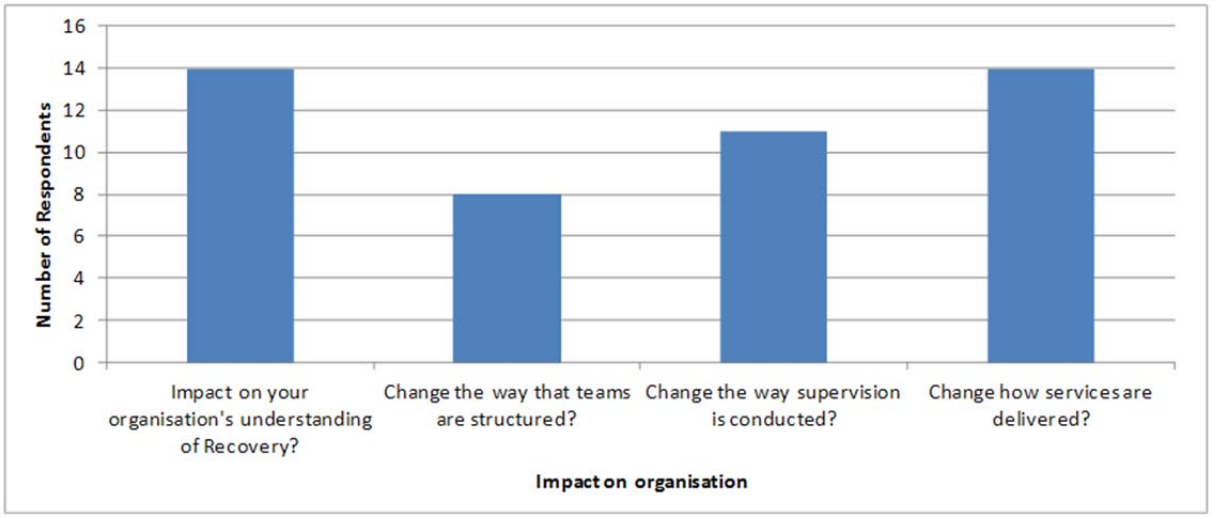
In addition to the examples of how respondents had applied the Manager training (Section 6.5.1) above, respondents also reported that the training resulted in a number of broader changes within the organisations employing training participants. These changes fell into two main categories:

- Internal processes and understanding
- Employment of peer workers.

Internal processes and understanding

The two areas where the manager training had the most pronounced impact within organisations were in relation to the organisation's understanding of recovery and how services were delivered, with 14 of 29 respondents listing each of these items. A further 11 of 29 listed changes to the way supervision is conducted as an organisational impact. Only 8 of 29 indicated that the training had impacted on the way teams are structured in their organisation.

Figure 6-13: Impact of Manager training on organisation



These findings suggest that the manager training was instrumental in generating greater workplace awareness of and receptiveness to recovery-based care models and resulted in changes to internal processes related to service delivery and supervision.

This viewpoint was reiterated in the consultations with non-COS managers and is illustrated from the following extracts:

> "*We weren't 100% right at the beginning about recruitment, selection and positions descriptions – but compared to people who hadn't done the training we were streets ahead."*
>
> *"It's not just about giving a solution to a problem, workers can facilitate, and lived experience gives extra insight, and allows better facilitation."*
>
> *"The IPSW has blossomed; we were also able to target a group that was missing out."*

Key Finding: Manager training is reported to have had a significant impact on organisations in the areas of internal process and understanding of recovery.

Key Finding: Organisational change related to IPS manager training is likely to have improved organisational readiness to effectively employ peer support workers.

6.5.3 Employment of peer workers

Following training, the number of managers who employed peer workers increased from 13 to 17 (*Table 6-4*).

Table 6-4: Employment of peer workers by managers before and after training

Employed peer workers	Before manager training	After manager training
Yes	13	17
No	14	11
Total	27*	28**

* 2 responses not provided
** 1 response not provided

The increased employment of peers not only facilitates greater workforce participation by peer support workers but may also be evidence of changes in organisational understanding and readiness. The following comment by one of the managers that had not yet employed peer workers illustrates the organisational changes that flow on from the manager training:

> *"While we have not employed peer workers, we are still working towards that goal. This training provides me with the data and understanding I need to continue to push for a peer workforce and was invaluable to set up the necessary work environment that would welcome and support peer workers."*

6.5.4 Workforce participation

The majority (17 of 29, 57%) of respondents were currently working as managers. The two main types of services in which these managers were employed were PHaMS and other NGOs (5 of 17 each) (*Table 6-5*).

Table 6-5: Type of services where managers work

Type of service where managers work	Respondents n=17
Funded under COS program	2 (12%)
Other consumer-run service	-
PHaMS	5 (29%)
Queensland Health	2 (12%)
Other NGO community mental health service	5 (29%)
Other community mental health	3 (18%)

A further 10 respondents indicated that they had never worked as a manager and two others had worked as manager but were no longer doing so. Of the latter group, one reported that their manager role had ended and the second left their management role by choice to pursue other career interests.

6. Findings: Effectiveness of Manager Training

The low number of respondents (10 of 29, 34%) who completed manager training but who had never worked as a manager is of concern given that the training is targeted towards people who have designated responsibility for developing workforce and organisation..

Key Finding: One third of manager training participants are not currently engaged as managers. While this may be accounted for by the inclusion of Co-ordinators in the promotional target group, an opportunity exists for the Department to maximise its future return on investment, by specifically targeting those managers who are in positions of designated responsibility for developing workforce and organisation.

6.6 Summary and implications of findings

Those participating in IPS manager training reported being motivated to do the training because they were interested in developing a peer workforce or providing better support for an existing peer workforce, which is in line with the designated target groups. However, one third of manager training participants are not managers. This raises issues regarding the screening of training applicants and whether current selection criteria and intake processes maximise the Department's return on investment.

Although the IPS managers training overall, was of assistance to the managers, and improved their knowledge of IPS, there were still gaps in the training that should be addressed to maximise the utility of the course in future. Several of the issues raised related to course participants not having a prior knowledge of IPS. This may suggest the need to:

- Modify entry screening processes for the manager training courses and/or streaming trainees so that trainees in each course have comparable knowledge of IPS
- Include a larger IPS component in the manager training
- Establish the 5-day IPS training as a prerequisite for entry into the manager training.

Manager training is reported to have had a significant impact on organisations in the areas of internal process and understanding of recovery. Organisational change related to IPS manager training is likely to have improved organisational readiness to effectively employ peer support workers.

Part 2: Evaluation of Consumer Operated Services Model

7 IMPLEMENTATION OF THE COS MODEL IN THE QUEENSLAND CONTEXT

This chapter focuses on the effectiveness and implementation of the COS program in the Queensland context. This includes a detailed examination of how the COS model is being interpreted and implemented by different organisations, and how well these service models align with the model outlined in the Department's *COS Service Model Guidelines.* The evolution and theoretical underpinnings of the COS model are described in Chapter 2.

Three organisations are currently funded by the Department of Health to provide consumer operated mental health services in Queensland. They are:

- The Brook R.E.D. (Recovery, Empowerment, Development) Centre (Brook RED), located in the south side of Brisbane; commenced COS operations in July 2009
- The Peer Engaged Assisted Recovery Lifestyle (PEARL) program of F.S.G. Australia (FSG-PEARL), in Maroochydore of the Sunshine Coast; commenced operations in July 2010
- The COS program of Psychiatric Rehabilitation Australia (PRA), based in Hervey Bay on the Fraser Coast; commenced operations in May 2012.

This chapter focuses on the implementation of the COS model in two of these organisations, namely Brook RED and FSG-PEARL COS, from their commencement in 2008 up to December 2012. The PRA COS site was not included in the evaluation as it had not been implemented at the commencement of the evaluation.

The analysis is based on interviews and information provided by the Department of Communities/Health, Brook RED and FSG-PEARL. Key sources of information included:

- Overview of Future Directions, Consumer Operated Services Program, November 2008, Updated October 2009, Queensland Government Disability Services
- Consumer Operated Services – Draft Service Model Guidelines. August 2011. Version 4, Department of Communities, Disability and Community Care Services
- Organisational profile information including operational policies and procedures provided by Brook RED and FSG-PEARL
- Interviews with Department of Health and former Department of Communities staff, December 2012
- Interviews with FSG-PEARL management and staff December 2012
- Interview with Brook RED management December 2012 and January 2013.

This chapter is presented under the following main headings:

1. Background to COS Model implementation in Queensland
2. Service implementation
3. COS Service provision
4. Risk management
5. Reporting requirements
6. Human resource and quality assurance profiles
7. Summary and implications of findings

7. Implementation of the COS Model in the Queensland Context

7.1 Background to COS Model implementation in Queensland

7.1.1 Policy and funding context

The Queensland Plan for Mental Health 2007 – 2017 outlined five priority areas for action to improve the state's mental health system. Under the priority area 'Participation in the Community' the Queensland Government 2007-08 state budget committed $98.09 million over four years for initiatives which increase access to community based services.

The initiatives included new consumer-operated crisis and relapse prevention or planned retreat/ respite places to provide short term support to service users. The consumer-operated services (COS) initiative was described by the Queensland Government department responsible for funding, developing and implementing it as, "recognition that people with a lived experience of mental illness can make a contribution to both the community and the mental health service system itself."

7.1.2 Adaptation of the Shery Mead IPS model

The Intentional Peer Support (IPS) model was developed by Shery Mead approximately fifteen years ago.[87] Research conducted by the Department of Communities indicated that outcomes for service users of Shery Mead IPS programs and centres in the USA and New Zealand closely aligned with the Queensland proposal to develop a non-clinical program, "run by service users for service users." The Department of Communities chose to develop an entirely new COS model in Queensland, "from the ground up", as it was thought that this process would best keep the integrity of Shery Mead's IPS approach.

However, unlike the Shery Mead centres in the US, the Department of Communities' vision for the Queensland COS model was that each COS forms part of the mental health service system, rather than operating in isolation. As one component of the range of acute and community based mental health services funded and provided by Department of Communities/Health, the COS were to be backed up as necessary by clinical mental health services. The Department of Communities' research into potential models for Queensland found that good relations amongst mental health service system stakeholders and support for COS programs would be strengthened by establishing local forums for regular exchange and review.

Like the Shery Mead centres in the US, COS service users were expected to have long-term moderate to severe mental illness with medium to high support needs, and receive individualised short to medium term support. Most importantly, their participation in the COS component of the Queensland mental health service system would be an empowering, rather than disempowering, experience.

7.1.3 Selected organisations

Using a competitive open tendering process, Brook RED and FSG-PEARL were selected by the Department of Communities to develop the COS model in Queensland in 2008: The selection of these organisations included regard for each organisation's capacity to acquit funding, manage risk and govern the service.

Brook RED

Established in 2001, the Brook RED Centre is a non-government organisation funded by the Department of Communities and the Department of Health and Ageing. Brook RED is a Peer Operated

[87] www.intentionalpeersupport.org (website of Shery Mead Consulting) accessed 7-1-2013

7. Implementation of the COS Model in the Queensland Context

Service providing a range of activities and supports for people who identify as having or having had a personal experience of a mental health concern or illness or has used mental health services for their own need. The Brook RED Centre currently operates from two community based centres in Brisbane South and Brisbane East. One of the centres is a dedicated COS (Norton St).

FSG-PEARL

FSG Australia was established in 1979 and was then known as Gold Coast Family Support Group. It is a non-government community based organisation offering an extensive range of services including, aged care, disability services, child protection, family support, training and employment, housing and mental health services. As a part of its mental health portfolio, FSG operates the PEARL program. Funded by the Department of Communities this is a consumer-operated service in which includes day resources, a residential component, outreach and a warm line.[88]

7.2 Service implementation

The COS service model framework[89] outlines the objectives of the COS as:

- To deliver an individualised, flexible and responsive consumer-operated service that will assist service users to develop self-management of personal crises with a focus on:
  - The development of personal wellness within a recovery framework, that is supported by trained peer workers.
  - An agreed range of support for agreed outcomes, for the individual and the program.
  - Support to individuals to establish links with a range of community stakeholders to sustain community integration and social connectedness, so that individuals do not become further enmeshed in services.

Details of how each of the two COS providers met these requirements up to December 2012, are addressed in the following sections.

7.2.1 An incremental approach

In accord with Department of Communities planning, the COS service delivery model was developed incrementally.[90] At both Brook RED and FSG-PEARL, community based supports were offered first via group and individual peer support programs, with after-hours warm lines following.[91] The final component to be introduced was the planned retreat/ respite short term residential based services. For example, Brook RED offered group and individual peer support programs from July 2009, after-hours warm lines from mid-2011 and the residential support service from September 2011. FSG-PEARL commenced their residential retreat component in July 2012, which was two years after the program established. Regardless of where or when the COS program is delivered, a core component of the service includes IPS.

[88] FSG Australia website, accessed 14-1-2013.

[89] Consumer Operated Services – Draft Service Model Guidelines. August 2011 Version 4; Section 3, Service Model Framework, 3.1 Purpose of COS, 3.2 Aim.

[90] Consumer Operated Services – Draft Service Model Guidelines. August 2011 Version 4, note that, "The Overview of Future Directions – Consumer Operated Services Program document (of 2008) discusses the frameworks used by overseas services that have developed consumer-operated services, and outlines a developmental model of service delivery, based on the experiences of these services."

[91] Warm lines are 'warm' or kind or friendly lines of outreach support provided to service users, via telephone or other media.

The IPS model prioritises, by definition, intentional rather than informal peer support. Shery Mead notes that while informal commiseration and sharing can occur among those with similar experiences, the outcomes may not always be positive and of mutual benefit to all parties; instead an intentional and systematic approach to peer support relations is warranted.[92] An individual's capability to enact an IPS relationship relies on a learning/training process. (How the IPS learning/training process was developed among the COS workforce in the Queensland context is discussed in Chapter 4).

7.2.2 Staff recruitment and work readiness

Both COS providers were clear they wished to recruit people with lived experience of mental illness, and preferably those who had persevered with finding ways to overcome their issues. Although recruiting a COS workforce was not particularly cited as a difficulty, ensuring the work readiness of the employees was more problematic and provided a major early challenge for both organisations.

Brook RED

Having first trialled the employment of informal peer support workers, Brook RED decided to prioritise the IPS model over other models of peer support. Many of Brook RED's staff had prior knowledge of the IPS approach having first read the Shery Mead Consulting Manual. This proved to be an enabler to undertaking and implementing IPS training on the job. Nonetheless, the organisation still found starting a new program while learning IPS 'on-the-go' challenging. In particular, role modelling IPS behaviour across the organisation or building IPS-informed team relationships was difficult.

Since then, all staff and Board members have now undergone training in the IPS Basic 5 day training course and 2 day Co-supervisors course.

FSG-PEARL

FSG-PEARL management highlighted the *'chicken and egg'* situation of recruiting staff with the necessary lived experience of mental illness, but not being able to start service delivery until those staff were trained in IPS. This situation was made difficult by FSG having to wait for the USA based Shery Mead Consulting trainers to be available to provide training in Australia. While all PEARL staff have now undertaken the IPS Basic 5 day training course and 2 day Co-supervisors course, some PEARL staff reported having started their employment without the benefit of IPS or any other formal training support. They also reported finding this experience challenging.

Key Finding: Recruiting staff to work in the IPS model is not problematic, but gaining the appropriate skills and confidence to practice the IPS approach can be challenging.

7.2.3 Governance

The service model framework outlines requirements regarding governance structures to support the COS model. This includes ensuring over 50% of the Board includes members who identify as having a lived experience of mental illness.

Brook RED

[92] Shery Mead on YouTube, What is Intentional Peer Support? www.intentionalpeersupport.org (website of Shery Mead Consulting) accessed 7-1-2013

7. Implementation of the COS Model in the Queensland Context

The Brook RED Board meets the criteria of majority of members with a lived experience of mental illness (four out of seven members). The Board plays a critical role in setting the strategic directions for Brook RED and have recently developed '*The Brook Red Centre Board Induction and Governance manual'* to guide their practices.

FSG - PEARL

Like all other FSG programs, the governance of the PEARL program sits with FSG Australia. At the PEARL program level, a 'Power Panel' has been established which aligns with the service model framework requirement on governance, by supporting a high level of substantial, consumer-led decision making at PEARL. The Power Panel is made up of service users who identify as having a lived experience of mental illness and who contribute to the strategic directions of the program.

Key Finding The COS programs are meeting the COS governance objectives as outlined in the model framework.

7.3 COS Service provision

Each COS provider is required to provide two key types of services:

- Mutual support and self-help (individual and group)
- Early intervention/ prevention crisis accommodation (short term – maximum of three weeks)

Table 7-1 outlines the range of services provided by each COS that align with these requirements.[93]

Table 7-1: Service provision by COS

Mutual support and self help	Brook RED	FSG-PEARL
Community based supports:		
One to one face to face IPS	✓	✓
Group based IPS program, held Monday – Friday	✓	✓
Drop in - self-support IPS	✓	✓
Social activities	✓	✓
Outreach and out of hours supports:		
One to one telephone IPS (warm lines)	✓	✓
IPS outreach calls and visits	✓	✓
Early intervention/ prevention respite accommodation and support:		
Planned retreat, including IPS, in a residential setting	✓ (2 week stay unless longer is negotiated)	✓ at pilot stage

[93] Data in Table sourced from information provided by each COS to AHA on their respective organizational profiles, in October 2012

In addition to the direct support provided, each COS provider also provided linkages to a variety of other community based supports as listed in *Table 7-2.*

Table 7-2: Linkages to community based supports

Community Based Support	Brook RED	FSG-PEARL
Facilitation of linkages to:		
Employment	✓	✓
Education	✓	✓
Vocational training	✓	✓
Housing	✓	✓
Volunteering opportunities in community	✓	✓
Drug and Alcohol services	✓	✓
Other mental health services	✓	✓
Volunteering opportunities at the COS	✓	✓

7.3.1 Framework and Guidelines for service delivery

The COS Service Delivery Framework acknowledges that COS service delivery is based on recovery-orientated values, and that self-determination is central to both the recovery planning process and the IPS approach used to deliver services.[94] The intentional aspect of IPS ensures that given the skilful application of IPS principles and tasks, sharing of similar experience can move to utilisation of the relationship with each other to create new ways of seeing, thinking and doing.[95] The COS Service Delivery Framework notes two key measures which indicate these approaches are in place, namely:

- Lead roles for service users in the design, delivery and evaluation of services
- Both the service user and provider hold a copy of the 'pro-active plan', which is developed at the commencement of support and updated at review discussions, through IPS-informed planning processes. The intent of the proactive plan is to individualise and guide interaction between service users and service providers. [96]

The COS Service Delivery Framework also requires that the COS and relevant local stakeholders establish collaborative working relationships to ensure consistency of service within and across sectors, organisations and initiatives providing support. The COS Service Delivery Guidelines provide further detail about this collaboration, by recommending that a Reference group, comprised of referral sources, be established to develop agreed processes for referral pathways and prioritisation of referrals.

Table 7-3 outlines the key elements of the COS Service Delivery Guidelines, including Priority of Referral processes:

[93] Consumer Operated Services – Draft Service Model Guidelines. August 2011 Version 4; Section 5, Service Delivery Framework, 5.4 Self-determination and peer support
[94] Shery Mead on YouTube, What is Intentional Peer Support? www.intentionalpeersupport.org Accessed 15-1-2013
[95] Consumer Operated Services – Draft Service Model Guidelines. August 2011 Version 4; Section 5, Service Delivery Framework, 5.4 Self-determination and peer support

Table 7-3: Key elements of the COS Service Delivery Guidelines

Process Milestones	Key Elements
Target Group	Adults 18 yrs and over Moderate to severe mental illness Medium to high support needs
Eligibility	Must agree to join COS program Fit with target group Residency and geographical catchment criteria
Priority of Referral	Establishment of Reference group to ensure referral and priority processes are effectively managed, such that COS has regular capacity to support new referrals
Entry into the COS	Agreed initial period of support and regular review via pro-active plan Timely communication with referral source and potential service user if COS lacks capacity to accept referral
Duration and level of support	Short to medium term support, to break cycle of frequent admission to inpatient or community mental health. Maximum of 3 weeks in residential respite.
Exiting the COS	Exit when service user: has achieved their defined outcomes; wishes to leave; has moved from catchment area or into residential aged care; support needs are above the COS capacity.

Findings in relation to each of the COS implementation relative to each of the COS Service Delivery Framework and Guidelines are provided below.

7.3.2 Service user participation

Strong levels of service user participation in all aspects of service delivery were evident at both COS providers. Examples included:

- Decision making
  At Brook RED, a Think Tank comprised of community member representatives has been established. The task of the Think Tank is to review processes, policy, procedures and organisational structures. While this group was in existence prior to COS funding, it has expanded to encompass the COS program as well as other programs. Some members of the Think Tank have gone on to become Board members or COS staff. Participation is also fostered via:
  - The IPS task of mutuality in action, which ensures, "everyone is equal", whatever their formal role at Brook RED
  - Both staff and service users answer the Brook RED 'phone and resource the temporary working parties which address arising issues of concern.
  - A complaints and feedback mechanism.

At FSG-PEARL service user decision making is fostered via its 'Power Panel' (see Section 7.3.2 for details). Regular group forums also address design, conduct and evaluation of service delivery.

- Facilitation and learning
  At both COS service users are encouraged to facilitate groups and learn IPS processes through attending IPS training sessions. They are also supported to provide aspects of the group and individual peer support program if they have an idea or interest to implement.
- Suggestions and complaints
  There is a suggestion box and comprehensive procedures to ensure service users know how to make a complaint or give feedback.

Key Finding: Service user participation in all aspects of service delivery is strong and in line with service delivery guidelines and frameworks.

7.3.3 Proactive plans

While neither Brook RED nor FSG-PEARL used the term 'pro-active plan', both COS providers had processes in place to identify individual service user needs, ways to get those needs met through participation in the program and review of progress were in place. Details of these processes are provided below.

Brook RED

During their initial visit to Brook RED, each service user is provided with information about the COS. A follow-up call is later made asking the potential service user to decide whether or not they will join the program. Provision of information about and referral to other services may be an outcome at this stage.

Once a service user requested services from Brook RED, the following process takes place:

- A peer support worker is allocated.
- An initial information form is completed by the peer support worker and service user together, and a pro-active conversation held. This conversation invited the service user to consider and identify how they have reacted in the past to crisis. For example, in incidences of self-harm, what situational variants, feelings and experiences led up to the self-harm?
- A recovery action plan is mutually developed. This focused on what the service user wishes to achieve from their participation in the program and identifies a 'mutuality action plan' (MAP), which addressed how any illness or crisis behaviour should be addressed by Brook RED.
- The MAP is reviewed every three months.

In Brook RED's draft *Addendum: Documentation of Individual Risk Management*, it states that pro-active discussion and MAP documentation should be filled in as soon possible, upon the service user engaging with Brook RED (within one month). The Addendum also indicates that care should be taken to ensure this documentation is updated whenever new information becomes available, and reviewed at minimum on a six monthly basis. Emergency contact and medical information should be collected as soon as possible (within two weeks of service user engaging with Brook RED), and provided further detail about what should be included in the MAP, where it should be documented and to which staff it should be disseminated.

There was no specific evidence found that the service user held a copy of the recovery action plan or MAP.

Service usage is reviewed each month by the co-ordination team. Each IPS worker is allocated between 12–18 service users was and is responsible for following up and reviewing their allocated case load.

FSG-PEARL

FSG-PEARL allows the potential service user three chats or visits before asking them to decide on whether they will join the program or not. If the person has an intellectual disability more decision making time may be allowed. Provision of information about the COS and/or referral to other services is also a feature of the PEARL entry process.

Once a service user requested services from FSG-PEARL, the following process takes place:

- Staff conduct pro-active conversations to establish agreed plans for actions PEARL could take in the event service users became unwell. While this agreement was not always documented as a plan for each service user, the conversation was always documented.
- An ongoing FSG-PEARL management review process determines which service users are actively engaging with the service, or choosing to remain inactive or requiring follow up from allocated staff. The outcomes of this review were documented in service user files.

The PEARL draft Policy Manual noted that service users had the right to:

- Access PEARL based on their need for a service compared to the needs of other service users
- Participate in proactive conversations to identify a service component that meets their individual needs
- Be supported to participate in PEARL activities of their choice
- Have their choices and decisions respected within duty of care requirements
- Work with IPS workers who have the relevant competencies in IPS.

Processes were also documented for service users to access personal information held about them. However no specific evidence was found that service users hold a copy of the results of any joint planning.

The PEARL draft Model Policy Manual indicates that for each service user who accessed PEARL, a file is established which contains:

- *About Me* form information including emergency contact information
- Records of any joint conversations held between the service user and their IPS worker.

Consultations with both COS indicated that certain key items of information were not recorded or requested of service users. In particular, details of diagnoses were not sought.

Key Finding: Record keeping and planning processes need to be strengthened in these areas to ensure transparency, consistency and practice quality.

Key Finding: While service users have access to their documentation, they are not routinely provided with copies of their service delivery plans such as Mutuality Action Plans or recovery action plans, or the outcomes of joint IPS conversations.

7.3.4 Reference groups

Both Brook RED and FSG-PEARL set up local Reference groups at establishment, comprised of relevant mental health and service system providers, including clinical, non-government (housing, disability, dual diagnosis), hospital and community based service providers.[97,98]. Each Reference group had spent effort establishing referral and priority processes and now works to maintain them.

7.3.5 Target groups and eligibility guidelines

During consultations, COS staff and management presented a strong perception was that service delivery aligned with the specific target group and eligibility guidelines. While some minor anomalies were evident in the data and reported in the consultations, overall this perception was found to be accurate.

Policy and procedural information was also found to be appropriately aligned.

Specific challenges were identified in relation to service delivery. These included:

- Brook RED advised that some potential service users with culturally and linguistically diverse backgrounds do not necessarily acknowledge mental illness, nor its signs and symptoms. In these instances, staff invite service users to consider whether the Brook RED service meets their needs.
- PEARL cited the size of their geographical catchment area as a challenge in delivering the program. In addition, if potential service users present with dual diagnosis issues, PEARL may prioritise mental illness over Alcohol and Other Drugs. If a potential service user has Acquired Brain Injury or other cognitive difficulties, PEARL is careful to ensure the person has the capacity to engage in IPS conversations.

Key Finding: Further work to address the needs of CALD potential service users should be considered. The cultural appropriateness of the services for Aboriginal and Torres Strait Islander service users also warrants consideration.

[97] Brook RED established a Collaborative which now has representation from 47 organisations across south side of Brisbane , including inpatient mental health services and Medical Local members. Brook RED has used its reference group to develop joint funding proposals, research initiatives and joint responses to Government planning initiatives. The Reference groups of both COS have worked to clarify referral processes, identify suitable COS service users and monitor availability of places at COS program components.

[98] The PEARL Reference group comprises Disability, Homelessness, Service Integration Coordination, Mental Health NGOs, Acute hospital based, Continuing Community Care, Outreach and Aboriginal and Torres Strait Islander mental health services, Alcohol and Other Drugs Services.

7.3.6 Referrals

In regard to COS capacity to support new referrals, Brook RED reported successfully overcoming waitlist issues with their They are also supported to provide aspects of the group and individual peer support program if they have an idea or interest to implement program once a second site for service delivery became available. While demand for their retreat/residential component has at times exceeded capacity, negotiation with potential service users to use the warmlines and/or pro-actively plan for a delayed service, has ensured continuity and satisfaction with service delivery. The FSG-PEARL program has not yet reached capacity and noted their outreach work to connect with potential users who do not necessarily use the mainstream mental health service system.

Key Finding: Both COS programs have put local reference groups in place. These reference groups are constituted in line with the appropriate guidelines.

7.3.7 Duration of support

Neither COS provider quantified what 'short to medium term support' means in practice, except in regard to length of stay in the retreat/residential component of service delivery where length of stay is always planned to work within the three week program guidelines. At interview, both COS providers emphasised the flexible and responsive nature of service delivery. For example, Brook RED advised that their retreat/ residential component can act as a 'step up step down' facility, and increasingly, service users can be referred to internal programs as needed.

7.3.8 Exit processes

Both organisation's policies and procedures include processes for determining and documenting an individual service user's reason for exiting the service and request for feedback on services provided. Both COS providers stated that service users have the option of re-engaging with the service at a later point if needed. Frequent re-engagement was reported during the service user consultations.

7.4 Risk management and quality assurance

The COS Service Model Guidelines outline other funding and reporting responsibilities, and refer to the continuous improvement frameworks in use in the sector.[99]

As quality controlled organisations, both Brook RED and FSG-PEARL reported a current focus on improving their risk management processes. The impetus for each program's continuous improvement of risk management however has differed.

Brook RED – external impetus

Brook RED's voluntary participation in the HSQF trial resulted in recommendations for improvement in the area of risk management. Brook RED reported recently spending approximately six months refining and developing six policy and procedures on risk management and specific risk situations. The new or refined policy and procedures addressed how to document risk management processes in place for individual service users, providing background information on the organisation's IPS-informed approach

[99] Consumer Operated Services – Draft Service Model Guidelines. August 2011 Version 4; Section 6. Funding and Reporting Responsibilities, 6.1 Service Agreement, 6.2 Monitoring/review, 6.3 Evaluation, 6.4 Privacy and Confidentiality

to risk management plus documentation and review of staff professional boundaries[100]. The specific risky situations addressed were:

- Service user violent behaviour
- Suspected abuse or neglect of a service user
- Service user self-harm.[101]

These remain in draft form, and like Brook RED's work to refine other organisational policies and procedures, the process for completion involves a rigorous process of stakeholder participation. Brook RED management also emphasised that the development of policies and procedures for specific risky situations was as a result of staff requests for clearer, more tangible procedural guidelines in regard to professional boundaries and managing risk in specific situations with service users, as the implementation of IPS, "can be very airy fairy."

FSG-PEARL – internal impetus

For FSG, the impetus for IPS-related risk management arose from internal sources. The expansion of IPS to their broader non-IPS community mental health programs presented a challenge to the organisation, as many of the clinically mental health trained managers went into "*risk management mode… [because]..IPS conflicts with how they have been trained*." FSG is currently addressing this situation by:

- Providing training on IPS for non-IPS managers of FSG community mental health programs
- Re-writing FSG policies and procedures on risk management, with particular focus on how risk of suicide is handled. FSG identify this as a situation where the IPS approach and conventional risk management approach differ most. The purpose of this redrafting is to reassure non-COS managers that their duty of care in relation to suicidal service users is covered by the IPS approach
- A concurrent process of drafting policies and procedures for the PEARL program. i.e.: via the draft *PEARL Model: Policy Manual*, which includes a chapter entitled, *Risk management and duty of care at PEARL*. The accompanying *The PEARL Model: Intentional Peer Support Worker Manual*, which includes chapters on bottom lines of behaviour for peer workers in IPS relationships and how to negotiate those limits, also remains in draft form.

Although the approach by both COS providers to risk management remains a work in progress, both emphasised their wish to uphold the empowering approach of IPS with service users. That is, a key concern of the IPS approach is to position itself in a place of hope rather than one of fear, such that times of distress and crisis can be reframed as opportunity for growth and personal discovery. The nature of the IPS relationship means that in practice IPS workers and service users alike may need to sit with considerable discomfort during an individual's time of distress or crisis, and share anxiety about the potential for risk. At the same time as an individual may be in crisis, the COS provider is obliged to ensure a safe environment exists for others present. In the IPS model, this demands a collaborative approach between service users and COS management on creating and maintaining a mutually respectful community.

[100] Brook RED policy and procedure provided to AHA January 2013 included: Draft Addendum –Documenting Individual Risk Management; draft Background to Risk Management; draft Friendship Declaration

[101] The other Brook RED policy and procedure provided to AHA January 2013 included draft RM3 Violent Behaviour Policy; draft RM4 Suspected Abuse or Neglect of a member; draft RM 2 Self Harm Policy;

Examples of how Brook RED and FSG-PEARL reported managing this fine balance between dignity of risk for the individual and organisational risk management follow (Table 7-4):

Table 7-4: Approaches to risk management: Examples from each COS provider

Brook RED	FSG-PEARL
All service users have a pro-active interview and MAP.	Use of emergency call buttons in COS service delivery premises or locks on staff bedroom doors in retreat/residential services or dedicated phone lines for staff have been rejected on the grounds that this would undermine the trust and respect that IPS builds.
Monthly reviews are conducted of the Brook RED Centre Bottom Lines with IPS workers, which state a number of 'must nots', or professional boundaries - such as not engaging in sexualised conduct with service users or not using social media sites in the same way as used with friendships	PEARL has successfully managed such risks to service users and staff as aggressive, intoxicated or bleeding service users entering the group and individual peer support program premises via the commitment of the IPS community to maintaining a safe and respectful environment for all. For example, when a service user wanted to bring his pet snakes into the group and individual peer support program, permission of service users and staff present was first sought and the service user abided by the community's decision.
Staff who need to call mental health services, as part of a pro-active conversation or enactment of a MAP, with service users, receive support.	A number of bottom lines or professional boundaries have been set with staff in relation to relationships with service users. Staff have received coaching on how to implement the boundaries; the boundaries are in the process of being written up into the IPS Worker Manual.
If the service user is unwilling to meet reasonable conditions required within the delivery of support, thus affecting the safe or effective delivery of a service to the peer and peer's community and/or the health and safety of all peers and staff, support is withdrawn.	PEARL staff have never had reason to call the police to assist in the management of service user unwanted behaviour. Staff have been supported to call ambulance services when a service user was at risk of self harm.

Key Finding: Work is currently underway in the area of risk management. This work needs to be continued as a high priority and the desire to maintain an empowering approach that maintains the fine balance between dignity of risk for the individual and organisational risk management needs to be reconciled.

7.5 Reporting requirements

Each COS provider is required to submit data to the Department of Communities on a six-monthly basis. The inadequacy of the information collected for monitoring and planning purposes is discussed in Chapter 9.

7.6 Human resource and quality assurance profiles

The human resource of both COS providers involved in the evaluation are summarised below (*Table 7-5* and *Table 7-6*).

Table 7-7: Human resource and quality assurance profile of Brook RED, at October 2012

Brook RED			
Staff: all have lived experience of mental illness; all are paid			
Title	Number	Full-time/part-time	Highest Qualifications held by staff
General Manager	1	Full-time	1 Cert IV Mental Health and AOD 1 Cert IV Mental Health 1 Diploma Community Services 1 Diploma Youth Work 1 B Ed
Senior Coordinator	1	Full-time	
Coordinators	3	Full-time	
Finance Officer	1	Full-time	Diploma Accounting
Office Manager	1	Full-time	Diploma Marketing
Peer Support Workers	12	2 Full-time 10 Part-time	1 No qualifications 3 Year 12 1 Cert III Cookery 4 Cert IV Mental Health 1 Bachelor Community Development 2 Masters Human Services
Total:	19		
Accreditation Profile:			
Whole of organisation quality accreditation was not a requirement of Brook RED funding from Department of Communities at the COS inception However, Brook RED applied and joined the trial of Queensland's Human Services Quality Framework (HSQF) in 2011, and achieved accreditation. Brook RED intends to continue with the accreditation process during the proposed roll-out of HSQF certification in early 2013.			

Table 7-8: Human resource and quality assurance profile of FSG-PEARL, at October 2012

FSG-PEARL				
Staff: all have lived experience of mental illness; all are paid				
Title	Number	F/T or P/T	Highest Qualifications held by staff	
Manager	2	F/T	Multiple Diplomas	1 BA

FSG-PEARL				
Staff: all have lived experience of mental illness; all are paid				
Title	Number	F/T or P/T	Highest Qualifications held by staff	
Senior Coordinator	1	F/T		
IPS Facilitator	1	P/T	3 Diplomas of Community Welfare or variant	3 in process of completing Cert IV in Mental Health
IPS workers	5	P/T		
Administration Assistant	1	P/T	Cert III in Administration	
Total:	10			
Accreditation profile:				
Whole of organisation quality accreditation was a requirement of funding from the Department of Communities at the COS inception. Having previously been accredited against the Disability Services Standards (DSS), FSG subsequently joined the trial of the HSQF in 2011 and achieved HSQF accreditation.				

These profiles indicate that all staff in both COS providers have a lived experience and occupy paid positions. However, the level of relevant work role qualifications differed between COS providers. Considerable differences exist between managerial/administrative staff and those in IPS positions at Brook RED. While all of the former had some relevant work-related qualification, 5 of 12 of the IPS workers did not. By implication, this means that those in IP roles in Brook RED are reliant on IPS training for role readiness.

Key Finding: While many of the COS managerial/administrative staff held relevant work-related qualifications, IPS workers were considerably less qualified. In some cases, IPS training was the only relevant work-related training that IPS workers had completed.

7.7 Summary and implications of findings

Recruiting staff to work in the IPS model is not problematic, but gaining the appropriate skills and confidence to practice can be challenging. While many of the COS managerial/administrative staff held relevant work-related qualifications, IPS workers were considerably less qualified. In some cases, IPS training was the only relevant work-related training that IPS workers had completed.

Record keeping and planning processes need to be strengthened to ensure transparency, consistency and practice quality. There is a lack of clinical and program data available to support planning and evaluation of outputs, impacts and outcomes of the program. Without prioritisation of data collection, it is, and will continue to be difficult to substantiate claims of spectacular program outcomes that are regularly communicated anecdotally by program stakeholders.

The COS providers appear to be meeting the COS objectives as outlined in the model framework. Service user participation in all aspects of service delivery is strong and in line with service delivery guidelines and frameworks. While service users have access to documentation recorded about them, they are not routinely provided with copies of their Mutuality Action Plan (nor recovery action or pro-active or other named service delivery plan; nor documented outcomes of joint IPS conversations).

7. Implementation of the COS Model in the Queensland Context

Both COS providers have put local reference groups in place. These reference groups are constituted in line with the appropriate guidelines.

Further work to accommodate the needs of CALD potential service users should be considered. The cultural appropriateness of the services for Aboriginal and Torres Strait Islander service users also warrants consideration.

Work is currently underway in the area of risk management. This work needs to be continued as a high priority and reconciled with the desire to maintain an empowering approach.

8 EFFECTIVENESS OF THE COS MODEL: ORGANISTATION LEVEL PERSPECTIVES

This chapter discusses the effectiveness of the COS model by considering the extent to which it has employed processes that enable provision of an individualised, flexible and responsive service. The following are addressed:

1. Building the peer support workforce
2. Providing a flexible and responsive service
3. Building relationships and linkages with other organisations in mental health service sector
4. Implementing sound governance processes and organisational practices.

For each of these areas, both achievements and barriers/challenges are highlighted.

The service-level perspectives that are addressed in this chapter have been drawn from consultations with:

- COS managers (n=2)
- Senior manager responsible for overseeing operations of one COS (n=1)
- Peer support workers (n=13)
- Department representatives – formerly with Queensland Department of Communities; now Queensland Health) (n=2)
- Representative formerly working with Department of Communities representative (n=1)
- Service system stakeholders (including representatives that refer service users to the COS and receive referrals from the COS) (n=7).

The effectiveness of the COS model in terms of service user outcomes is separately addressed in Chapter 10 and therefore is not described in this chapter.

8.1 Building the peer support workforce

8.1.1 Achievements

All of the stakeholders interviewed were positive about the extent to which the COS had contributed to developing the peer support workforce. Employment in the COS was seen as an important way of building experience in implementing the principles of the IPS training. As discussed in Chapter 5, COS managers and peer support workers agreed that the IPS training itself was insufficient to build a peer support workforce, and that 'on the ground' experience was vital.

Key Finding: COS programs are a key employer of IPS workers in Queensland, and as such, they are an important training ground that is helping to build the IPS workforce.

8.1.2 Challenges and barriers

As discussed in previous chapters (Chapters 2 and 5), the role of IPS worker is challenging, not only because it involves developing deep and trusting relationships with people who may be considerably

troubled, but also because it requires that people with a mental illness self-disclose highly personal information. According to one COS manager, this has proven too discomforting for some IPS workers, who have reverted to regular support worker roles.

COS managers experienced some initial difficulties in establishing the COS program difficult because workers needed to be '*recruited on potential and then trained*'. One COS manager reported that it can take up to a year for the workers to begin working effectively. In the early days, a chicken-and-egg situation existed, where the COS management wanted to commence service delivery but did not have sufficiently skilled staff to do so. The IPS workforce tends to be mostly part-time, which adds a further challenge. COS managers also indicated that the cost of training, and, for one COS, access to training provided were challenges in building the workforce.

Key Finding: Selection procedures for training recipients are important as the work is challenging from a personal perspective for many workers and requires intense practice and self-reflection.

8.2 Providing a flexible and responsive service

8.2.1 Achievements

All service sector stakeholders interviewed reported that the process for referring their service users to the COS provider was straightforward, with one interviewee stating that no paperwork was required for referral. To their knowledge, waiting times were either non-existent or negligible. The COS programs accepted referrals from a range of organisations, and proactively promoted themselves to other services, such as acute mental health services.

According to COS managers, the COS services were comfortable with referring service users to other organisations for certain services (e.g. AOD), or on-referring those service users who were not in a position to engage effectively in IPS conversations at the COS. Service sector stakeholders concurred that the COS programs were responsive to service users' needs and referred on to other organisations when required.

Key Finding: Referrals into and out of COS programs are reported to be working well.

8.2.2 Barriers and challenges

Three barriers/challenges were raised during consultations regarding the ability of the COS model to provide a flexible and responsive service. Firstly, access to the services by public transport was difficult for some service users. Secondly, one service system stakeholder, who worked primarily with Aboriginal and Torres Strait Islander service users, felt that the lack of Aboriginal and Torres Strait Islander staff at the COS providers meant that Aboriginal and Torres Strait Islander service users were less likely to engage with the service, and if they did so, they often took their Aboriginal workers with them. Despite this limitation, the same interviewee reported that the COS service would call his team if they had specific questions about cultural issues. The third challenge, reported by one COS manager, was that the geographical catchment area for the service was large, and made providing outreach services costly and time-consuming.

Key Finding: There are few barriers and challenges to providing flexible and responsive services. Primarily they relate to transport issues and geographical location which is a function of the fact there are presently only two services available.

8.3 Building relationships with other organisations in the mental health service sector

8.3.1 Achievements

The interviewees were consistently positive about the relationship between the COS providers and other organisations in the mental health service sector. COS management were reported to invest considerable effort to engage with other organisations, including sitting on boards and reference groups, conducting presentations and other promotional activities and proactively raising awareness of the services on hospital wards and in other settings. According to COS managers and peer support workers, interest in the COS model amongst other organisations continues to grow over time because of the positive outcomes achieved for service users. This is illustrated by the following quote:

'The best advertisers are our peers who go to their doctor or case manager with positive stories'

Department representatives described the COS model as a paradigm shift in mental health service delivery: '*people [with mental illness] can make a contribution not only to the community but also to the service system'*. An important measure of success is the fact that other areas of Queensland have learned of the two COS programs operating and are now reportedly requesting a COS in their area. Department representatives reported that the COS model has achieved considerable success in taking the principles of recovery and consumer empowerment and putting them into practice.

Key Finding: Without exception, the COS providers were viewed positively by all stakeholders involved in the evaluation. Although the paradigm shift in care provision was acknowledged as an issue, those familiar with the services always reported positive interactions and results.

8.3.2 Barriers and challenges

It appears to have taken some time for the COS providers to negotiate their position in the service system and raise awareness about what they offer. One Queensland Health representative felt that the COS providers could have done more to promote the availability of the accommodation service in particular. One COS manager suggested that initially, the COS was seen as a 'dump and run' option to which services would send service users who were making no headway with clinical management. Conversely, some clinically oriented services initially were reluctant to refer to the COS as they viewed it as not sufficiently professional with inadequate risk management processes. However, all stakeholders agreed that these challenges had been overcome, and that the COS fills a vital niche in the service system as one option amongst a spectrum of services.

Key Finding: Initially, the COS providers had to negotiate their position in the service system and raise awareness about what they offer. COS now fills a vital niche in the service system as one option amongst a spectrum of services.

8.4 Implementing sound governance processes and organisational practices

8.4.1 Achievements

Both of the COS providers have effectively implemented the key elements of consumer control within their programs and have participated in Queensland's 2011 Human Services Quality Framework accreditation trial. As discussed in Chapter 6, as quality assured organisations each reports a current continuous improvement focus on risk management.

8.4.2 Barriers and challenges

The key barrier in relation to implementation of sound governance and organisational practices was articulated by COS managers and Department representatives, who spoke of a tension that exists between the principles of IPS and the statutory approach to risk management that applies to all Australian workplaces. While COS managers described risk management as a dynamic process in which the risk of harm to peer support workers was constantly being assessed, they also suggested that the imperative of risk management needs to be balanced with the need for trust and openness in relationships (a key tenet of the IPS approach). For example, within the accommodation service at one centre there were no locks on the doors of staff bedrooms, as this was seen to inhibit the development of trust with service users.

The COS managers explained that in most cases, risky situations with service users can be defused by having open and honest ('pro-active IPS') conversations which work through individual service user issues. The COS managers claim that the effectiveness of this approach is demonstrated by the way in which critical incidents or potentially violent situations have been effectively managed in group and individual peer support programs and retreat/residential settings to date. Department representatives acknowledged that there were some concerns when the accommodation services first opened, with staff having raised concerns about their ability to deal with crisis situations, but these were subsequently resolved. However, as crisis training was not introduced until 2012, staff involved in the provision of residential services did so without crisis training.

Another challenge relating to risk management concerned the support provided to peer support workers. While COS managers claimed that the co-supervision processes in place are sufficient to support the self-care needs of peer support workers, they also reported that some clinically-oriented staff at other services felt that this was inadequate and that a formal, professional supervision process was preferable. As reported in Chapter 6, organisational policy and procedure in relation to staff professional boundaries in IPS relationships were in re-drafting stage in both COS at the time of consultation.

Consultations also revealed stories of the reactive manner in which risk management occurs in the COS i.e. in the absence of formalised risk management policies and procedures, risk management is undertaken through a reactive process whereby staff subjectively respond to risk situations without direction from pre-approved procedural guidelines. This reactivity raises concerns regarding whether adequate protections are in place for workers. Given the lack of service users' diagnostic details and the absence of clinical training for staff, IPS workers and staff have little if any knowledge of clinical signs of deterioration in a peer's condition. Consequently, the risk management procedures that have been implemented within COS would not be deemed satisfactory in other community health settings. Whilst the need for innovation in mental health services is acknowledged and applauded, the health and safety of workers should remain the highest priority. Furthermore, during focus groups with IPS workers indicated that they would like to learn more about mental health diagnoses.

Risk management policies have also developed reactively. At Brook RED, policy development was primarily in response to the HSQF audit. At FSG, policy was developed in response to rolling out the IPS model to staff with a strong clinical background throughout the broader FSG organisation; and as part of their continuous quality improvement processes.

Reactive risk management therefore appears to be the most prevalent form of risk management at the COS at the moment. This means that once a risk becomes apparent, processes to deal with the risk are put in place. Unfortunately this means that in the interim staff are potentially put at risk. Lack of education and clinical knowledge puts IPS workers into a situation where they are ill-informed and ill-equipped to deal with situations and keep themselves safe from risk in the workplace.

Key Finding: Tension remains between principles of IPS and the statutory approach to risk management that applies in all workplace settings throughout Australia.

Key Finding: Risk management procedures are generally reactive and need to be strengthened to protect both the IPS workforce and service users.

8.5 Summary and implications of findings

COS services are primary settings in Queensland that employ IPS workers, and as such, they are an important training ground that is helping to build the IPS workforce. Selection procedures for training recipients are important as the work is challenging from a personal perspective for many IPS workers and requires intense practice and self-reflection. Care should be taken to ensure workers are supported appropriately as they continue their own recovery journey whilst conducting their mutuality relationships with their assigned peers.

There are few barriers and challenges to providing flexible and responsive services. Transport issues and geographical location are problematic but this is primarily a function of the fact there are presently only two COS providers available in the region.

Without exception, the COS providers were viewed positively by all stakeholders involved in the evaluation. Although the paradigms shift in care provision is acknowledged as an issue, those familiar with the services always report positive interactions and results. Referrals into and out of COS are reported to be working well.

Although early program problems have been resolved, a remaining issue exists around the adequacy of current risk management processes. Tension remains between principles of IPS and the statutory approach to risk management that applies in all workplace settings throughout Australia. For this reason, risk management procedures within the COS need to be strengthened to ensure greater alignment with statutory requirements and thus better protect the IPS workforce.

9 COS: PROFILE OF SERVICE USERS

This chapter presents a profile of COS service users in terms of:

- Demographic characteristics
- Type and duration of support.

The profile has been drawn from the Statistical Reports submitted by the COS program managers to the Department on a six-monthly basis. Significant data limitations (described in Section 9.1 below) have prevented development of a detailed profile of COS service usage, and the data presented in this chapter should be interpreted with caution.

9.1 Data limitations

The main source of COS activity data available to the evaluation is the Statistical Report submitted by each COS provider to the Department. A blank Statistical Report template is provided in Appendix H.

The Statistical Reports were designed to capture the following information for Accommodation Services and Mutual Support Services:

- Service user demographics (gender, age range, Aboriginal or Torres Strait Islander status, CALD status)
- Number of referrals received and accepted
- Referral sources
- Support duration (length of stay) for Accommodation Service service users only
- Location of services provided.

Analysis of the Statistical Reports identified a number of limitations which are itemised below.

Table 9-1: Data limitations of Statistical Reports

Issue	Details/examples	Implications
Errors in the template design	Overlap between age ranges categories (e.g. 25-35 years, 35-50 years)	Service users on the borderline between two age ranges could potentially be allocated to one of two categories, thus weakening age group analysis
	The age category '60-65 years' is listed twice for the accommodation services	Potential double counting of service users in this age group
	The age range 25-35 years is listed twice in the mutual support services component of the template provided to Brook RED	Potential double counting for service users in this age group Comparability between COS providers compromised.
	Referral categories not defined	See inconsistent interpretation of measures below
	Lowest age group is 15-18 years	Under the COS service Delivery

9. COS: Profile of service users

Issue	Details/examples	Implications
		Guidelines (Chapter 7), the target group for service users is 18 years and over.
	Warm line usage details not captured	Full details of COS activities not captured (i.e. number of calls, characteristics of caller, etc).
	Intensity of service usage not adequately captured	Capturing data on new clients only results in significant under-reporting of COS activities as number and characteristics of recurrent users not captured. Exception being the duration of stay in accommodation services.
Data entry errors	For example, discrepancies were evident between the total number of service users shown by gender and other categories e.g. age	Reliability of data compromised
Inconsistent interpretation of the measures described.	For example, one service interpreted 'referrals received' to include a combination of new referrals into the program, referrals between mutual support and accommodation services, and referrals to external services (such as housing or vocational services).	Reliability of data compromised
Uncertainty regarding whether the data captured for each reporting period relates to new service users only, or to both new and ongoing service users.	COS advised that: ▪ All data reported to Dec 2011 included cumulative figures. Analysis of data provided for the period did not support this. ▪ From January 2012, only new clients were reported	▪ It is impossible to determine the total number of service users for each COS during a reporting period. ▪ Under-reporting likely as return service users would not be counted if that were the case.

No guidelines for were provided to the COS providers to assist in completing these Statistical Reports, hence the limitations listed above. Attempts to clarify data inconsistencies with COS staff failed to yield explanations that fully resolved the observed inconsistencies.

Accordingly, it has not been possible to develop a detailed profile of COS users, nor to analyse changes in levels of service usage between reporting periods. The profile presented below therefore provides limited information about the demographic characteristics of services users and patters of service usage.

9. COS: Profile of service users

Key Finding: Inconsistencies and gaps in the data captured within the Statistical Reports completed by each COS provider meant that it is not possible to present an accurate picture of the demographic characteristics of COS service users, referral patterns or levels of service usage.

Key Finding: There is a lack of clinical and program data available to support planning and evaluation of outputs, impacts and outcomes of the program.

Key Finding: Without prioritisation of data collection, it is, and will continue to be difficult to substantiate claims of spectacular program outcomes that are regularly communicated anecdotally by program stakeholders.

9.2 Demographic characteristics

To optimise the likelihood of data consistency, the demographic profile presented in this section is based on the most recent Statistical Report data (July-December 2012 reporting period). This was the first period where Mutual Support Services and Accommodation Services were operating at both Brook RED and FSG-PEARL. The figures presented represent aggregated service usage data for Brook RED and FSG-PEARL. In conducting this analysis, it has been assumed the data relates to new service users who entered the program during the reporting period.

9.2.1 Gender

As shown in the following *Table 9-1*, the majority of clients accessing both accommodation services and mutual support services were male (59% and 64%, respectively).

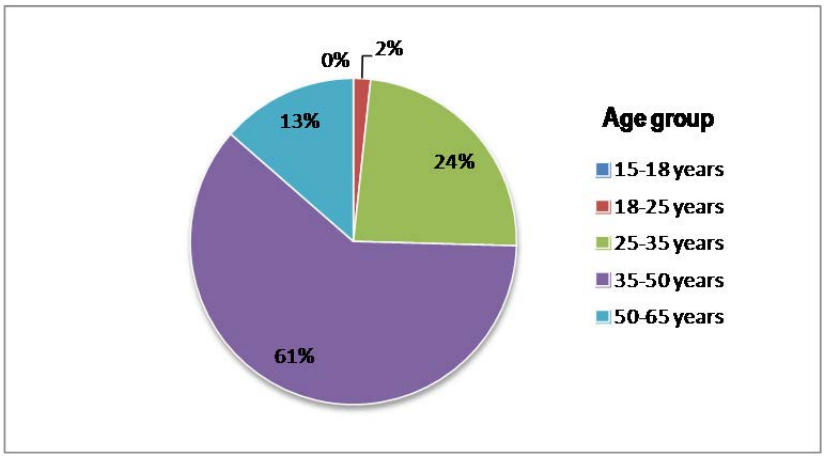
Table 9-2: Gender of clients

Gender	Accommodation services, n (%)	Mutual support, n (%)
Male	35 (59%)	221 (64%)
Female	24 (41%)	126 (36%)
Total	59 (100%)	347 (100%)

9.2.2 Age

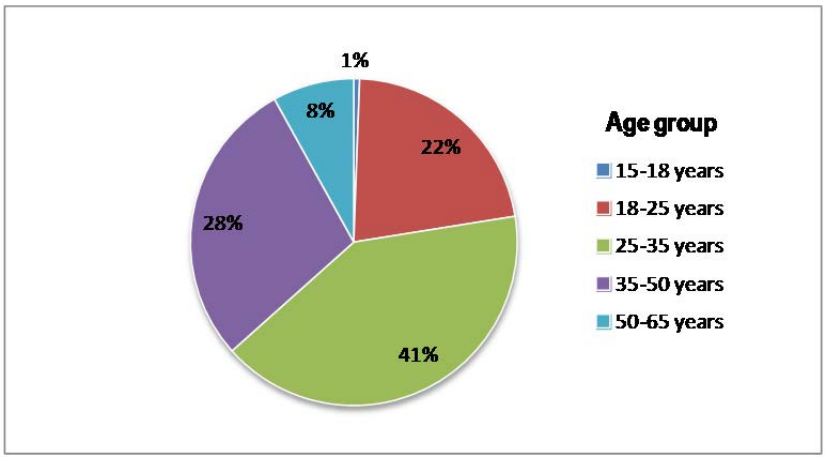
The majority (61%) of service users accessing accommodation services were between 35-50 years of age (*Figure 9-1*). The second largest service user age-group was the 25-35 years cohort (24%).

Figure 9-1: Age group for accommodation services



The age group profile of those accessing mutual support services differed from those using the accommodation services (*Figure 9-2*). The majority (41%) of mutual support service users were between 25-35 years of age, followed by 35-50 years (28%).

Figure 9-2: Age group for mutual support



One per cent of service users fell into the 15-18 year age group. The target group specified in the COS Service Delivery Guidelines are persons 18 years and over. Whether this signifies that the age range of service users in this age category was inconsistent with the target group guidelines is unclear. A service user as young as 16 years was recorded in an earlier Statistical Reports (not presented here).

9.2.3 Aboriginal and Torres Strait islander and CALD background

As shown in *Table 9-3*, people from Aboriginal and Torres Strait Islander and CALD background represented a relatively small proportion of the COS service user population. None of the accommodation service users were of Aboriginal and Torres Strait Islander background and only five of the mutual support services (1%) were. While proportionately more people of CALD background were evident in the service usage profile, they comprised only 5% and 8% of accommodation services and mutual support service users respectively.

9. COS: Profile of service users

Table 9-3: Cultural background

Cultural background	Accommodation services, n (%)	Mutual support, n (%)
Aboriginal and Torres Strait Islander	0 (0%)	5 (1%)
CALD	3 (5%)	27 (8%)
Neither Aboriginal and Torres Strait Islander or CALD	56 (95%)	315 (91%)
Total	59 (100%)	347 (100%)

9.3 Referral patterns, type of support and support duration

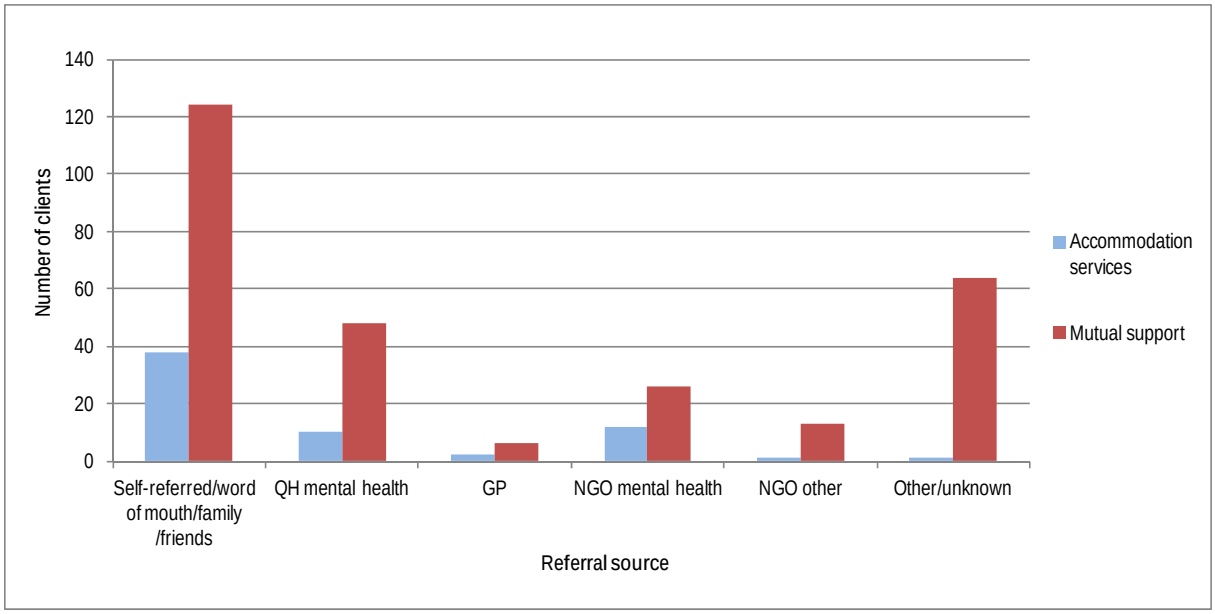
9.3.1 Referral patterns

Conflation of internal and external referrals as well as inconsistencies in terms of what constituted a referral meant that the number of referrals received and accepted by each COS could not be established from the Statistical Report data.

Referral sources

Figure 9-3 shows the range of referral sources cited by the COS for the July-December 2012 reporting period.

Figure 9-3: Referral source



As shown in *Figure 9-3*, the most commonly cited referral source for both the COS accommodation and mutual support services was 'self-referral/word of mouth/family'. Queensland Mental Health services and 'other mental health non-government organisations' were also important referral sources for mutual support services while other NGO mental health services featured as referral sources to the accommodation services. The referral source for a substantial number of mutual support service users was unknown.

Again, it should be noted that due to inconsistencies in the interpretation of what constitutes a referral, the absolute numbers of referrals shown in Figure 9-3 should be interpreted with caution.

9.3.2 Type of support

While the Statistical Reports indicate that both Accommodation Services and Mutual Support services were provided for the July-December 2012 period, no further information is provided regarding the type or range of services.

Chapter 10 provides some more detail about the services/activities used by those service users who replied to the service user survey at each COS. However, it should be noted that the extent to which the survey sample is representative of the broader COS population is unknown.

9.3.3 Duration of support

Duration of support has been reported for people using the Accommodation Services only and specifically refers to length of stay. Duration of support differed by COS, ranging from 1 to 14 days (average of 4.1 days) at one COS site, and 2 to 4 days (average 2.8 days) for the other COS site.

9.4 Summary and implications of findings

Inconsistencies and gaps in the data captured within the Statistical Reports completed by each COS mean that it is not possible to present an accurate picture of the demographic characteristics of COS service users, referral patterns or levels of service usage.

To ensure that more consistent, accurate and useful data is captured during future reporting periods, the Statistical Report template needs to be revised and refined, and a data dictionary developed to ensure users have clear definitions of what data is required for each variable. Capacity building with COS staff may also need to be considered particularly in relation to data collection and entry processes.

10 EFFECTIVENESS OF THE COS MODEL: SERVICE USERS' PERSPECTIVES

In this chapter, the effectiveness of the COS model is examined from the following perspectives:

- Service user satisfaction with the services provided
- Outcomes for the target cohort
- Progress towards recovery.

The data informing this discussion has been obtained from:

- The service user survey conducted in November 2012 (refer Chapter 3 for details)
- Interviews of service users
- Interviews with COS managers and IPS workers
- Interviews with external/referring organisations.

Details of these data sources are described in the following Section 10.1.

10.1 Service user outcomes: Data sources

10.1.1 Service user survey

The service user survey collected information from COS service users regarding usage of COS programs, satisfaction with the service, and outcomes resulting from the support they received at the COS (refer Chapter 3 for details). A profile of the survey respondents (including demographic details and information on COS service usage) is provided in Section 10.2

10.1.2 Interviews of service users

Interviews were held with service users at both Brook RED and FSG-PEARL. In total, nine service users were interviewed either individually or in small groups. Six interviewees were female and three were male.

10.1.3 Interviews with peer workers and management

Further information regarding service user satisfaction and outcomes was obtained through interviews with peer workers and management at both COS sites. Interviews with peer workers were a particularly rich source of information because many peer workers were previously service users of the COS and were therefore able to comment from a personal perspective, as well as being able to describe the outcomes of the service users they worked with in their subsequent role as peer workers.

In addition, interviews with COS managers elicited some information about the service user outcomes observed through the programs.

It should be noted that at both COS sites, baseline and outcomes data is not routinely collected or documented. Therefore, given the relatively small number of respondents to the survey, the information in this chapter should not be considered representative of the COS.

10.1.4 Interviews with service system stakeholders

Telephone interviews were conducted with representatives from a number of mental health organisations that work with the COS program, including:

- Three representatives from mental health non-government organisations
- Three representatives from Queensland Health, covering acute inpatient and community mental health services (including one psychiatrist)
- One representative from a Queensland Health team which works specifically with Aboriginal and Torres Strait Islander service users.

These organisations have made referrals to, and accepted referrals from, the COS program, and were therefore in a position to provide some information about the service user outcomes that they had observed.

10.2 Demographic profile of COS service user survey respondents

The demographic profile of COS service usage patterns of the survey respondents are described in this section. The extent to which survey respondents are representative of the broader COS service user population is unknown as limitations in overall service usage data (described in Chapter 3.6) make comparisons with the survey cohort impossible. Whether those who completed the survey had higher levels of cognitive functioning than those who elected not to participate also cannot be determined.

10.2.1 Demographic characteristics

Gender

The gender composition of survey respondents by COS organisation is shown in *Table 10-1*. Of the 32 service users who completed the survey, 18 (56%) were male and 14 (44%) were female. Almost half of all respondents were from Brook RED.

Table 10-2: Gender of survey respondents

Gender	Brook RED	PEARL	Total	%
Female	10	4	14	44%
Male	11	7	18	56%
Total	21	11	32	100%

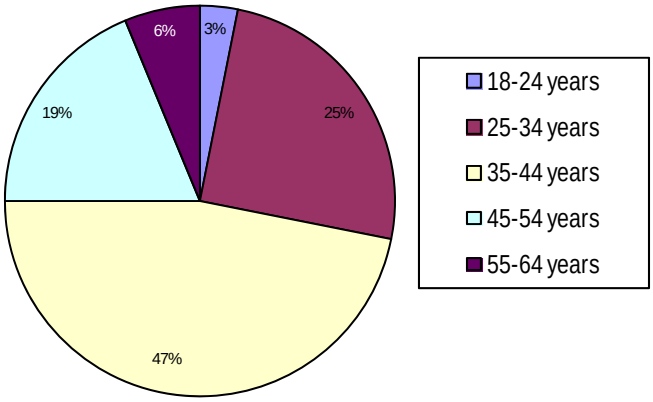
Country of origin and Aboriginal and Torres Strait Islander status

Only two respondents (6%) reported being born in a country other than Australia, and only one respondent (3%) reported being of Aboriginal background. None reported being Torres Strait Islander.

Age

The age breakdown of survey respondents is shown in *Figure 10-1*. Fifteen respondents (47%) were aged 35-44 years, and the vast majority (26 of 32, 91%) were aged 25-54 years.

Figure 10-2: Age of survey respondents



10.2.2 COS program usage

Duration of attendance at COS

Table 10-3 shows how long the respondents reported that they had been attending the COS program. It is important to note that in the free text responses provided for this question, some respondents indicated they had started attending FSG-PEARL or Brook RED prior to the implementation of the COS models at those organisations.

Responses were aggregated for analysis purposes. The most frequently reported durations of attendance were 'less than 6 months' and '1-2 years' with 10 of 32 respondents (31%) falling into each of these categories.

Table 10-3: How long respondents had been attending COS

Duration	Total	%
less than 6 months	10	31%
6 months - 1 year	6	19%
1-2 years	10	31%
More than 2 years	5	16%
blank	1	3%
Total	32	100%

Range of COS services/programs used

Table 10-4 and *Table 10-5* indicate the range of services/programs/activities that respondents had used at their respective COS. Respondents had the option of choosing multiple responses.

10. Effectiveness of Consumer Operated Services: Consumer - level perspectives.

Table 10-4: Use of program activities - Brook RED

Program activities: Brook RED	Respondents	%
One to One Support Norton St	14	67%
Social Group - Norton St	11	52%
One to One Support - Retreat	10	48%
Community Support Line - Night	9	43%
Men's Group - Norton St	9	43%
Peer Support Group - Norton St	9	43%
Art Group - Norton St	8	38%
Creative Writing - Norton St	8	38%
Phone Support - Norton St	6	29%
Active Group - Norton St	5	24%
Music Group - Norton St	5	24%
Bowling Group - Norton St	4	19%
Intentional Peer Support - Norton St	4	19%
Women's Group - Norton St	3	14%
Outreach - Norton St	3	14%
PA Outreach - Norton St	2	10%

10. Effectiveness of Consumer Operated Services: Consumer - level perspectives.

Table 10-5: Use of program activities - FSG-PEARL

Program activities: FSG PEARL	Respondents n=11
FSG-PEARL Program activities	
One-on-one conversations with an IPS (at PEARL Resource Centre or House)	11 (100%)
Groups (at PEARL Resource Centre)	11 (100%)
Peer Support Line (phone conversations with an IPS Worker)	9 (82%)
Outreach (IPS Worker meeting with peers for conversations at any location external to PEARL's Resource Centre or House, i.e. in Hospital, at another service, or at home)	5 (45%)
Short-term stays at PEARL House in Pheasant St	4 (36%)
Other FSG-PEARL Activities.	
Volunteering	5 (45%)
Engaging in discussions about PEARL through Friday lunch group conversations and/or the Pearls of Wisdom (POW) Panel discussions	9 (82%)
Providing feedback on PEARL in general (i.e. feedback forms, discussions with workers or POW Panel) and/or regarding feedback on Groups	7 (64%)
Supporting other peers through connections (i.e. via natural conversations arising during time together at Resource Centre, informal discussions over jointly doing a jigsaw puzzle, etc.)	9 (82%)
Being a source of referral to PEARL for others who wish to access the service	6 (55%)
Representing PEARL at community events (i.e. PEARL Open Day, Mental Health Week activities, etc.)	5 (45%)
Discussions and involvement in Resource Centre planning and improvements (i.e. decorating with IPS themed materials, preparing for Open Days, Christmas celebrations, etc.)	5 (45%)
Accessing information and community resources and referrals	7 (64%)
Having the space and resources for self-reflection and growth (i.e. via PEARL Resource Centre library, etc.)	9 (82%)

As shown in *Table 10-4* and *Table 10-5* multiple service usage was the norm for the service users. The most popular activities at Brook RED were One to One Support (67%) and the Social Group (52%) at Norton St. Likewise, the most popular activities at FSG PEARL were One on One conversations with IPS workers (at the PEARL Resource Centre or House) and Groups (at the PEARL Resource Centre), with 100% of respondents taking part in each of these activities.

At FSG-PEARL, each consumer reported using, on average, 66% of the services/programs on offer. At Brook RED, service users used, on average, 33% of the services/programs on offer.

Frequency of attendance at the COS

As shown in *Table 10-6*, across the two services, half the respondents (16 of 32, 50%) reported attending the service two or more times a week, with a further seven respondents (22%) attending almost every day. These figures suggest that the COS was a central element in the lives of many service users.

Table 10-6: Frequency of attendance at COS

Frequency of attendance	Total	%
2 or more times a week	16	50%
A few times a year	1	3%
About once a month	3	9%
About once a week	5	16%
Almost every day	7	22%
Total	32	100%

Key Finding: The majority of survey respondents attend the COS at least twice per week, and use a number of the services/activities on offer.

Use of other community services

Respondents were asked if they used any other community services besides the COS they attended. Eighteen respondents (56%) provided a range of responses to this question. The range of other services used included:

- community based aged care supports
- community mental health support and education
- clinical mental health
- health promotion fitness and smoking cessation programs
- outreach and recovery psycho-social support for people at risk of homelessness
- GP clinics
- Vocational skills programs
- Other (non-IPS) mental health peer support programs

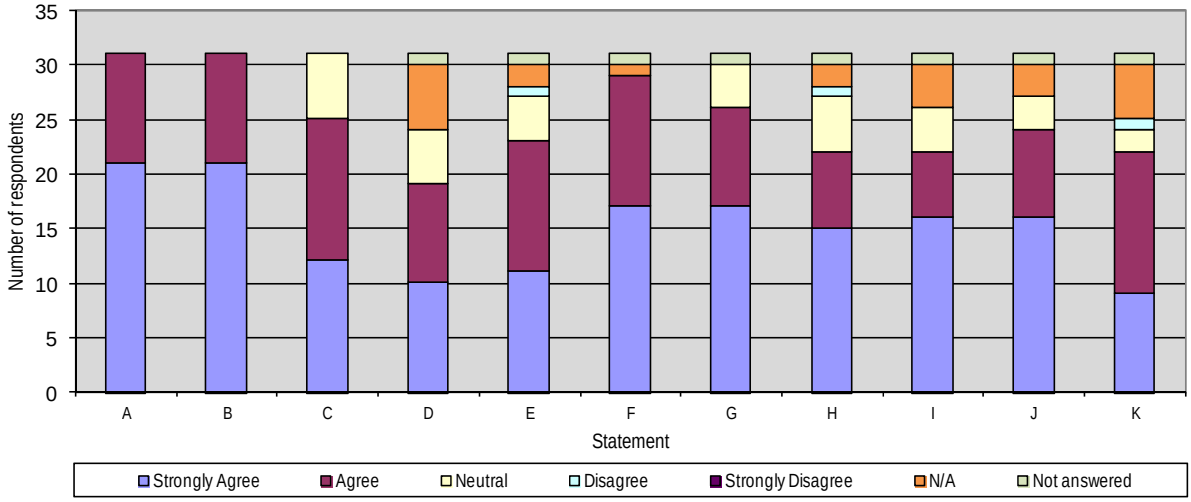
10.3 Satisfaction with services provided

This section presents information about consumer satisfaction with the COS program, based on information provided through the service user survey and the service user interviews.

10.3.1 Service user survey

The c service user survey asked respondents to score eleven statements relating to their level of satisfaction with aspects of the COS program using a five-point Likert Scale (from strongly disagree to agree). Figure 10-3shows the responses from 31 of the 32 respondents (one set of responses could not be interpreted and was excluded).

Figure 10-3: Satisfaction with COS program



Statements:
A: Overall I am satisfied with the service
B: I would recommend this service to other people
C: The location of services is convenient (parking, public transport, distance etc)
D The Intentional Peer Support Workers/Peer Workers return my calls in a timely manner
E: The Intentional Peer Support Workers are available at times that are good for me
F: I am able to get the support I need at this service
G: At this service I get information when I need it
H: I feel free to make suggestions or complain at this service
I: Instead of the worker identifying my goals for me, we talk together about what "moving forward" could be like for me
J: Discussions with Intentional Peer Support Workers helped me to learn more about myself so that I could improve my mental wellbeing
K: I am encouraged to access other services when needed

As shown in *Figure 10-3* the majority of respondents either strongly agreed or agreed with all statements, indicating high levels of satisfaction with the COS. The strongest positive responses were to the statements '*Overall I am satisfied with this service*' and '*I would recommend this service to other people*', for which all 31 respondents either agreed or strongly agreed. The next most strongly positive response was to the statement '*I am able to get the support I need at this service*' with 29 of 31 respondents strongly agreeing or agreeing. No respondents strongly disagreed to any statement.

Key Finding: Survey respondents reported high levels of satisfaction with the COS services.

Suggestions for improvements to the service

Respondents were given the opportunity to make suggestions for improvements or changes to the COS program. Twenty-three respondents completed this section, with a number of providing positive comments about how much they appreciated the service. Suggestions for improvements related to the range of services on offer and practical suggestions for enhancements. They included:

- Greater integration and participation with other community-based services
- Open on Saturdays and Sundays
- Weekend support phone
- Group cooking
- Help to fold and put away clothes
- More music
- Dry clean the sofa once every three months
- New scrap-bookings.

10.3.2 Service user interviews

Although the number of service users was small and they were a 'convenience sample' of people willing and able to contribute their views to the evaluators, the views expressed mirrored and reinforced the survey responses. The service users presented glowing reports of their experience with the COS and had consistently high levels of satisfaction. Several themes emerged as key factors in enhancing consumer satisfaction, as follows.

Time

Service users appreciated the amount of the time that peer workers put in to talking with them and understanding their situation. This was seen as a clear difference between the COS and hospital (or other more clinically based) services. One service user reported that the COS picked up that she was at risk of suicide and 'rescued' her. She said that "*no other service could have done this – they are all too busy."* Given that one to one support was the most frequently undertaken activity at the COS (as shown in *Table 10-4* and *Table 10-5*), the time and effort that peer workers put in to having conversations with service users is clearly a central feature of the COS.

Understanding and support

Service users consistently spoke of the value they placed on the understanding and support they received at the COS, and of the sense of belonging they felt. They appreciated being part of a group of people who had 'something in common'. This appeared to be largely due to the interactions they had with the peer support workers, as illustrated by the following quotes:

> *"They don't tell you how to feel; they know how you feel. You are not on your own."*
>
> *"Here they don't look at the problem; they talk with you about what you want to change."*
>
> *"Here I can release stuff to someone who knows. It's a unique place where you feel at home and don't feel you have a mental illness and are encouraged to participate in stuff."*

The non-judgmental approach of peer support workers and other service users was also important, with several interviewees commenting on the difference in their experience with the COS compared with mainstream mental health services:

> *"[I had] been to other respite services before but was treated like a child."*
>
> *"Psychiatrists just have book knowledge, not experiences."*

Hope

Several service users described the way that staff led by example and helped them to realise that they too could have a career and a 'normal life'. This was considered important in engendering hope:

> *'Staff are willing to share their own experience. Sharing helps with hope. You see that you can recover and get a job. Peer workers demonstrate recovery.'*

Responsiveness

Service users valued the way that the COS programs were flexible and responsive to their needs. They felt comfortable suggesting new ideas, and were encouraged to help set up new groups and activities, such as writing and photography sessions. They also consistently reported that the peer workers were available when they needed them, and in some cases would call them if they had not come for a while.

> "*People pick up on when you are not travelling well'.*
>
> *"In other respite places they'd ring for the ambulance. Here they help work it out before it gets to that stage.''*

Key Finding: A number of factors contributed to the high levels of satisfaction of the COS users. In particular, service users valued the responsiveness of the COS, the time and understanding that IPS workers put into understanding them, and the hope that this engendered.

10.4 Outcomes for target cohort

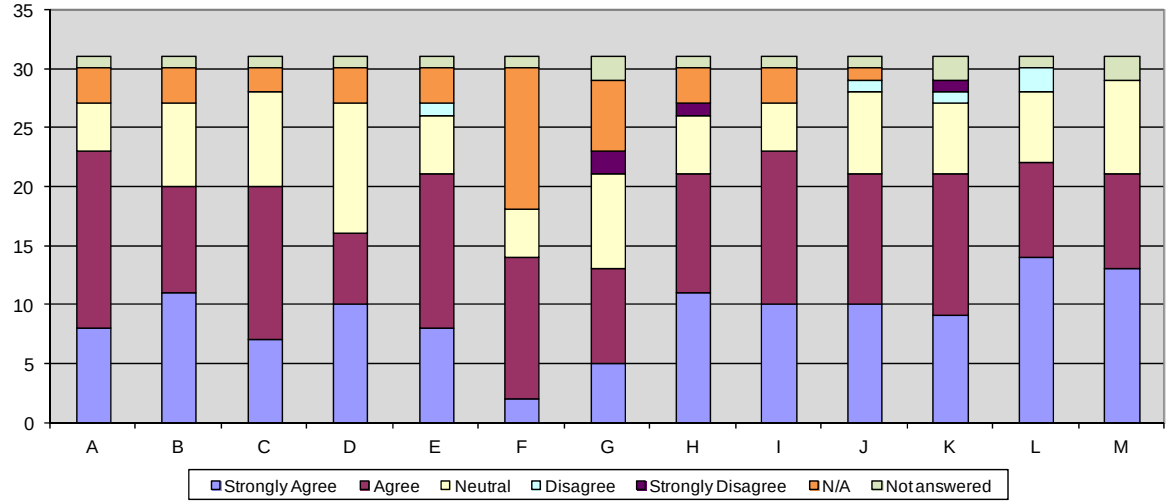
In this section, the consumer survey results relating to outcomes are presented, followed by a discussion of results from the interviews with service users, IPS workers and COS managers relating to outcomes.

10.4.1 Service user survey

Survey respondents were asked to rate their level of agreement with a number of statements relating to positive outcomes they had experienced through their involvement in the COS using a 5 point Likert

scale (from strongly disagree to strongly agree). *Figure 10-4* shows the responses from 31 of the 32 respondents (one set of responses could not be interpreted and was excluded).

Figure 10-4: Consumer outcomes from COS program



Statements: As a direct result of the peer support at Pearl FSG/Brook RED
A: I manage daily issues more successfully
B: I am better able to control my life
C: I am better able to manage challenging times in my life
D: I am getting along better with my family or friends
E: I do better in social situations
F: I do better at work/study
G: My housing situation has improved
H: I am better able to manage my mental health or engage with others to keep improving my mental health
I: I do things that are more meaningful to me
J: I am better able to handle things when they go wrong
K: I have family or friends with whom I can do enjoyable things
L: I am happier with the friendships I have
M: I feel I belong in my community

As shown in *Figure 10-4*, strongly positive responses were recorded for most statements. The highest levels of agreement were for the statements: '*I manage daily issues more successfully*' and '*I do things that are more meaningful to me*'. There were two statements for which the level of agreement was less than 50%. These were: '*I do better at work/study*' and '*My housing situation has improved*'. For these two statements, larger proportions of respondents indicated that the statement was not applicable (N/A). Overall, these results suggest that a range of important outcomes, relating to service users' ability to better manage and enjoy their day-to-day life, are being achieved through the COS program.

10.4.2 Service user interviews

The service user interviews elicited a number of reports of positive outcomes in terms of the development of social and personal skills and improvements in community participation, as described below.

Relationships

Several interviewees noted that their involvement with the COS had led to improved relationships with partners and re-connection with family. One service user explained that her relationship with her daughter was strained as a result of her mental illness, but that the COS had helped her to improve this relationship and secure her daughter's forgiveness.

Managing emotions

A number of interviewees commented that the COS had helped them to better deal with their emotions, as illustrated by the following quotes:

> *"I was able to put things in place so I don't internalise things and then explode'.*
>
> *"For the first time in five years I don't have depression*."

Consistent with this finding, several interviewees indicated that the coping mechanisms they developed through their involvement with the COS led to a reduction in alcohol misuse and self-harming behaviour.

Development of new hobbies and interests

A key outcome for many of the service users interviewed was a focus on new interests and activities in life. Creative pursuits, such as singing and story-writing were prominent. Several interviewees reported that they had commenced, or were planning to commence, work or study (including doing IPS training, a consumer companion course, a human services course or work as a cleaner). One interviewee claimed that '*now I have focus'* and was no longer sitting at home '*waiting to go to hospital'.*

Improved community interaction

For many interviewees, getting out of home more often and making new friends was an important outcome. While the COS appeared to be a focal point for social interaction for many participants, engagement with the COS also helped people to '*get out of the house more'* for other purposes. It is important to note that some service users had significant limitations which they did not entirely overcome. Part of the recovery process for one service user, who reported being agoraphobic, was that he learned to "*sit with my own discomfort and anxiety. Now I go out and just feel uncomfortable."*

10.4.3 IPS worker interviews

Information about service user outcomes was also elicited through the interviews with IPS workers. Some of the IPS workers interviewed had been COS service users before going on to do the IPS training and securing employment in the COS. These workers outlined the recovery process that had led them to take on roles at the COS. One IPS worker described her previous existence as a '*revolving door with up to six* [hospital] *admissions every year*.' Through her involvement with the COS she had ceased her engagement with her psychiatrist and psychologist, completed the IPS training and commenced work as an IPS worker.

The IPS workers interviewed were unanimous in the view that working in a setting that '*values lived experience'* made the transition to the workforce more achievable than it may otherwise have been if they were seeking employment in a workplace '*where mental illness is not talked about*'.

The consumer outcomes described by the IPS workers largely echoed those described in the service user interviews. One key difference was that some IPS workers more frequently acknowledged that there is a place for clinical services in service users' lives:

> *"[It is] naive to believe there isn't need for hospital."*
>
> *"[You] realise [that some people] can't live independently of clinical services. Some people need it."*

10.4.4 Manager interviews

COS managers reported that service users outcomes data is not routinely collected. However, they spoke of observing encouraging outcomes for people who have used the program. A key factor in success was considered to be the opportunities for in-depth conversations and to "*challenge people about their current behaviour.*"

Managers also reported reductions in use of hospital services as a result of participation in the COS program. One manager reported that 80% of service users were using hospital services extensively when they commenced with the COS, but that very few go back to hospital after engaging with the service (although some continue to use the Acute Care (community) team). Another COS manager cited a 78% reduction in hospital admissions in the year following involvement with the COS. One manager described a particularly positive case in which a consumer with a history of self-harming behaviour (with frequent emergency department presentations) gradually broke this pattern of behaviour with the support of the IPS worker. No data was available to substantiate the percentage reductions in hospital admission quoted by the managers.

10.4.5 Service system stakeholder interviews

The mental health service system stakeholders interviewed commented on outcomes they had observed in people they had referred to the COS, or people who had been referred to their service from the COS. The stakeholders were consistently positive about service user outcomes, which included:

- Improved community engagement (including improved awareness of what is socially acceptable behaviour)
- Improved independence
- Empowering people, through encouraging them to engage in social activities without being judged.

In particular, they noted that the COS program helps service users to stay out of hospital. This was considered very important for Aboriginal and Torres Strait Islander service users, whose healing tends to be impeded in the hospital setting where they are separated from the natural environment (in the opinion of the stakeholder interviewed). There was a consistent view that the COS provided an important addition to clinical services because they focus on social outcomes, rather than management of symptoms.

One service system stakeholder raised concerns about what they described as "the anti-mental health services" attitude they observed being evident on occasions in the COS provider they had associations with. While they lauded the COS provider's goal of helping people become more independent, they were concerned with the COS provider was perceived by service users as promoting an "*animosity towards the mental health service*s" or "*not working collaboratively*" with mental health services.

Key Finding: COS users experienced a number of positive outcomes as a result of their participation in the COS. These included improvements in ability to manage daily life, better relationships, improved ability to manage emotions, improved social interaction and reductions in hospitalisations.

Key Finding: Some concerns were expressed by an external stakeholder regarding what they perceived to be, on occasion, a negative attitude towards mainstream mental health services in the COS environment.

10.5 Progress towards recovery

As discussed in Chapter 2, 'recovery' has a specific meaning in the context of mental health, drawing on concepts of empowerment, hope, choice and responsibility, and maximising individual potential. As indicated in Section 10.4, service users participating in the COS program achieved many important outcomes. Many of these outcomes point to recovery taking place. However, service users and peer support workers also spoke in the interviews explicitly about what recovery meant to them, and how their participation in the COS had encouraged their recovery. These views are illustrated in the following quotes:

"I've been on the road to recovery quite a few times. The backwards steps are not as far back because of [COS]."

"Recovery is a good way of saying looking forward. Positiveness into the future. Mental illness is part of life, not all consuming. Furthering your horizons."

"You see that you can recover and get a job. Peer workers demonstrate recovery."
'"COS] has helped with my recovery. I feel like I've been going ahead in leaps and bounds since I came here."'

Two interviewees described recovery in terms of freedom from psychiatrists, hospitals and medication:

"Recovery is about cutting down your medication."'

"If I'm getting high I understand what to do without drugs now. I hate medication. I don't take it.'

Key Finding: COS users reported that their participation in the COS assisted with their progress towards recovery from mental illness.

10.6 Summary and implications of findings

Survey respondents reported high levels of satisfaction with the COS programs. A number of factors contributed to these high levels of satisfaction. In particular, service users valued the responsiveness of the COS, the time and understanding that IPS workers put into understanding them, and the hope that this engendered.

10. Effectiveness of Consumer Operated Services: Consumer-level perspectives.

The majority of survey respondents attended the COS at least twice per week, and used a number of the services/activities on offer.

COS users experienced a number of positive outcomes as a result of their participation in the COS. These included improvements in ability to manage daily life, better relationships, improved ability to manage emotions, improved social interaction and reductions in hospitalisations.

Participation in the COS was also reported by COS users as having played an important role in their progress towards recovery from mental illness.

Consultations with service providers who referred to or received referrals from the COS endorsed these positive service user outcomes. In particular, the extent to which COS services assist service users to stay out of hospital was highlighted. One service provider voiced concern that some COS staff had negative attitudes towards mainstream mental health services. While not pervasive, this attitude had the potential to undermine the importance of collaboration between the COS program and the broader mental health system.

Appendix A

Appendix A: Literature review

1 LITERATURE REVIEW: PEER SUPPORT – CONSUMER AND WORKER PERSPECTIVES.

1.1 Introduction

As part of the evaluation of the IPS and COS model, a literature review was undertaken to explore peer support from the persective of service users and peer support workers (PSW). The review included a focus on the training and support needs of peer support workers. The key findings are described in the following sections.

1.2 Peer Support: Service user perspectives

Peer support has been described as 'a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful'.[1] From a service user's perspective, this most likely represents a radically different model of care to that of traditional clinical services. Exposure to peers who have been through similar experiences and who are now working in a peer support role could do much to counteract the stigma and prevailing cultural stereotypes about mental illness, and could offer the person hope and motivation to work for a better future.[2] Using peers to provide support to service users has been found to be 'highly effective as an adjunct to mainstream mental health services, offering personal benefit to service users and peers, substantial savings to systems, as well as much potential for encouraging mental health service culture and practice towards a greater recovery focus and improved collaboration with GPs'.[3]

1.3 Peer Support Workers

For the PSW, the opportunity to operate in a peer support capacity offers many benefits. Being designated a recognised role means that the PSW acquires an identity other than that of 'service user'.[4] Through a structured process of social interaction, PSW can 'adopt socially valued roles, in which they no longer are restricted to a passive role of 'patient' relying on expert advice, but now also may serve as role models for newer members, provide feedback and assistance to others, and receive feedback for their own efforts to address their problems'.[5]

Through this new identity, improved self-efficacy and self-esteem, a greater sense of empowerment and hope, and an improved quality life may also be experienced by the PSW, [6] all of which are instrumental in advancing the PSW's own recovery journey. Indeed, sharing similar life experiences with peers can increase a person's understanding of his or her situation, reduce social isolation, and assist both the PSW and consumer in making sense of their experiences.[7]

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[1] S Mead (2003). Defining Peer Support. http://www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf Accessed 24/01/13.
[2] L Gerry, C Berry, and M Mayward, Evaluation of a training scheme for peer support workers. *Mental Health Practice*, 2011, 14(5), 24-29.
[3] S Lawn, A Smith and K Hunter, Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*, 2008, 17(5), 498-508, p.498.
[4] Gerry, Berry and Mayward, 2011.
[5] M Davidson, M Chinman, B Kloos, et al, Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence *Clinical Psychology Science and Practice*,1999, 6:165-187, p.181.
[6] Gerry, Berry and Mayward, 2011.
[7] Davidson, Chinman, Kloos et al 1999.

However, providing peer support may not always be positive or enriching. From a personal perspective, constant exposure to peers in distress may result in emotional fatigue.[8] Describing or sharing personal experiences can be potentially re-traumatising and trigger distressing recollections.[9] Job stress can generate fears of relapsing into acute mental illness[10] Indeed, a study of PSWs in Adelaide found that some PSWs choose to negotiate a 'Ulysses' agreement with the service director, describing the action they would like to have taken if they become unwell while working as a PSW.[11]

Systemic factors may also lead to job-related stress. As Gates and colleagues point out, inclusion of PSWs in the staff of mental health agencies may be negatively received. This is particularly true if the professional staff in these agencies continue to conceptualise recovery in clinical terms and therefore do not believe that recovery is possible for people with mental health conditions. Tensions may also arise because the peer support role can sometimes lack adequate supervision or be poorly defined.[12] More junior nursing staff may sometimes be ambivalent or negative, partly because of a sense of vulnerability and fear that their positions are at risk of being replaced by unpaid or less expensive PSWs.[13]

The literature suggests that clear definitions of roles and provision of appropriate training would do much to address these systemic and personal stresses.

1.4 Training and Support

The importance of training and support for PSWs is firmly articulated by Stewart and colleagues who argue that:

> 'Without clear job descriptions, common understandings of their roles, adequate preparation, ongoing support and access to supervision we may well be setting consumer workers up to fail in a system that has already failed many of them.' [14]

Peer support differs from informal social support in that it is *an intentional process* which occurs in a specific behavioural setting.[15] As outlined earlier, the mutual sharing that occurs in this setting can be stressful for the PSW who is simultaneously on their own recovery journey. With training, PSWs learn how to talk about those parts of their personal story that they wish to share, and to provide support for one another.[16]

Gerry and colleagues' evaluation of a training scheme for PSWs in the UK highlighted a number of key benefits of training for participants:

[8] N Kinnane, T Waters and S Aranda, Evaluation of a pilot 'peer support' training programme for volunteers in a hospital-based cancer information and support centre, *Support Care Cancer*, 2011, 19, 81–90.
[9] P Nestor and C Galletly, The employment of service users in mental health services: politically correct tokenism or genuinely useful? *Australasian Psychiatry,* 2008, 16(5), 344-347.
[10] H Meehan, C Coveney and R Thornton. Development and evaluation of a training program in peer support for former service users *International Journal of Mental Health Nursing,* 2002, *11,* 34–39.
[11] Nestor and Galletly, 2008.
[12] B Lauren, L Gates, J Mandiberg et al. Building Capacity in Social Service Agencies to Employ Peer Providers *Psychiatric Rehabilitation Journal,* 2010, 34, 2, 145–152.
[13] Nestor and Galletly, 2008.
[14] Stewart, S., Watson, S., Montague, R. & Stevenson, C. Set up to fail? Consumer participation in the mental health service system. *Australasian Psychiatry,* 2008, 16, 5, 348- 353, p.352.
[15] Davidson, Chinman, Kloos et al, 1999.
[16] Nestor and Galletly, 2008.

- The concept of recovery became more meaningful to them. They became less sceptical about the concept of recovery as they were encouraged to consider their own recovery journeys and the incorporation of recovery approaches into mental health services.
- New skills were acquired that they were able to apply when they experienced mental distress, and that this allowed them to continue their recovery journeys.
- They developed strategies for dealing with other people in distress and said that seeing other people recover helped them to understand why they behave in certain ways.
- They became more confident when going for interviews and in their relationships with colleagues, family and friends.
- They experienced personal growth, increased self-esteem and confidence, a sense of empowerment and hope, and an improved quality of life.[17]

However, these positive aspects must also be contextualised in terms of how these PSWs described the training programme.[18] Phrases such as 'a battle', as well as 'exhausting', 'hectic', 'intense' and 'overwhelming', indicate that despite the overall positive outcomes of the training, it is also important to consider the short-term toll that such training may impose on PSWs.

Coveney and Thornton's Queensland study also raises some issues that need to be considered in the training of PSWs. They highlighted the following key points:

- some trainees needed considerable staff support particularly in the early stages of the program
- the relationship boundary between former patients working in a peer support role needed attention
- accountability within the relationship between PSW and service user should not be neglected
- development of a code of conduct would help alleviate many of the boundary and accountability issues.[19]

Lessons can also be learned from other settings where PSWs are also deployed. An evaluation of a peer support program conducted at the Peter MacCallum Cancer Centre illustrates the importance of assessing PSWs' pre- and post-training skills.[20] All PSWs in that study self-ranked their support skills as being 'high' prior to training. However, during training these PSWs recognised the inadequacy of their earlier skill sets. This serves as a timely caution to both PSWs and the organisations in which they work that that PSWs may be overly confident, and therefore overestimate their skills levels and under-appreciate the demands of the work.

Another important finding of the Peter MacCallum study was the extent to which training was instrumental in:

- increasing PSWs' knowledge of role definition and boundaries, supportive communication skills, supports available for patients and families/carers and the importance of self-care
- reinforcing with the group the differences between peer support and counselling and to reinforce referral procedures
- increasing emotional resilience

[17] Gerry, Berry and Mayward, 2011.
[18] Gerry, Berry and Mayward, 2011.
[19] B Meehan, C Coveney and R Thornton, 2002.
[20] Kinnane, Waters and Aranda, 2011.

- highlighting the need for effective supervision.[21]

Other issues that have been raised in relation to peer support training include how competency is measured and how many attempts are permitted before a candidate is considered unsuitable,[22] and the need to evaluate the program from service users' perspectives so that it can be confirmed whether the peer program, and the training that underpins it, is actually meeting the needs of the service user group.[23]

Provision of adequate training can yield major benefits to the PSW, their service users and the system. Meehan and colleagues found that following training, the psychological well-being of PSWs who were exposed to people with acute mental health problems (in this case, inpatients) was not adversely impacted.[24] Evidence also suggests that peer support workers often benefit from the training they receive and employment opportunities they are offered, tending to be admitted to hospital less often than other people with mental health problems. [25]

Conclusion

This review has considered peer support from the perspective of both the consumer and the PSW, and discussed the training needs of peer support workers. The review has highlighted that peer support models are not only beneficial to support recipients (service users) but can also yield many benefits to the peer support workers and the services within which they operate. It has also emphasised the need for training that can equip participants for the role of PSW, while also being sensitive to the unique needs of people with lived experience of mental illness who aspire to take on this challenging role.

[21] Kinnane, Waters and Aranda, 2011.
[22] T Tang, M Funnell, M Gillard et al. Self management: Training peers to provide ongoing diabetes self-management support (DSMS): Results from a pilot study. *Patient Education and Counselling*, 2011, 85, 2,160-8.
[23] S Power, and J Hegarty, Facilitated Peer Support in Breast Cancer: A Pre- and Post-Program Evaluation of Women's Expectations and Experiences of a Facilitated Peer Support Program. *Cancer Nursing*, 2010, 33, 2, E9-E16.
[24] B Meehan, C Coveney and R Thornton, 2002.
[25] Gerry, Berry and Mayward, 2011.

Appendix B

Intentional Peer Support Survey

Australian Healthcare Associates (AHA) has been appointed by the Department of Communities to evaluate the effectiveness of the Intentional Peer Support (IPS) training program developed by Shery Mead Consulting and delivered by Shery Mead, Chris Hansen, the Brook Red trainers or Discovery. Obtaining feedback from people who have completed this training is an essential part of this evaluation. Your feedback will help guide future development of this training and ensure it continues to support the building of a peer support workforce (paid and volunteer).

The information gathered from this survey is confidential and will not be identifiable. All data gathered for reporting purposes will be de-identified and will be used in accordance with the Information Privacy Principles set out in the Privacy Act 1988. We ask for your name and phone number as we will be phoning a small number of people and asking if they would give us some more detailed information on their experiences of the training. There is an opportunity to opt out of the phone follow up at the end of the survey. Simply tick the box at the end if you do not wish to be contacted.

Should you have any questions or concerns, please call us on 1300 788 667 for the cost of a local call.

Please complete this short form and press the **Submit Survey** button once finished.

This survey will take approximately 10 to 15 minutes to complete.

Please complete the following questions by selecting the most appropriate response and providing any comments in the applicable text boxes.

Your Details

Name:

Phone Number:

What is your Age?

○ 18-29 ○ 30-39 ○ 40-49 ○ 50-59 ○ 60+

Are you:

- ○ Male
- ○ Female

Are you from an Aboriginal and Torres Strait Islander background?

- ○ Yes
- ○ No

Are you from a Culturally and Linguistically Diverse Background?

- ○ Yes
- ○ No

Do you have a lived experience of mental illness or have you been a mental health service user?

- ◉ Yes
- ○ No

IPS Training

Which of the following Intentional Peer Support (IPS) training courses have you attended? (please tick all that apply)

	Date	Location	Trainers
5 Day IPS Training			
☑	Aug 2008	Brisbane	Chris Hansen
☐	Feb 2009	Brisbane	Shery Mead/Chris Hansen

☐	Mar 2010	Sunshine Coast	Shery Mead/Chris Hansen
☐	Jun 2010	Brisbane (Brook RED center staff)	John Maher/Tyneal Hodges
☐	Jun to Aug 2010	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
☐	Jan 2011	FSG-PEARL(Sunshine Coast staff)	Adam Dunne/John Maher
☐	Mar 2011	Hervey Bay	Shery Mead/Chris Hansen
☐	Apr to Jun 2011	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
☐	Sept 2011	Brisbane(Brook RED center staff)	Adam Dunne/Adrian Promnitz
☐	Sept 2011	Brisbane(FSG Ipswich & Gold Coast staff)	Adam Dunne/John Maher
☐	Sept to Nov 2011	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
2 Day Co-Supervisor training			
☑	Feb 2009	Brisbane	Shery Mead/Chris Hansen
☐	March 2011	Sunshine Coast	Shery Mead/Chris Hansen
5 Day Train the Trainer in training IPS Facilitation			
☑	Feb 2010	Brisbane	Shery Mead/Chris Hansen

5 Day IPS training

What was your main reason for undertaking the 5 day IPS training?

- ○ I wanted to become a Peer support worker
- ○ I was interested in finding out more about the Peer support worker role
- ○ I wanted to assist other consumers towards recovery
- ○ I wanted to do it for my personal or self development
- ○ I wanted to work within the mental health sector
- ○ My manager suggested I do the training
- ○ Other

Did you work as a paid or volunteer Peer worker before undertaking the IPS training listed above?

- ◉ Yes
- ○ No

If Yes, Approximately how long had you been in this role? Years Months

What type of service was this role in?

- ○ Funded under the Consumer Operated Service Program
- ○ Consumer-run services (other)
- ○ Personal Helpers and Mentors (PHaMS)
- ○ Queensland Health
- ○ Other non-government community mental health service
- ○ Other

Was this role:

○ Full-Time ○ Part-Time

Was this:

○ Paid ○ Voluntary

Do you get supervision in your Peer worker role?

- ○ Yes
- ○ No

Before the IPS training how would you have ranked your understanding of Intentional Peer Support?

I had very little understanding 1	2	3	4	I had a strong understanding 5
○	○	○	○	○

After the IPS training how would you have ranked your understanding of Intentional Peer Support?

My understanding hadn't changed at all 1	2	3	4	I had a much stronger understanding 5
○	○	○	○	○

Please rate the IPS training in terms of the following statement

	Strongly Disagree 1	2	3	4	Strongly Agree 5
The training was effective in preparing me for the Peer worker role					

At the end of the IPS training, how ready were you to:

	Not at all ready 1	2	3	4	Very Ready 5
Do "first contact"?					
Listen Differently?					
Develop trauma-informed, mutually responsible relationships?					
Set boundaries?					
Be safe in peer relationships?					
Manage conflict?					
Self care?					
Participate in co-supervision?					

Have you been able to apply the IPS training in your work role?

- Yes

Please specify ways you have used the training:

- No

Were there any topics not covered in the IPS training that you would like to have had included?

- Yes

Please specify:

- No

How satisfied were you with how the IPS training was delivered?

Very dissatisfied 1	2	3	4	Very Satisfied 5

Is there anything you could suggest to further improve the IPS training?

- Yes

Please specify:

- No

What do you think were the best features of the IPS training program?

Previous training

Had you undertaken any peer support training before undertaking the IPS training with SheryMead/Chris Hansen/Brook Red/Discovery?

- Yes

Please provide details of this training:

- No

Had you completed any previous training related to recovery?

- Yes

How was this training similar and/or different to the IPS training?

- No

Current role

Are you currently working (paid/volunteer) in the mental health sector?

- (•) Yes
- ( ) No

Are you currently working as a (paid/volunteer) Peer worker?

- (•) Yes
- ( ) No

Approximately how long have you been in this role? Years Months

What type of service was this role in?

- ( ) Funded under the Consumer Operated Service Program
- ( ) Consumer-run services (other)
- ( ) Personal Helpers and Mentors (PHaMS)
- ( ) Queensland Health
- ( ) Other community mental health service
- ( ) Other

Is this role:

( ) Full-Time ( ) Part-Time

Is this:

( ) Paid ( ) Voluntary

Do you get supervision in your Peer role

- ( ) Yes
- ( ) No

In which region do you work?

2 Day Co-Supervisor training

Are you currently undertaking co-supervision?

- (•) Yes
- ( ) No

Approximately how long had you been doing so? Years Months

How well do you think the Co-Supervisor training equipped you to undertake co-supervision?

Not at all 1	2	3	4	Very well 5
( )	( )	( )	( )	( )

Were there any topics not covered in the Co-Supervisor training that you would like to have had included?

- (•) Yes

Please Specify:

- ( ) No

How satisfied were you with the trainers and the way the training was delivered?

Not at all satisfied 1	2	3	4	Very satisfied 5
( )	( )	( )	( )	( )

Is there anything that you could suggest to further improve the Co-supervisor training?

- (•) Yes

Please Specify:

- ( ) No

5 Day Train the Trainer in training IPS Facilitation

Had you any experience of delivering training courses before doing the IPS Train the Trainer course?

- (•) Yes

Please Specify:

- ( ) No

Had you completed any other train the trainer courses before doing the IPS Train the Trainer course?

- Yes
- No

Are you currently working as an IPS Trainer?

- Yes
- No

Approximately how long have you been in this role? Years Months

How well do you think the IPS Train the Trainer training equipped you for a role as a Trainer?

Not at all 1	2	3	4	Very well 5

At the end of the IPS Train the Trainer training, how ready were you to:

	Not at all ready 1	2	3	4	Very Ready 5
Teach the course with a thorough knowledge of the content in the IPS Manual?					
Role model peer support while facilitating?					
Deliver training or a workshop to a group of adult learners?					
Administer the final assignment and assess participant learning?					

Were there any topics not covered in the IPS Train the Trainer training that you would like to have had included?

- Yes

Please Specify:

- No

Is there anything you could suggest to further improve the IPS Train the trainer training?

- Yes

Please Specify:

- No

Please rate the IPS Train the Trainer training in terms of the following statement:

	Strongly Disagree 1	2	3	4	Strongly Agree 5
The training was effective in preparing me for the IPS Trainer role					

Are there any other comments you would like to make?

- Yes

Please Specify:

- No

Please tick the box if you do not wish to be contacted by telephone to talk about the training you received in more detail.

Submit Survey

AHA is a member of the International Society for Quality in Healthcare (ISQua) ABN: 82 072 790 848 ACN: 072 790 848

Appendix C

Intentional Peer Support Manager Survey

Australian Healthcare Associates (AHA) has been appointed by the Department of Communities to evaluate the effectiveness of the Intentional Peer Support (IPS) training program developed by Shery Mead Consulting and delivered by Shery Mead/Chris Hansen. Obtaining feedback from people who have completed this training is an essential part of this evaluation. Your feedback will help guide future development of this training and ensure it continues to support the building of a peer support workforce (paid and volunteer).

The information gathered from this survey is confidential and will not be identifiable. All data gathered for reporting purposes will be de-identified and will be used in accordance with the Information Privacy Principles set out in the Privacy Act 1988. We ask for your name and phone number as we will be phoning a small number of people and asking if they would give us some more detailed information on their experiences of the training. There is an opportunity to opt out of the phone follow up at the end of the survey. Simply tick the box at the end if you do not wish to be contacted.

Should you have any questions or concerns, please call us on 1300 788 667 for the cost of a local call.

Please complete this short form and press the **Submit Survey** button once finished.

This survey will take approximately 10 to 15 minutes to complete.

Please complete the following questions by selecting the most appropriate response and providing any comments in the applicable text boxes.

Your details

Name:

Phone Number:

What is your Age?

○ 18-29 ○ 30-39 ○ 40-49 ○ 50-59 ○ 60+

Are you:

- ○ Male
- ○ Female

Are you from an Aboriginal and Torres Strait Islander background?

- ○ Yes
- ○ No

Are you from a Culturally and Linguistically Diverse Background?

- ○ Yes
- ○ No

Do you have a lived experience of mental illness or have you been a mental health service user?

- ○ Yes
- ○ No

Manager Training

Which of the following IPS manager training courses did you attend? (please tick all that apply)

	Date	Location	Trainers
1 Day training for managers			
☑	Sept 2008	Brisbane	Chris Hansen
2 Day training for managers			
☑	Feb 2009	Brisbane	Shery Mead/Chris Hansen

☐	Feb 2011	Brisbane	Shery Mead/Chris Hansen
☐	Feb 2011	Hervey Bay	Shery Mead/Chris Hansen

What was your main reason for undertaking the IPS Manager training?

- My organisation was interested in developing a peer support workforce
- I was interested in finding out more about how to build a peer support workforce
- My organisation was interested in better supporting our peer support workforce
- Other

How much experience did you have in management roles before doing the IPS Manager training?

None	Less than 1 Year	1-5 Years	More than 5 Years

How well did the training course meet your needs?

Not at all 1	2	3	4	Very well 5

What do you think were the best features of the IPS Manager training program?

Before the training how would you have ranked your knowledge of Intentional Peer Support?

I had very little understanding 1	2	3	4	I had a strong understanding 5

After the training, how did you rank your knowledge of Intentional Peer Support?

My understanding hadn't changed at all 1	2	3	4	I had a much stronger understanding 5

Please rate the IPS Manager training in terms of the following statements:

The training provided me with a good understanding of:	Strongly Disagree 1	2	3	4	Strongly Agree 5
The IPS model					
What it means to help someone as a peer support worker					
The particular issues involved in supervising Peer workers					
How to create a peer-friendly work environment					

Were there any topics or skills not covered in the training that you would like to have had covered?

- Yes

Please specify:

- No

How satisfied were you with how the IPS training was delivered?

Very dissatisfied 1	2	3	4	Very Satisfied 5

Is there anything you could suggest to further improve the IPS Manager training?

- Yes

Please specify:

- No

Since completing the IPS Manager training, have you put your learning into practice?

- Yes

Please give example(s)

- No

Have you used the Intentional Peer Support Core Competencies tool in the workplace, with Peer workers?

- (•) Yes

Please give example(s)

- ( ) No

How well did the Manager Training equip you to use the Intentional Peer Support Core Competencies tool in the workplace, with Peer workers?

Not at all 1	2	3	4	Very well 5
( )	( )	( )	( )	( )

How useful did you find the Intentional Peer Support Core Competences tool in assessing the development of Peer workers' skills on the job?

Not at all useful 1	2	3	4	Very useful 5
( )	( )	( )	( )	( )

Previous training

Had you undertaken any peer support training before undertaking the IPS Manager training?

- (•) Yes
- ( ) No

Which of the following Intentional Peer Support (IPS) training courses have you attended? (please tick all that apply)

	Date	Location	Trainers
5 Day IPS Training			
☑	Aug 2008	Brisbane	Chris Hansen
☐	Feb 2009	Brisbane	Shery Mead/Chris Hansen
☐	Mar 2010	Sunshine Coast	Shery Mead/Chris Hansen
☐	Jun 2010	Brisbane (Brook RED center staff)	John Maher/Tyneal Hodges
☐	Jun to Aug 2010	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
☐	Jan 2011	FSG-PEARL Sunshine Coast staff)	Adam Dunne/John Maher
☐	Mar 2011	Hervey Bay	Shery Mead/Chris Hansen
☐	Apr to Jun 2011	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
☐	Sept 2011	Brisbane(Brook RED center staff)	Adam Dunne/Adrian Promnitz
☐	Sept 2011	Brisbane(FSG Ipswich & Gold Coast staff)	Adam Dunne/John Maher
☐	Sept to Nov 2011	Maroochydore Staff - Community Focus (Discovery program)	Michael Burbank
2 Day Co-Supervisor training			
☑	Feb 2009	Brisbane	Shery Mead/Chris Hansen
☐	March 2011	Sunshine Coast	Shery Mead/Chris Hansen
5 Day Train the Trainer in training IPS Facilitation			
☑	Feb 2010	Brisbane	Shery Mead/Chris Hansen
Other Peer Support Training			
☐	Other	Please Specify:	

Had you completed any training related to recovery before doing the IPS training?

- (•) Yes
- ( ) No

5 Day IPS training

What was your main reason for undertaking the 5 day IPS training?

- (•) I wanted to become a Peer support worker
- ( ) I was interested in finding out more about the Peer support worker role
- ( ) I wanted to assist other consumers towards recovery
- ( ) I wanted to do it for my personal or self development
- ( ) I wanted to work within the mental health sector
- ( ) My manager suggested I do the training
- ( ) Other

Did you work as a paid/unpaid Peer worker before undertaking the IPS training listed above?

- Yes
- No

If Yes, Approximately how long had you been in this role? Years Months

What type of service was this role in?

- Funded under the Consumer Operated Service Program
- Consumer-run services (other)
- Personal Helpers and Mentors (PHaMS)
- Queensland Health
- Other non-government community mental health service
- Other

Was this role:

Full-Time Part-Time

Was this:

Paid Voluntary

Do you get supervision in your Peer worker role?

- Yes
- No

Before the IPS training how would you have ranked your understanding of Intentional Peer Support?

I had very little understanding 1	2	3	4	I had a strong understanding 5

After the IPS training how would you have ranked your understanding of Intentional Peer Support?

My understanding hadn't changed at all 1	2	3	4	I had a much stronger understanding 5

Please rate the IPS training in terms of the following statement

	Strongly Disagree 1	2	3	4	Strongly Agree 5
The training was effective in preparing me for the Peer worker role					

At the end of the IPS training, how ready were you to:

	Not at all ready 1	2	3	4	Very Ready 5
Do "first contact"?					
Listen Differently?					
Develop trauma-informed, mutually responsible relationships?					
Set boundaries?					
Be safe in peer relationships?					
Manage conflict?					
Self care?					
Participate in co-supervision?					

Have you been able to apply the IPS training in your work role?

- Yes

Please specify ways you have used the training:

- No

Were there any topics not covered in the IPS training that you would like to have had included?

- Yes

Please specify:

No

How satisfied were you with how the IPS training was delivered?

Very dissatisfied 1	2	3	4	Very Satisfied 5

Is there anything you could suggest to further improve the IPS training?

Yes

Please specify:

No

What do you think were the best features of the IPS training program?

Had you undertaken any peer support training before undertaking the IPS training with SheryMead/Chris Hansen/Brook Red/Discovery?

Yes

Please provide details of this training:

No

Current Role

Are you currently working as a manager of a service that employs Peer workers?

Yes
No

Approximately how long have you been in this role? Years Months

What type of service is this role in?

Funded under the Consumer Operated Service Program
Consumer-run services (other)
Personal Helpers and Mentors (PHaMS)
Queensland Health
Other community mental health service
Other

Is this role:

Full-Time Part-Time

Did the IPS Manager training: (Tick all that apply)

Impact on your organisation's understanding of Recovery?
Change the way that teams are structured?
Change the way supervision is conducted?
Change how services are delivered?

As a manager, had you employed Peer workers prior to doing the Manager Training?

Yes
No

Have you employed Peer workers since doing the Manager Training?

Yes
No

Relevant previous work experience

Are there any other comments you would like to make?

Yes

Please Specify:

No

Please tick the box if you do not wish to be contacted by telephone to talk about the training you received in more detail.

Submit Survey


AHA is an accredited quality organisation, certified under ISO 9001-2000
AHA is a member of the International Society for Quality in Healthcare (ISQua)

Australian Healthcare Associates Pty Ltd
ABN: 82 072 790 848 ACN: 072 790 848

Appendix D

Brook RED - Consumer Survey

Introduction

Australian Healthcare Associates has been asked by the Department of Communities, Child Safety and Disability Services to undertake an evaluation of the Consumer Operated Services Model. Brook RED is one of the Consumer Operated Services in this evaluation. Obtaining your views and feedback is very important to this evaluation.

The information you provide in this survey will help us to understand what is currently working well and what improvements could be made to the Model.

Please feel free to be as honest as you can as this will be the way that we can best work out how well people's needs are being met by the Model.

The survey should take less than ten minutes of your time. All your responses are voluntary and will remain confidential.

When you have completed your survey please place it in the marked box at Brook RED.

If have any questions or concerns about this survey please contact Jess or Tracey at Australian Healthcare Associates on 1300 788 667.

Thank you for your help with this,

Australian Healthcare Associates Evaluation Team

Date survey completed	
How long have you been coming to Brook RED?	

How often do you come to Brook RED? Please tick the best option.	Almost every day ☐ 2 or more times a week ☐ About once a week ☐ About once a month ☐ A few times a year ☐			
What is your age?	Under 18 ☐	18 – 24 years ☐	25 - 34 years ☐	35 – 44 years ☐
	45 – 54 years ☐	55 – 64 years ☐	65 - 74 years ☐	75 + years ☐
Country of Birth (if not Australia)				
Are you	Aboriginal ☐	Torres Strait Islander ☐	Neither ☐	
Gender	Male ☐	Female ☐		

1. Here is a list of services at Brook RED. Please tick the ones that you have used or been involved in.

Brook RED	Venue	Tick
One to One support	Norton St	
One to One support	Retreat	
Community Support Line	Night	
Phone Support	Day Norton St	
Men's Group	Norton St	
Peer Support Group	Norton St	
Women's Group	Norton St	
PA Outreach	Norton St	
Social Group	Norton St	
Bowling Group	Norton St	
Active Group	Norton St	
Art Group	Norton St	
Intentional Peer Support Training	Norton St	
Creative Writing	Norton St	
Music Group	Norton St	
Outreach	Norton St	

2. Do you use any other community services (besides Brook RED)? Please list below. (You can tell us the type of service for example Community Health Centre or the name of the service for example Baker Medical Clinic).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. In relation to Brook RED, in the following section, please indicate your agreement/disagreement with the following statements by circling the number that best represents your opinion. If the questions are about something you have not experienced, circle 9 to indicate this statement is not applicable to you.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
Overall I am satisfied with the service	1	2	3	4	5	9
I would recommend this service to other people	1	2	3	4	5	9
The location of services is convenient (parking, public transport, distance, etc)	1	2	3	4	5	9

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
The peer workers return my calls in a timely manner	1	2	3	4	5	9
The peer workers are available at times that are good for me	1	2	3	4	5	9
I am able to get the support I need at this service	1	2	3	4	5	9
At this service I get information when I need it	1	2	3	4	5	9
I feel free to make suggestions or complain at this service	1	2	3	4	5	9
Instead of the peer worker identifying my goals for me, we talk together about what "moving forward" could be like for me	1	2	3	4	5	9
Discussions with peer workers helped me to learn more about myself so that I could improve my mental wellbeing	1	2	3	4	5	9
I am encouraged to access other services when needed	1	2	3	4	5	9
As a direct result of the peer support at Brook RED:						
I manage daily issues more successfully	1	2	3	4	5	9
I am better able to control my life	1	2	3	4	5	9
I am better able to manage challenging times in my life	1	2	3	4	5	9
I am getting along better with my family or friends	1	2	3	4	5	9
I do better in social situations	1	2	3	4	5	9
I do better at work/study	1	2	3	4	5	9

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
My housing situation has improved	1	2	3	4	5	9
I am better able to manage my mental health or engage with others to keep improving my mental health	1	2	3	4	5	9
I do things that are more meaningful to me	1	2	3	4	5	9
I am better able to handle things when they go wrong	1	2	3	4	5	9
I have family or friends with whom I can do enjoyable things	1	2	3	4	5	9
I am happier with the friendships I have	1	2	3	4	5	9
I feel I belong in my community	1	2	3	4	5	9

4. Thinking about the services you use at Brook RED, is there anything you would like to see done differently? Do you have any suggestions for improvements or things that you feel should be changed?

_____

_____

_____

_____

_____

5. Thinking about the services you use at Brook RED, is there anything else you would like to share about how these services have been useful for you?

_____

_____

_____

_____

_____

Thank you for taking the time to complete this survey

FSG Australia's PEARL Program - Consumer Survey

Introduction

Australian Healthcare Associates has been asked by the Department of Communities, Child Safety and Disability Services to undertake an evaluation of the Consumer Operated Services Model. FSG PEARL Program is one of the Consumer Operated Services in this evaluation. Obtaining your views and feedback is very important to this evaluation.

The information you provide in this survey will help us to understand what is currently working well and what improvements could be made to the Model.

Please feel free to be as honest as you can as this will be the way that we can best work out how well people's needs are being met by the Model.

The survey should take less than ten minutes of your time. All your responses are voluntary and will remain confidential.

When you have completed your survey please place it in the marked box at FSG PEARL.

If have any questions or concerns about this survey please contact Jess or Tracey at Australian Healthcare Associates on 1300 788 667.

Thank you for your help with this,

Australian Healthcare Associates Evaluation Team

Date survey completed	
How long have you been coming to FSG Pearl Program?	

How often do you come to FSG Pearl Program? Please tick the best option.	Almost every day ☐ 2 or more times a week ☐ About once a week ☐ About once a month ☐ A few times a year ☐			
What is your age?	Under 18 ☐	18 – 24 years ☐	25 - 34 years ☐	35 – 44 years ☐
	45 – 54 years ☐	55 – 64 years ☐	65 - 74 years ☐	75 + years ☐
Country of Birth (if not Australia)				
Are you	Aboriginal ☐	Torres Strait Islander ☐	Neither ☐	
Gender	Male ☐	Female ☐		

1. Here is a list of Services at FSG PEARL Program. Please tick the ones that you have used or been involved in.

FSG PEARL Program activities	Tick
One-on-one conversations with an Intentional Peer Support Worker (at PEARL Resource Centre or House)	
Groups (at PEARL Resource Centre)	
Peer Support Line (phone conversations with an Intentional Peer Support Worker)	
Outreach (Intentional Peer Support Worker meeting with peers for conversations at any location external to PEARL's Resource Centre or House, i.e. in Hospital, at another service, or at home)	
Short-term stays at Pearl House in Pheasant St	
Other activities	
Volunteering	
Engaging in discussions about PEARL through Friday lunch group conversations and/or the Pearls of Wisdom (POW) Panel discussions	
Providing feedback on PEARL in general (i.e. feedback forms, discussions with workers or POW Panel) and/or regarding feedback on Groups	
Supporting other peers through connections (i.e. via natural conversations arising during time together at Resource Centre, informal discussions over jointly doing a jigsaw puzzle, etc.)	
Being a source of referral to PEARL for others who wish to access the service	
Representing PEARL at community events (i.e. PEARL Open Day, Mental Health Week activities, etc.)	
Discussions and involvement in Resource Centre planning and improvements (i.e. decorating with IPS themed materials, preparing for Open Days, Christmas celebrations, etc.)	
Accessing information and community resources and referrals	
Having the space and resources for self-reflection and growth (i.e. via PEARL Resource Centre library, etc.)	

2. Do you use any other community services (besides FSG PEARL Program)? Please list below. (You can tell us the type of service for example Community Health Centre or the name of the service for example Baker Medical Clinic).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. In the following section, please indicate your agreement/disagreement with the following statements by circling the number that best represents your opinion. If the questions are about something you have not experienced, circle 9 to indicate this item is not applicable to you.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
Overall I am satisfied with the service	1	2	3	4	5	9

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
I would recommend this service to other people	1	2	3	4	5	9
The location of services is convenient (parking, public transport , distance etc)	1	2	3	4	5	9
The Intentional Peer Support Workers return my calls in a timely manner	1	2	3	4	5	9
The Intentional Peer Support Workers are available at times that are good for me	1	2	3	4	5	9
I am able to get the support I need at this service	1	2	3	4	5	9
At this service I get information when I need it	1	2	3	4	5	9
I feel free to make suggestions or complain at this service	1	2	3	4	5	9
Instead of the worker identifying my goals for me, we talk together about what “moving forward” could be like for me	1	2	3	4	5	9
Discussions with Intentional Peer Support Workers helped me to learn more about myself so that I could improve my mental wellbeing	1	2	3	4	5	9
I am encouraged to access other services when needed	1	2	3	4	5	9
As a direct result of the Intentional Peer Support at FSG PEARL:						
I manage daily issues more successfully	1	2	3	4	5	9
I am better able to control my life	1	2	3	4	5	9
I am better able to manage challenging times in my life	1	2	3	4	5	9
I am getting along better with my family or friends	1	2	3	4	5	9

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
I do better in social situations	1	2	3	4	5	9
I do better at work/study	1	2	3	4	5	9
My housing situation has improved	1	2	3	4	5	9
I am better able to manage my mental health or engage with others to keep improving my mental health	1	2	3	4	5	9
I do things that are more meaningful to me	1	2	3	4	5	9
I am better able to handle things when they go wrong	1	2	3	4	5	9
I have family or friends with whom I can do enjoyable things	1	2	3	4	5	9
I am happier with the friendships I have	1	2	3	4	5	9
I feel I belong in my community	1	2	3	4	5	9

4. Thinking about the services you use at FSG PEARL Program, is there anything you would like to see done differently? Do you have any suggestions for improvements or things that you feel should be changed?

_____

_____

_____

_____

_____

5. Thinking about the services you use at the FSG PEARL Program, is there anything else you would like to share about how these services have been useful for you?

_____

_____

_____

_____

_____

Thank you for taking the time to complete this survey

Appendix E

Intentional Peer Support Core Competencies – Condensed Version

Revised December 29, 2011

For more detailed descriptions and examples, please refer to the full version of this tool.

Staff ID # (if applicable): _____ **Date:** _____

Method:

❒ 1. Guest scoring team member (ID #: ___)
❒ 2. Team member scoring other team member (ID #: ___)
❒ 3. Team member scoring self
❒ Other: _____

❒ 4. Team member scoring group
❒ 5. Evaluator scoring group
❒ 6. Guest scoring group

Criterion	Description	Rating (1 to 5)
1. Demonstrates the intention of learning as opposed to the intention of helping	Be curious Be open to new ways of looking at things Stand on a position of not knowing Ask questions to explore meaning and further understanding Be aware of one's judgments and preferences Challenge any assumption that the other is fragile and therefore does not have to take responsibility in relationships Be willing to change Have the courage to try and see what emerges rather than controlling the outcome Shift focus away from problem-solving	
2. Focuses on the relationship (rather than individual) and how it is working for both people	Pay attention to the dynamics in the relationship (e.g. connection/disconnection) Reflect the way people relate to one another Be aware of and talk about power imbalances and power dynamics Be aware meaning gets made in relationships Share (in a way that can be heard) what one is feeling and thinking, and negotiate if needed	
3. Has awareness of own intentions (e.g. agendas, assumptions)	Be self reflective Own one's motivation Don't act on one's own agenda Be open about assumptions	
4. Values and validates others and demonstrates mutual empathy	Be respectful of the story being told Maintain non-judgment Listen deeply for themes Refrain from refutation Be honest and authentic Show the other what one understands and how one is affected by the story	
5. Uses language that describes things as they are experienced; uses language that is free of medical jargon, assumptions, judgments, generalizations and characterizations	Refrain from using language of medical jargon Refrain from using language of assumptions Refrain from using language of judgments (e.g., I am stupid. I should have known better) Refrain from using language of generalizations Refrain from using language of characterizations	

Intentional Peer Support Core Competencies – Condensed Version

Revised December 29, 2011

Criterion	Description	Rating (1 to 5)
6. Understands how a person's past experiences impacts who they are, how they think, and how they relate	Collaboratively inquire into how people have learned the ways in which they see themselves and others and relate with others Show respect of the other Work to become less reactive and judgmental Have space for reflecting different views and exploring new ways of thinking and relating	
7. Invites conversation that shifts from a problem focus to a creating focus	Open up new perspectives, but do not impose one's own perspective Reflect team type dialogue Does not necessarily mean avoiding topics that are perceived as problems	
8. Gives and receives difficult messages with awareness of other worldviews as well as one's own	Be aware of own judgments and preferences Ask what the other sees Communicate in a way that the other can hear with observational, non-judgmental language	
9. Has ability to sit with discomfort and negotiate fear, anger, and conflict	Be aware of one's reactions (sensing, feeling, thinking, action) and notice discomfort Be tolerant with dissonance/disturbance Resist an urge to control Make space for the other to tell his/her story Sit with the other's pain Know one's limits Be honest and authentic Remember one's own feelings are important too Try to understand where the other stands Speak in a way that the other can hear Inquire what both need and want Self-reflect and acknowledge fear, anger, conflict Ask if this is an old response to some tough feelings and if there is a way to talk together both feel comfortable enough	
10. Attends and fully participates in co-supervision and has the desire and ability to self reflect	Describe interactions with observational, non-judgmental language – have a distance Be aware of one's feeling and thinking, and be honest about them Pay attention to what strikes and intrigues Suspend one's own judgments and remain open to other perspectives Be comfortable with not knowing Maintain an intention of learning	
	Total Score	

Intentional Peer Support Core Competencies – Full Version

Revised December 29, 2011

Staff ID # (if applicable): _____ Date: _____

Method:

❒ 1. Guest scoring team member (ID #: ___)
❒ 2. Team member scoring other team member (ID #: ___)
❒ 3. Team member scoring self
❒ Other: _____
❒ 4. Team member scoring group
❒ 5. Evaluator scoring group
❒ 6. Guest scoring group

Criterion 1: Demonstrates the intention of learning as opposed to the intention of helping					
Description	• Be curious rather than operating from one's own agenda • Be open to new ways of looking at things rather than imposing or guiding the other to look at things in a certain way • Stand on a position of not knowing • Ask questions to explore meaning and further understanding		• Be aware of one's judgments and preferences • Challenge any assumption that the other is fragile and therefore does not have to take responsibility in relationships • Be willing to change • Have the courage to try and see what emerges rather than controlling the outcome (i.e. try to get the person to get or do things one wants) • Shift focus away from problems and problem-solving		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Usually assumes the role of helper, with little effort to learn about the other.	Makes some effort to learn about the other, but usually begins with or lapses into helper role.	Combines helper and learner role in approximately equal measure.	Primarily learning about the other or from the other.	Shows intention of mutual learning.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	You look depressed. You should write in your journal.	How's it going? You look a little down. Maybe you should write in your journal.	How's it going? You look a little down, but I'd like to know your perspective.	I realize that I don't know you beyond talking about your experience. I'd like to get to know you better.	I realize that I don't know you very well other than the conversations we've had about your experience. I'd love for us to get to know each other more.
Outcome	Naming or simplifying the other's experience and taking control of the solution.				Learning for both people (e.g. both say things like, "I've never thought about it that way before").

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Criterion 2: Focuses on the relationship (rather than individual) and how it is working for both people					
Description	• Pay attention to the dynamics in the relationship (e.g. connection/disconnection) • Reflect the way in which people relate to one another • Be aware of and talk about power imbalances and power dynamics			• Be aware that meaning gets made in relationships • Share (in a way that can be heard) what one is feeling and thinking, and then negotiate if needed	
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Allows for little or no discussion of the relationship. Focuses on an outcome for the other.	Gives some attention to the relationship, but mostly focuses on an outcome for the other.	Communicates feelings in the relationship, but does not sufficiently address the topic of the relationship.	Communicates feelings in the relationship, but not sufficiently to explore how it looks like for the other.	Addresses the topic of the relationship sufficiently to ensure that it is working for both people.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	I'm here to support you in your recovery.	Let's share some ideas about what might support your recovery.	I got frustrated in our conversation last week, but how are you doing today?	I got frustrated in our conversation last week. I wish you'd be more open with me in the future.	I got frustrated in our conversation last week. I wonder how it was for you.
Outcome	Expert/client relationship.	Friendly, helping relationship with a focus on the other.	A disconnect is noticed, but focus is still on the other. No movement toward reconnection.	Movement toward reconnection.	Both people have a willingness to ask for what they need and a responsibility to consider the views of others. A focus on taking care of the relationship rather than taking care of each other. An understanding that both people are responsible for themselves and their part of any relationship.

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Criterion 3: Has awareness of own intentions (e.g. agendas, assumptions)					
Description	• Be self reflective • Own one's motivation • Don't act on one's own agenda • Be open about assumptions (and open to being challenged)				
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Demonstrates limited awareness of how one's values and assumptions are affecting the interaction.	Has some recognition of one's values and assumptions but often imposes these on the interaction.	Generally able to separate one's values and assumptions but has limited awareness about the ways they can be imposed on the interaction.	Generally aware of one's values and assumptions and acknowledges it if they are imposed on the interaction.	Demonstrates full awareness of one's values and assumptions and seldom if ever imposes these on the interaction.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	Why don't you listen to me when I tell you what worked for me?	I realize that not everything that worked for me will work for you, but at least you should try it.	I realize that not everything that worked for me will work for you.	I realize I've quietly been pushing my own agenda. I'd like to try work towards noticing when my agenda seems to come up.	How would you like me to respond when you tell me you're depressed?
Outcome	Use of power to push one's own agenda.				Shared power and openness to creating possibilities.

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Criterion 4: Values and validates others and demonstrates mutual empathy					
Description	• Be respectful of the story being told • Maintain non-judgment • Listen deeply for themes • Refrain from refutation		• Be honest • Be authentic • Show the other what one understands and how one is affected by the story		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Almost never demonstrates that the other is valued or validates the other in the interaction. Imposes one's judgment on the other.	Demonstrates that the other is valued or validates the other, but imposes one's judgment on the other.	Demonstrates that the other is valued or validates the other, but responds to the other based on one's own values.	Demonstrates that the other is valued or validates the other. Refrains from responding based on one's own values, and tries to get the other's perspective.	Demonstrates that the other is valued or validates the other, and shares what resonates and/ or relevant personal experience.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	Why don't you just get over it? You can't always be depressed.	Depression is hard, but maybe you're too focused on it.	It must be hard for you. You must be tired, but you have to remember that you'll get through it.	Sounds like things have been really hard for you lately.	I can imagine that it's been really hard for you lately. I remember a time when it seemed the only thing I felt was depressed.
Outcome	Invalidation and disconnection from the other.				People feel seen, heard and validated and know that they're not alone.

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Criterion 5: Uses language that describes things as they are experienced; uses language that is free of medical jargon, assumptions, judgments, generalizations and characterizations					
Description	• Refrain from using language of medical jargon (e.g. decompensate, psychotic) • Refrain from using language of assumptions (e.g. she must be sick, have you taken your medication?) • Refrain from using language of judgments (e.g., I am stupid. I should have known better) • Refrain from using language of generalizations (e.g., women are sensitive) • Refrain from using language of characterizations (e.g., she is an advocate)				
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Nearly always uses jargon and language that implies helping relationship in the treatment context.	Uses person-first language within a medical framework and language that implies a helping relationship in the treatment context.	Uses language that describes things as they are experienced and language that implies a helping relationship in the treatment context.	Seldom uses jargon and uses language that implies a helping relationship in the peer support context.	Almost never uses jargon, and uses language that describes things as they are experienced, free of assumptions about the relationship.
Example: *Jim works in a peer run crisis center. He is describing who he works with.*	We work only with SMI who are decompensating.	We work with people with mental illness who are in crisis.	We work with people in crisis to help them manage their symptoms.	We support people in distress by offering our own recovery experiences.	We welcome people who want to move through distressing experiences differently than they have in the past.
Outcome	People are judged, categorized and assessed, reinforcing an illness framework.				People no longer see themselves through the lens of a diagnosis and the assumptions of others.

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Criterion 6: Understands how a person's past experiences impacts who they are, how they think, and how they relate					
Description	• Collaboratively inquire into how people have learned the ways in which they see themselves and others and relate with others • Show respect of the other • Work to become less reactive and judgmental • Have space for reflecting different views and exploring new ways of thinking and relating				
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Assesses the other's experience based on the medical framework.	Assesses the other's experience based not necessarily on the medical framework but nonetheless on one's own judgment.	Assesses the other's experience without any particular pre-judgments or assumptions.	Tries to understand the other's experience in the context of his or her past experiences.	Tries to build mutual understanding of the other's experience. Negotiates meaning and reflects on how both people make meaning.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	It sounds like your medication is off. Have you talked to your doctor?	You know trauma leads to depression!	There are many factors that contribute to depression.	What happened to you that lead to you feeling depressed so much of time?	I wonder what depressed means for you. I know there was a time when I learned to think of my feelings as dangerous and so it was easy to adopt medical language.
Outcome	Reinforcement of an illness identity and narrowed framework for understanding feelings. Peer supporter becomes assessor and holder of truth.				Acceptance, interest, and curiosity about different ways of thinking. Valuing other perspectives/truths as opportunities for personal growth and discovery. People begin to understand their experiences based on what's happened to them rather than what's wrong with them. The effects of trauma are not viewed as illness but rather a reaction to what has been experienced.

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Criterion 7: Invites conversation that shifts from a problem focus to a creating focus					
Description	• Open up new perspectives, but do not impose one's own perspective • Reflect team type dialogue • Does not necessarily mean avoiding topics that are perceived as problems				
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Focuses on problems, problem solving, and giving advice.	Focuses on problems and explores solutions with the other.	Does not focus on problems and refrains from problem solving.	Focuses on what the other wants.	Focuses on the relationship and explores new ways of relating.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	You should try…	What has worked for you in the past?	I wonder what we would talk about if the focus wasn't on depression.	I wonder how you'd rather feel.	I realize that I've been simply trying to solve this for you. I wonder what we might do differently.
Outcome	Peer supporter judges success by the extent to which he or she helps others with their problems.				Person feels validated yet curious about other ways of thinking.

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Criterion 8: Gives and receives difficult messages with awareness of other worldviews as well as one's own					
Description	• Be aware of own reactions • Be aware of own judgments and preferences		• Ask what the other sees • Communicate in a way that the other can hear with observational, non-judgmental language		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Shows little awareness of one's feelings and blames the other.	Demonstrates awareness of one's feelings, but blames the other for them.	Demonstrates awareness of one's feelings and refrains from blaming the other.	Demonstrates awareness of one's feelings and describes them with observational language.	Demonstrates awareness of one's feelings and describes them in a way the other can hear; is curious about what it is like for the other.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed.*	No one is depressed all the time.	I'm finding that I've been really frustrated with our conversations. No one is depressed all the time.	I'm finding that I've been really frustrated with our conversations.	I'm finding that I've been really frustrated with our conversations that have been so focused on depression.	What has it been like for you that our conversations have been so focused on depression? I know that sometimes I find it difficult.
Outcome	Total disconnect and lack of honesty (talking about people behind their backs).				Trust and depth in the relationship, leading to a willingness to tolerate discomfort in the relationship

Criterion 9: Has ability to sit with discomfort and negotiate fear, anger, and conflict					
Description	• Be aware of one's reactions (sensing, feeling, thinking, action) and notice discomfort • Be tolerant with dissonance/disturbance • Resist an urge to control • Make space for the other to tell his/her story • Sit with the other's pain • Know one's limits		• Be honest and authentic • Remember one's own feelings are important too • Try to understand where the other stands • Speak in a way that the other can hear • Inquire what both need and want • Self-reflect and acknowledge fear, anger, and conflict • Ask if this is an old response to some tough feelings and if there is a way to talk together both feel comfortable enough		
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Not able to sit with discomfort. Imposes a solution based on one's assessment.	Not able to sit with discomfort. Suggests a solution based on one's assessment.	Able to sit with discomfort. Makes space for the other to consider a solution based on one's assessment.	Able to sit with discomfort. Makes space to explore solutions together.	Able to sit with discomfort. Makes space to explore meaning and negotiate fear, anger, and conflict.
Example: *Sarah has been talking to Lisa for the last couple of weeks, and each time they get together, Lisa tells Sarah she's depressed. Today she tells Sarah she's ready to end it!*	I'll have to call emergency services.	How serious are you? Do you think we should call emergency services?	I feel afraid when you say you're going to end it. I wonder if we should call emergency services.	I feel afraid when you say you're going to end it. I wonder what we can do to make you feel better.	I feel afraid when you say you're going to end it, but I realize I don't know what you mean by saying you're ready to end it.
Outcome	The "safety" problem is passed on to a professional who "knows more" than the other. Results in coercion.				People consider discomfort a natural part of the learning process. Increased ability to work through hard times without professional intervention. People feel more capable and have hope even in difficult situations.

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Criterion 10: Attends and fully participates in co-supervision and has the desire and ability to self reflect					
Description	• Describe interactions with observational, non-judgmental language – have a distance • Be aware of one's feeling and thinking, and be honest about them • Pay attention to what strikes and intrigues • Suspend one's own judgments and remain open to other perspectives • Be comfortable with not knowing • Maintain an intention of learning				
Score	**1**	**2**	**3**	**4**	**5**
Rating Scale	Never reflects on one's way of relating. Gets defensive and blames the other.	Has limited self-reflection and little awareness of one's assumptions about the other.	Somewhat self-reflective and refrains from making assumptions about the other.	Self-reflective on relationship patterns and one's intention. Limited awareness of one's values.	Self-reflective on relationship patterns and one's own intentions. Open to new ways of relating.
Example: *Bruce has been working with Joe whom he's been getting frustrated by. Every time Joe says he's going to do something, he doesn't do it.*	Joe is a difficult client. He's just not motivated.	I feel frustrated because of Joes' lack of motivation.	I don't know what Joe wants to do with his life.	I realize I've been trying to get Joe to do something based on my agenda, but he's got so much potential.	I realize I've been trying to get Joe to do something based on my agenda. I wonder if I should go apologize to him.
Outcome	People blame others.				People are self-reflective and able to consider other ways of relating.

Appendix F

Appendix F: Certificate IV in Mental Health Peer Work

1 CERTIFICATE IV IN MENTAL HEALTH PEER WORK

This section provides an overview of the Certficate IV in Mental Health Peer Work qualification.

The Community Services Training Package (2008) includes a Certificate IV in Mental Health Peer Work (CHC42912). This qualification descriptor is:

- Consumer workers and carer workers who are employed within the mental health sector in government, public, private or community managed services. This qualification is specific to workers who have lived experience of mental health problems as either consumer or carer and who work in mental health services in roles that support consumer peers or carer peers. Occupational titles may include:
  - Consumer consultant, consumer representative, peer support worker, peer mentor, youth peer worker, carer consultant, carer representative, Aboriginal peer worker, participation coordinator, family advocate.[1]

Fifteen units of competency must be selected for award of this qualification. Of the 15 units, six are deemed core units to earn the qualification, and therefore are compulsory. These are:

- CHCPW401A Apply peer work practices in the mental health sector
- CHCPW402A Contribute to the continuous improvement of mental health services
- CHCPW403A Apply lived experience in mental health peer work
- CHCPW404A Work effectively in trauma informed care
- CHCPW405A Promote and facilitate self-advocacy
- HLTWHS300A Contribute to workplace health and safety processes.

Nine elective units make up the remainder of the 15 required units. Of the 9 elective units, at least one must be chosen from the following units:

- HLTHIR403C Work effectively with culturally diverse service users and co-workers
- HLTHIR404D Work effectively with Aboriginal and/or Torres Strait Islander people.

The following four electives are also required to make up the 15 units:

- CHCPW406A Work effectively in consumer mental health peer work
- CHCPW407A Support self-directed physical health and wellbeing
- CHCPW408A Work effectively in carer mental health peer work
- CHCICS304B Work effectively with carers.

The remainder of the elective units must be selected in line with specified packaging rules and from the following electives clusters:

- BSBWOR204A Use business technology
- CHCINF303B Contribute to information requirements in the community sector
- CHCAD401D Advocate for service users

[1] http://training.gov.au Accessed 19-12-2013 and 4-1-2013

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- CHCAD402D Support the interest, rights and needs of peers within duty of care requirements
- CHCAD603B Provide systems advocacy services

- CHCAOD402A Work effectively in alcohol and other drugs sector
- CHCNET404B Facilitate links with other services

- CHCCD402B Develop and provide community education programs
- CHCCD401E Support community participation
- CHCCD508D Support community action

- CHCCD307D Support community resources
- CHCCD401E Support community participation
- CHCCD404E Develop and implement community programs
- CHCCD413E Work within specific communities
- CHCCD420B Work to empower Aboriginal and/or Torres Strait Islander communities

- CHCDIS302A Maintain an environment to empower people with disabilities
- CHCDIS410A Facilitate community participation and inclusion
- CHCICS406B Support service user self-management
- CHCICS407B Support positive lifestyle

- TAEDEL401A Plan, organise and deliver group based learning
- TAEDEL402A Plan, organise and facilitate learning in the workplace
- TAEDES401A Design and develop learning programs
- BSBCMM410A Make a presentation

- CHCFAM417B Identify and use strengths based practice
- CHCFAM421B Work with parents of very young children
- CHCICS410A Support relationships with carers and families

- CHCGROUP403D Plan and conduct group activities
- CHCGROUP410B Deliver a structured program
- CHCGROUP302D Support group activity
- CHCIC405D Facilitate groups for individual outcomes

- CHCICS406B Support service user self management

- CHCFAM417B Identify and use strengths based practice

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- CHCICS407B Support positive lifestyle
- CHCICS408B Provide support to people with chronic disease
- CHCCS426B Provide support and care relating to grief and loss

- CHCCH410B Manage and maintain tenancy agreements and services
- CJCCH427B Work effectively with people experiencing or at risk of homelessness
- CHCCH428B Working effectively within the Australian housing system
- CHCCH522B Undertake outreach work

- CHCNET301A Participate in networks
- CJCNET402B Establish and maintain effective networks
- CHCNET404B Facilitate links with other services

- CHCPOL402C Contribute to policy development
- CHCPOL403C Undertake research activities
- CHCPOL 404A Undertake policy review

- CHCLD514B Analyse impacts of sociological factors on service users in community work and services
- CHCCS514B Recognise and respond to individuals at risk
- CHCCS521B Assess and respond to individuals at risk
- CHCCS426B Provide support and care relating to loss and grief
- CHCFAM504B Respond to and contain critical incidents

- CHCSW401A Work effectively with forced migrants
- CHCSW402B Undertake bicultural work with forced migrants in Australia

- CHCYTH301D Work effectively with young people
- CHYTH404E Support young people in crisis
- CHCYTH403B Support young people to create opportunities in their lives
- CHCYTH511B Work effectively with young people and their families

- CHCLD315A Recognise stages of lifespan development
- CHCAC317A Support older people to maintain their independence
- CHCAC318A Work effectively with older persons
- CHCAC319A Provide support to people living with dementia
- CHCCS426B Provide support and care relating to grief and loss[2]

[2] http://training.gov.au Accessed 19-12-2013 and 4-1-2013

Appendix G

Training in Intentional Peer Support (IPS)

The Department of Communities, Community Mental Health is providing a series of training in Intentional Peer Support across Queensland in February/March 2011. These will include:

5-Day Training in Intentional Peer Support – training for paid/unpaid peer workers (people who have a lived experience of mental health issues).

2-Day training for Managers/Coordinators of NGO Mental Health services, who have, or are interested in developing, a peer workforce.

It is recommended that organisations registering peers for the 5-day training also register at least one manager/coordinator from their organisation to attend the 2-day managers' training.

What is Intentional Peer Support?

IPS is a way of thinking about purposeful relationships. It is a process where both people (or a group of people) use the relationship to look at situations from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new approaches. IPS relationships are viewed as partnerships that enable both parties to learn and grow--rather than as one person needing to 'help' another.

What will the training include?

1. 5-Day Training for Peer Workers

A more detailed list is found on page 3 of this factsheet.

- What makes intentional peer support different?
- The 4 tasks (connection, worldview, mutual responsibility and moving towards)
- Listening with intention
- Challenging old roles
- Understanding trauma worldview and trauma re-enactment
- Working towards shared responsibility and shared power
- Creating a vision
- Using supervision as a tool to maintain values in action

2. 2-Day Managers Training

IPS Overview

Overview of Intentional Peer Support tasks and key messages - language, power dynamics, self care, limits & boundaries, challenging situations and importance of Co -supervision.

Creating Peer Friendly Work Environments

- Recognising skills of Peer Workforce.
- Recruitment - Position descriptions, interview process etc considerations
- Staff development for traditional team members
- Co Supervision vs Supervision from non Peer.
- Challenges - Boundaries, overt involvement in decision making processes.
- Sustaining IPS in the workplace beyond the "training".

Who Should Apply?

Training is open to peer workers and managers/coordinators of non-government mental health services. In the event of any of the sessions being over-subscribed, priority will be given to organisations that are funded for community mental health programs through the Department of Communities, and consumer-operated services.

Benefits to Participants

Participants will;

- Receive training from Shery Mead and Chris Hansen of Shery Mead Consulting. Chris and Shery provide this training in the USA, UK, Japan and New Zealand, and are recognised leaders in the field of peer training. Their website is www.mentalhealthpeers.com
- Participants in the 5-day IPS peer work training will receive a manual.
- Have opportunities to network with others from a range of non-government services.
- Receive a certificate of attendance.

Workshop details

All workshops will start at 9.30 AM and finish by 4.30 PM. Morning/afternoon tea and lunch are provided. Please provide any dietary requirements and any access needs when you complete the Application Form.
The training is provided **free of charge.** The Calender of Training is listed below

How to register

Workshop places are limited to 25 participants for the 5-day Intentional Peer Support training and 25 participants for each of the 2-day Managers' Training.

Please complete the relevant Application Form accompanying this Information Sheet and email to gaynor.ellis@communities.qld.gov.au **Application forms should be returned by 12th February if possible. DO NOT FAX OR POST THE FORMS.**

For further information about the Intentional Peer Support (IPS) training contact:

Gaynor Ellis
Senior Program Officer
Community Mental Health, Department of Communities
Email: gaynor.ellis@communities.qld.gov.au

Phone (07) 3006 8790

Training Calender

Location	Dates	Training and Venue details
Brisbane	Mon 21st & Tues 22nd February 9.30am-4.30pm	2-Day Managers/Coordinator Training in Intentional Peer Support (IPS) and implementing a peer workforce. Venue: Merthyr Uniting Church Centre 52 Merthyr Rd New Farm.
Hervey Bay	Thurs 24th & Fri 25th February 9.30-4.30 pm	2-Day Managers/Coordinator Training in Intentional Peer Support (IPS) and implementing a peer workforce. Venue: Ozcare Training Room, Shop2, 14 Torquay Rd, Pialba Hervey Bay.
Hervey Bay	Mon. 28th Feb - Fri. 4th March	5-Day Intentional Peer Support Training for paid/unpaid peer workers. Venue: Ozcare Training Room, Shop 2, 14 Torquay Rd, Pialba, Hervey Bay.

Detailed Overview of the 5-day Intentional Peer Support training:

(Daily topics may vary from these – this is just an overview)

Day One

What is intentional peer support?
• Learning vs. helping
• Thinking beyond the individual to the relational
▪ The four tasks: (and what is unique about peer support)
1. Connection and disconnection
2. Worldview
3. Mutuality
4. Moving towards,
▪ Focus planning

Day Two

The power of language
Telling our stories in different ways
Symptoms vs feelings
Listening:
• Listening Differently
• Listening from a position of not knowing
• Listening for the untold story
• Problem-solving vs validation
First Contact

Day Three

Mutual responsibility
Shared risk
The impact of trauma
Relationship patterns
• Moving forwards in relationships
Boundaries and limits

Day Four

Issues of power and privilege
Conflict:
• Dynamics
• Resolution
Challenging situations and conversations:
• Suicide
• Self-harm
• When someone's reality is different from our own

Day Five

▪ Co-supervision
• (Presentations)
• Values
• Competencies

Appendix H

Attachment 1

Dept of Communities, Community Mental Health - Statistical Report

Service Provider Name:	
Reporting Period:	
Year:	

Service Outlet:		**Location:**	

Consumer Operated Services	Service Provider's Strategy The service provider implements Consumer Operated Services service delivery in accordance with the Service Model Guidelines and provides peer services based on recovery-focused procedures and practices that maximise the service user's self-management of wellness and the development of social and personal skills and meaningful community participation.

Initiative	Statistical measures	Number	Comments (if applicable)
Consumer Operated Services - accommodation	Gender - Male		
Consumer Operated Services - accommodation	Gender - Female		
Consumer Operated Services - accommodation	Age range - 15 to 18 years		
Consumer Operated Services - accommodation	Age range - 18 to 25 years		
Consumer Operated Services - accommodation	Age range - 25 to 35 years		
Consumer Operated Services - accommodation	Age range - 35 to 50 years		
Consumer Operated Services - accommodation	Age range - 50 to 65 years		
Consumer Operated Services - accommodation	Age range - 50 to 65 years		
Consumer Operated Services - accommodation	Referrals received		
Consumer Operated Services - accommodation	Referrals accepted		
Consumer Operated Services - accommodation	Referrals - self referral/word of mouth/friends/family		
Consumer Operated Services - accommodation	Referrals - Qld Health - mental health		
Consumer Operated Services - accommodation	Referrals - GP		
Consumer Operated Services - accommodation	Referrals - NGO - mental health		
Consumer Operated Services - accommodation	Referrals - NGO other		
Consumer Operated Services - accommodation	Referrals - other/unknown		***Please name "Other" referral sources here.***
Consumer Operated Services - accommodation	Aboriginal or Torres Strait Islander people being supported		
Consumer Operated Services - accommodation	People from a CALD background being supported		
Consumer Operated Services - accommodation	Maximum duration of support		***Please read "support" as "length of stay" in the accommmodtion***
Consumer Operated Services - accommodation	Minimum duration of support		***Please read "support" as "length of stay" in the accommodation***
Consumer Operated Services - accommodation	Average duration of support		***Please calculate the average stay taking into account the effects of unusually long stays on the overall average***
Consumer Operated Services - mutual support	Gender - Male		
Consumer Operated Services - mutual support	Gender - Female		
Consumer Operated Services - mutual support	Age range - 15 to 18 years		
Consumer Operated Services - mutual support	Age range - 18 to 25 years		
Consumer Operated Services - mutual support	Age range - 25 to 35 years		
Consumer Operated Services - mutual support	Age range - 25 to 35 years		
Consumer Operated Services - mutual support	Age range - 35 to 50 years		
Consumer Operated Services - mutual support	Age range - 50 to 65 years		
Consumer Operated Services - mutual support	Age range - over 65 years		
Consumer Operated Services - mutual support	Referrals received		
Consumer Operated Services - mutual support	Referrals accepted		
Consumer Operated Services - mutual support	Referrals - self referral/word of mouth/friends/family		
Consumer Operated Services - mutual support	Referrals - Qld Health - mental health		

Consumer Operated Services - mutual support	Referrals - GP		
Consumer Operated Services - mutual support	Referrals - NGO - mental health		
Consumer Operated Services - mutual support	Referrals - NGO other		
Consumer Operated Services - mutual support	Referrals - other/unknown		
Consumer Operated Services - mutual support	Aboriginal or Torres Strait Islander people being supported		
Consumer Operated Services - mutual support	People from a CALD background being supported		
Consumer Operated Services - mutual support	locations where services are provided - Centre		
Consumer Operated Services - mutual support	locations where services are provided - persons own home		
Consumer Operated Services - mutual support	locations where services are provided - Telephone		
Consumer Operated Services - mutual support	locations where services are provided - Other		