LEADING THE CHANGE

Co-producing safe, inclusive workplaces for consumer mental health workers

Final Report
2020

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1.   EXECUTIVE SUMMARY

Consumer workers play an important role in mental health service provision by providing support and advocacy in a way that draws on their lived experience of being a consumer of these services. The past two decades has seen a groundswell of interest from policy makers and service providers about incorporating consumer workers within the mental health system. Consumer workers occupy a variety of roles, but all seek to embed a consumer perspective on service provision within the mental health sector. This perspective drives a particular approach to supporting consumers, one that is built on core values such as self-determination, mutuality, authenticity, and transparency (Victorian Mental Illness Awareness Council et al., 2018). Consumer perspective work also necessitates a focus on systemic change within the mental health system with a focus on creating a more humane, rights focused sector.

In Victoria, consumer workers were originally introduced in the 1990s in consumer consultant roles aimed at building dialogue between service providers and consumers and using systemic advocacy to represent consumer perspectives in quality improvement mechanisms (Department of Health and Community Services, 1996). Increasingly, they have been deployed in peer support roles within public area mental health services including the "Expanding post-discharge support initiative", a Department of Health and Human Services funded program that has seen peer support roles established at all adult public mental health services in Victoria. International and Australian research suggests employment of a consumer workforce has the potential to be a highly effective use of resources, as they have a positive impact on consumers, help to drive service innovation, and improve quality of care (Grey & O'Hagan, 2015; Happell & Scholz, 2018; Repper & Carter, 2011). However, for this potential to be realised, the consumer workforce requires adequate resourcing, support, and inclusion within the organisations in which they work. While the consumer workforce in Victoria has grown in recent years, there have also been indications that many consumer worker roles have been poorly implemented, leading to negative outcomes for consumer workers themselves, and a loss of valuable expertise to mental health care services and consumers (Centre for Evaluation and Research, Department of Health and Human Services, 2019). This represents a risk that the consumer workforce may be unsustainable, and resources invested to date are not being optimally utilised.

The Leading the Change project study sought to investigate the experiences of consumer workers employed in Victorian services, with a particular focus on their experiences of safety and discrimination. This project was designed and implemented using principles of co-production. A Consumer Worker Action Group (CWAG) was responsible for designing, implementing and reporting on this project. This study utilised a mixed method approach that incorporated two phases. The first phase involved an online survey and semi-structured interviews with Victorian consumer workers exploring their experiences of workplace safety, discrimination, and inclusivity. The second phase involved a focus group where consumer workers workshopped potential solutions to the issues raised in phase one.

The findings of this project indicate that there is a pressing need for significant improvement in the inclusion and use of consumer workers within mental health care services funded by the Victorian Government. Participants detailed a lack of clear organisational support for consumer worker roles, a high rate of discrimination and bullying, and a clash of values between consumer work and the mental health system. Participants also highlighted several ways to improve the safety and inclusivity of mental health workplaces for consumer workers. What is evident is that the implementation of consumer work within the current mental health system requires a systemic approach to change that targets organisational and individual support alongside mental health sector reform.

1.1.   Key Findings

The following themes were present both in the survey and the interviews and point to strengths within the consumer workforce, the systemic challenges that consumer workers face, and potential avenues for change. These avenues for change were further developed within focus group discussions.

The positive impact of the consumer worker roles

Interview and survey participants described the positive impact their roles had on consumers within mental health services and how the use of lived experience and mutuality created a unique space for connection, one that may not exist in other relationships with health professionals. Participants also identified that working in consumer worker roles often had positive impacts within their own lives through helping them make sense of past difficult experiences and the use of these perspectives to assist others. Finally, they saw their roles as having benefits for their colleagues by creating space for them to be more vulnerable and to gain a broader understanding of the consumer experience.

Numbers in the workforce

Participants detailed feelings of isolation in the workplace. Over a third (36.9%) agreed or strongly agreed with the statement "I feel isolated in my workplace because of being a consumer worker". This isolation is in part related to the fact that consumer workers often work without a team of other consumer workers. Amongst survey respondents 18.3% reported having no consumer worker colleagues and a further 11.3,% reported having just one other consumer worker colleague. Participants also highlighted experiences where they felt excluded by the behaviours and attitudes of their non-consumer worker colleagues.

Participants stressed that this isolation was not as much an issue within teams where there was a greater number of consumer workers. A key avenue for change, noted by participants, was to build the consumer workforce so that there were consumer worker positions across all levels of the mental health system. To successfully achieve this, participants strongly argued the need for a strategic approach to the training and development of consumer workers, and one that is flexible to the varied needs and educational backgrounds of consumer workers.

Lack of organisational support

Several features of the organisational context of mental health services were found to pose challenges for consumer workers. Over a third (36.5%) disagreed or strongly disagreed with the statement "I feel that I have enough support from my organisation to do my role". Participants frequently described supervision and consumer specific supervision as a key component of successful roles. Despite this, almost a third (29.2%) of survey respondents reported that they did not receive any form of regular professional supervision. Participants also frequently reported that they were not resourced to obtain consumer specific supervision and had to use their own financial resources to obtain this.

Professional development was highlighted as an important feature of career development for consumer workers and yet a third (33.3%) of survey respondents disagreed or strongly disagreed with the statement "I feel that I have received enough training to be successful in my role". Participants spoke very highly of consumer led training such as Intentional Peer Support, but many indicated their employers were unwilling to pay for such training.

Safety, bullying, and discrimination in the workplace

Consumer workers reported high levels of discrimination. A majority of participants felt they were treated differently based on their position as a consumer worker. A total of 59.1% of respondents agreed or strongly agreed with the statement "I feel like I am treated differently in my workplace because I am a consumer worker." Over a third (65.2%) of respondents felt their employment conditions were different (less favourable) than their non-consumer colleagues. Participants also reported being the target of discriminatory behaviour by colleagues. Over half (53%) of respondents to the survey agreed or strongly agreed with the statement "I feel that others in the workplace make judgements about me based on my disclosed lived experience".

Experiences of bullying were frequently detailed in both the surveys and the interviews. Half (50.8%) of survey respondents reported being verbally abused in the workplace and 41.5% reported feeling threatened by others in the workplace. Over a third (36.9%) agreed or strongly agreed with the statement "I feel isolated in my workplace because of being a consumer worker".

In addition to this, participants expressed concerns around confidentiality in the workplace. Close to one quarter (22.7%) of survey participants reported that they did not feel confident that their privacy around their personal use of mental health services would be respected.

These experiences can be seen to have a significant impact on the sustainability of this workforce. A total of 25% of survey respondents reported leaving consumer roles because they felt unsafe or felt discriminated against and 60.9% reported that they had remained in roles where they felt unsafe or discriminated against as they felt that they needed the job.

Systemic barriers for a consumer workforce

Beyond the behaviour of individual colleagues or organisational structures, participants also identified systemic barriers in the mental health system itself which impeded the development and sustainability of a consumer workforce. Consumer workers experience first-hand the contradictions between two paradigms toward mental health care. The medically oriented approach that dominates culture and practice within mental health services is often at odds with the paradigm that underpins consumer work. Widespread undervaluing of lived experience perspectives and the dominance of the medical model on the mental health system, were both seen as underlying problems that inhibited consumer workers from being able to provide appropriate service to users, consistent with their role. This was exacerbated by the strong hierarchy and power imbalance in the mental health workforce, in which consumer workers occupied the lowest level. Negative and highly stigmatising communication about consumers within the mental health system, which flies in the face of a consumer-focused philosophy, was experienced as highly problematic by consumer workers. For example, over half (53.3%) of survey respondents agreed or strongly agreed with the statement "I have heard my colleagues talk in a derogatory way about consumers or in relation to certain diagnostic categories." Participants reported that hearing this way of discussing consumers was very distressing. This was particularly the case when commentary about consumers or specific diagnoses were shared features of a consumer worker's own lived experience.

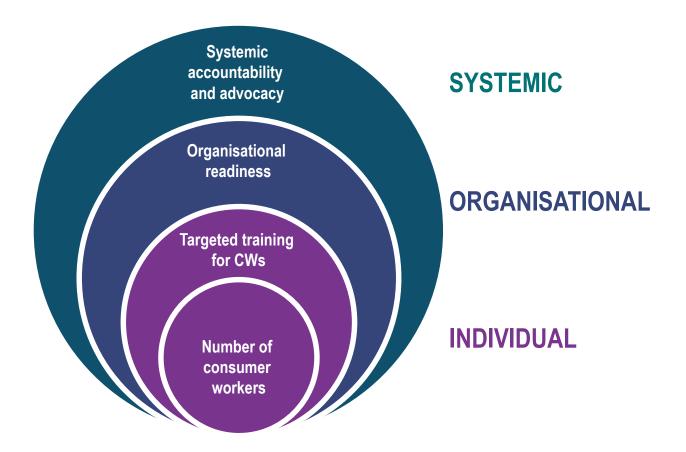## Embedding rather than tolerating a consumer workforce

In order to create safe, inclusive workplaces for consumer workers, participants indicated that organisations needed to have a greater degree of readiness to best support these roles. This would include fostering a good level of understanding of consumer work and consumer work values within organisational culture. This could assist with developing clearer definitions of consumer worker roles and embedding their input into any policy or procedures relating to their work. Organisations also needed to be made more accountable by funders for adequately supporting and retaining their consumer workers. Participants pointed to the need for strong leadership, both within organisations and externally, to address issues relating to safety, bullying, and discrimination experienced by consumer workers. Management, in particular, needed to take a strong lead in encouraging cultural change and setting standards of appropriate behaviour.

Throughout the focus group participants stressed the value of utilising Enterprise Bargaining Agreement (EBA) negotiations in order to mandate better conditions for consumer workers. Focus group participants nominated this strategy as the quickest method to address some of the issues faced by consumer workers. Participants further noted the importance of building better connections with unions to support this process.

1.2. Recommendations

These findings indicate that while there are unique challenges present in creating a safe and inclusive sector for consumer workers, there are also avenues for change. To meaningfully incorporate consumer workers into mental health services in a way that best utilises their potential, requires more than simply the addition of consumer workers into current mental health staffing. Given the uniqueness of the consumer worker role, and the consumer worker value base that often sits at odds with current approaches to mental health service delivery, there is a need for a systemic approach to efforts to incorporate consumer workers into the sector. With any system change there is no magic bullet, change must occur at multiple points. The following recommendations were developed by the CWAG with this premise in mind. As illustrated in Figure 1, they are designed to target the challenges evident in the findings of this study at an individual, organisational, and sector level.

Figure 1 - A model for systemic change

Systemic accountability and advocacy

SYSTEMIC

Organisational readiness

ORGANISATIONAL

Targeted training for CWs

Number of consumer workers

INDIVIDUAL

1.   Ensure that all new approaches to supporting the consumer workforce are fully co-produced.

Co-production should be an overarching principle to guide any approach to support consumer workers within the mental health sector. This study found that organisational and sector efforts to effectively incorporate consumer workers into mental health services have often failed to consider the unique nature of consumer work. This has resulted in a lack of resourcing for consumer led supervision, professional development, and education about consumer work for non-consumer staff. Furthermore, human resources and complaints processes have not been tailored to consider the

needs of consumer workers. This may be a result of a lack of genuine input from consumer workers into the design of consumer worker roles and support structures. We suggest that utilising co-production as a mechanism for developing initiatives to address the problems and needs identified in this report will lead to a more effective approach to including consumer workers within mental health services.

2. **Build the consumer workforce to increase the number of consumer workers within organisations and across all levels of services, including management and leadership roles.**

Isolation and a lack of career development opportunities were two key findings of this study. Consumer worker roles are often deployed in isolation from each other and can have limited opportunities for peer interaction or developmental supervision. In addition to this, a lack of consumer workers in leadership positions results in limited career pathways, as well a lack of capacity to influence the cultural change that is needed to enable inclusive workplaces for consumer workers. Increasing the number of consumer workers within organisations and across organisational hierarchies will go some way towards redressing this.

3. **Provide resources and training, developed by consumer experts, to build the capacity of organisations to effectively incorporate consumer workers into their workplace.**

One of the challenges experienced by consumer workers in this study was the misunderstanding and devaluing of the consumer worker role within the sector. The potential value of the consumer workforce will only be realised if the organisations that employ them have developed their capacity to support and utilise them appropriately. One of the avenues for change most detailed by participants was the need for greater organisational readiness efforts so that staff within organisations had a better understanding of the consumer worker role and that there were better support structures in place for consumer workers. In addition to this was the need for clearer role descriptions for consumer workers that match well to both consumer worker values and the role they are being asked to perform.

We recommend that the Department of Health and Human Services (DHHS), or a commissioned organisation, could play a role in supporting organisations to improve their capacity to meaningfully incorporate consumer workers within services. This could take the form of a two-tiered approach:

•   Tier 1 would involve working with organisations who express interest in employing consumer workers but have yet to do so. This would include strategic consultancy and training packages to help prepare organisations to employ consumer workers.
•   Tier 2 would involve working with organisations currently employing consumer workers to self - assess their current approaches and develop action-plans to improve their capacity to meaningfully include consumer workers into their services.

DHHS could play a role in incentivising organisations to undertake such processes through the use of grants and other resources.

4. **Resource support mechanisms for consumer workers so that they receive adequate training, consumer led supervision, and peer support throughout their career.**

Inadequate training and supervision were a major problem reported by consumer workers. Organisations that employed consumer workers were often unwilling to support or resource training that was available. Consumer workers enter the workforce with a variety of education and training backgrounds, so it is important that a range of training opportunities are available to match their learning needs. Table 1 (pg. 6), illustrates a model of professional development that could be funded to meet these needs consisting of four tiers that target consumer workers at different stages of their careers:

The use of micro-credentialing could open the potential to deliver a range of tailored training options for consumer workers. A suite of micro-credentials could be developed targeting specific skill areas required in the consumer workforce that would match to unique training needs of each consumer worker. These credentials are often warranted and linked to Australian Qualifications, meaning they can be used to open up further educational pathways for consumer workers. This would provide certified training pathways that are flexible rather than the fixed vocational certificates currently available.

DHHS could play an important role in funding consumer worker professional development opportunities which require services to release consumer workers for these activities. Changes to EBAs could also mandate set professional development or study leave for consumer workers.

Table 1 - Internship model

	TIER 1	TIER 2	TIER 3	TIER 4
TARGET GROUP	Any person who has used public mental health services and has an interest in beginning work as a consumer worker.	Consumer workers who have recently commenced working in the mental health sector.	Consumer workers who have been working for over one year and wish to develop their skills.	Consumer workers with over five years of experience.
STRUCTURE	A series of 1 day workshops delivered throughout the year.	A year-long internship where consumer workers from partner organisations receive monthly professional development and ongoing networking opportunities, and where partner organisations agree to release participants to attend training.	A range of professional development opportunities tailored to consumer workers. Consumer workers will be supported to identify their training pathways.	Quarterly reflective practice sessions along with brokerage to spend on professional development opportunities.

5. **Support the development of consumer led organisations to provide key services within the mental health sector.**

In addition to continuing to improve conditions and understanding within mainstream mental health services, we recommend the concurrent development of consumer-led programs and organisations that could employ consumer workers in workplaces that are innately more supportive and aligned with consumer values. These could be modelled after organisations such as the Leeds Survivor Crisis Service (2020) which is a charity set up by mental health service users in 1999 and provides crisis support delivered by people with lived experience of distress.

6. **Resource advocacy positions within consumer led organisations that can provide individual and systemic advocacy for consumer workers.**

What was evident in our findings was a lack of effective advocacy mechanisms for consumer workers experiencing discrimination or unjust working conditions. Current complaint and employee assistance mechanisms in organisations are ineffective in dealing with the issues experienced by consumer workers. For that reason, we recommend a specific advocacy program delivered by consumer led organisations to support consumer workers when workplace disputes arise and who can develop coordinated advocacy targeting systemic change.

7. Support ongoing research into the experiences of the consumer workforce

Ongoing consumer led research into the experiences of the consumer workforce is necessary to develop approaches to best practice within consumer work, to evaluate strategies implemented to develop the workforce, and to build the evidence base supporting the efficacy for consumer work.

The Leading the Change project has highlighted the value of the consumer workforce but has indicated several challenges currently at play that may inhibit the mental health sectors ability to meaningfully and safely incorporate consumer workers. There is significant potential to improve this current situation through a systemic approach to organisational and sector initiatives that are co-produced. Such changes will enable the full value of consumer work to be better realised within the Victorian mental health sector.

2. BACKGROUND

Consumers have been employed in lived experience roles within the Victorian mental health sector since 1996, with the introduction of consumer consultant roles that were aimed at fostering dialogue between consumers and service providers, and advocating for consumer perspectives to be included in quality improvement mechanisms (Department of Health and Community Services, 1996). The consumer workforce has evolved over the past two decades and now serves several roles within the service system including enabling consumer perspectives to be represented in service planning, delivery, and evaluation; assisting in improving the responsiveness to consumer needs; and to support consumers directly using a lived experience perspective (Department of Health, 2013). There are a range of distinct roles and job titles associated with consumer work including consumer consultants, peer workers, consumer providers, peer specialists, and lived experience practitioners. The term consumer worker will be used in this report and refers to all workers that are employed with an explicit reference to their lived experience of mental health service use as a requirement of their employment. Consumer work is emerging as a profession in its own right and there is growing consensus about the value base that drives this work. As illustrated in Figure 2 (pg. 9), consumer work is characterised by a range of values that are informed by human rights, principles of recovery, and values derived from Intentional Peer Support (Mead, 2005).

Emerging evidence indicates that consumer workers are highly valued by consumers of mental health services and have a positive impact on consumer health outcomes (Grey & O'Hagan, 2015). The impacts on consumer outcomes includes decreased hospitalisation, earlier hospital discharge, increased feelings of independence and empowerment, increased social support, and increased feelings of hope (Repper & Carter, 2011). There is also an increasing recognition of the value of consumer workers in leadership roles within mental health services, which can be seen to lead to service innovation, greater accountability to consumers, and increased quality of care (Happell & Scholz, 2018).

At the same time, questions about worker safety have been raised in relation to ethical dilemmas, conflicts between organisational expectations and consumer values, and a lack of appropriate support (Ibrahim et al., 2019; Roper, 2003). There is also a mismatch between the enthusiasm of policy makers and service providers around the incorporation of consumer workers, and the level of resourcing needed to support the development of consumer workers and to develop infrastructure to meaningfully include consumer workers in the mental health workforce (Stewart et al., 2008).

Similar to other emerging professions, the consumer workforce faces significant issues of defining the discipline as separate and unique to that of other mental health disciplines (Watson, 2013). Given that mental health consumer workers practice work that is unique from other mental health professionals, it is imperative that systems and processes are developed to support this work with the incorporation and leadership of those employed within these positions.

Recent policy and funding initiatives have seen a dramatic increase in the employment of consumers in new roles. For example, in 2015, under the DHHS funded "Expanding post-discharge support initiative", the consumer workforce expanded rapidly. This program provided funding for mental health services to provide peer support for consumers in the 28 day period after being discharged from an inpatient unit (Department of Health and Human Services, 2016). Recent informal consultation with consumers regarding consumer workforce supervision has found that these workers consistently experience discrimination, bullying, and role confusion leading to unsafe work environments. Such environments have the potential to cause emotional and psychological distress resulting in a high turnover of staff which threatens the ongoing development of the consumer workforce and the services it provides. The Leading the Change project aimed to further explore unsafe workplace experiences of mental health consumer workers with an intention to develop recommendations to inform a safer, more inclusive workplace.

Figure 2 - Consumer work values

Value	Definition
SELF-DETERMINATION	Being aware of power imbalances and their effects, knowing and respecting human rights, facilitating personal agency.
CONNECTION	Lived/common experience is used to make connection in the relationship. Connection is the basis on which trust and meaningful, effective learning is possible.
MUTUALITY	Both people learn, grow and are challenged through the relationship. Mutuality means being in relation with another person, developing skill and expertise while staying present and aware of our own reactions, viewpoints, needs and assumptions.
LIVED EXPERIENCE AS EXPERTISE	The expertise that arises from lived experience including lived experience of being a consumer worker, is of equal value to other types of expertise.
RESPONSIBILITY	We are not responsible for the other person, we are responsible for our own thoughts, feelings and actions. We are considerate, and we share responsibility for the relationship. We acknowledge and respect each others needs.
AUTHENTICITY	We are honest in relating with one another and act from our fundamental humanness.
TRANSPARENCY	Availability of full information required for collaboration, cooperation, and decision making without hidden agendas.
HOPE	Having an expectation of positive outcomes for each other.
CURIOSITY	Rather than making assumptions and being informed by preexisting ideas, having genuine intrigue, openness and interest.

(Victorian Mental Illness Awareness Council et al., 2018)

3.   RESEARCH DESIGN

This project has been informed by principles of co-production that seek to accomplish knowledge production with consumers and academics working together to conceptualise, design, implement, analyse, and disseminate research (Orr & Bennett, 2012). Co-produced research brings together the unique viewpoint of individuals with lived experience of the phenomenon being studied, with the research expertise of trained academics, in a way that is sensitive to current and historical power differences within the research team and with outside stakeholders. The importance of involvement and potentially leadership of consumers in all aspects of the research process is based on the premise that there is an ethical imperative to enable people to shape the services that they use (Roper et al., 2018).

A Consumer Worker Action Group (CWAG) was formed to support and undertake this research. It comprised of five University of Melbourne academics, three of whom had experience working as consumer workers, and four additional co-researchers, all with experience working as consumer workers. The group included representatives from the DHHS and the Victorian Mental Illness Awareness Council (VMIAC) to ensure connection to related lived experience workforce activity and expertise. The role of this group was to inform and deliver the design, implementation, and analysis of this project.

The CWAG developed the research design and methods used in this project. As indicated in Figure 3, a multi-phased mixed method approach (Teddlie & Tashakkori, 2009) was used that incorporated an online survey, semi-structured interviews, and a focus group. The project involved two phases- the first collecting data from consumers workers in relation to their workplace experiences; the second inviting research participants to contribute to recommendations in response to the findings from the first phase.

Figure 3 - Research design

PHASE 1

ONLINE SURVEY [QUAN + QUAL]

Capturing quantitative data and qualitative feedback about discrimination, bullying, support, role confusion, and what could be different.

Invitation to participate in interview.

+

INTERVIEW [QUAL]

Semi-structured exploring discrimination, bullying, support, role confusion, and what could be different.

ANALYSIS

Descriptive statistics from survey.

Thematic analysis from interview transcripts and open-ended questions in survey.

INTERPRETATION

CWAG collectively decided on key themes to take to focus group.

PHASE 2

FOCUS GROUP [QUAL]

Participants from interviews and surveys invited to focus group.

Focus group workshopped actions to address findings from survey and interviews.

FINAL REPORT

CWAG used findings from survey and interview, and actions identified in focus group to inform recommendations for final reporting.

Phase one - Survey and Interviews

Phase one of this study involved the distribution of an online survey to consumer workers in Victoria followed by semi-structured interviews with consumer workers who had completed the survey and nominated their interest in participating in an interview.

Online Survey

An online survey was developed to better understand consumer worker experiences in the workplace. The survey questions were developed using the shared lived experience of members of the CWAG who identified key topics that required investigation: workplace discrimination, bullying, support, and role recognition. With these four topics in mind the CWAG developed questions aimed at eliciting different features of each topic. Likert Scales and open-ended questions were used to collect information about these topics along with three open-ended questions designed to elicit suggestions for change in workplaces that hired consumer workers. The survey also collected basic demographic information and basic details about participants' experience working in the consumer workforce. The survey was anonymous, and no personal details were collected. Survey participants were asked if they wished to participate in the interviews or focus groups and were redirected to a separate survey to collect contact information.

The survey was initially piloted with four consumer workers who provided feedback on the clarity of the questions and the time taken to complete the survey, with minor changes made based on this feedback.

Consumer workers living in the state of Victoria and who had worked as a consumer worker in the past 2 years were eligible to participate in the survey. The survey was promoted through VMIAC along with promotion through other mental health workplace newsletters. The survey was open from April 2019 until June 2019.

Semi-structured interview

Interviews were conducted with survey respondents who registered their interest. The interview aimed to gain more in-depth descriptions of issues relating to workplace discrimination, workplace safety, support, and role recognition. The interviews were all conducted by members of the CWAG that had a lived experience of being a consumer worker. The interviews were guided by an interview schedule that was developed by the CWAG and served to prompt interviewers to ask broad questions relating to the research question. Interviews were held either face to face or via phone at the University of Melbourne. All interviews were recorded and then transcribed.

Analysis of phase one

The online survey was analysed for descriptive statistics and the raw findings were discussed within the CWAG to identify which findings contributed to the overall understanding of the research questions. The CWAG also identified which elements of the survey warranted further analysis to test any variable relationships. The interview transcripts and the open-ended responses from the survey were analysed using a co-produced approach to thematic analysis. Initially, four members of the CWAG used nVivo software to thematically code two transcripts in order to generate the first round of coding. The CWAG then met to review the initial coding in order to generate a coding framework, which was to be used for further analysis. This framework condensed the first round of coding and added definitions to each code so that it could be understood by multiple researchers. The researcher group used this coding framework to analyse the interview transcripts and survey responses. Each transcript and the survey were coded by two researchers and this coding was analysed for inter-rater reliability and any significant discrepancies in coding was mediated by a third researcher. The CWAG then met to review the coding and to identify key themes that were present within the coding. These decisions shaped the further organisation of codes into themes and subthemes. A summary of these key findings from this stage was compiled to be used as a resource for analysis in the focus groups.

Phase two - Focus group

Phase two of this project focused on working with research participants to develop recommendations in response to the findings from phase one. Participants who had registered their interest in participating in a focus group were invited to a two-hour focus group at the University of Melbourne. Participants were emailed a summary of findings from phase one prior to the focus group and were asked to consider what could be done to address the issues highlighted in the findings. Participants were split onto four tables that addressed the four key themes from the phase one findings. The tables had a brief description of findings and a series of questions designed to guide discussion around actions that could be undertaken to address the issues identified within the theme. The small groups each spent 15 minutes on each table and wrote down key ideas on butcher's paper. Participants spent 20 minutes highlighting ideas that were generated at each table and these were noted on a whiteboard. Participants were then asked to put a sticker next to what strategy they felt would be the most important to implement and which strategy they felt would be the easiest to implement. The audio of the discussion was recorded, and researchers took note of key content present in this audio. This was compiled together with the notes taken at each table. The CWAG reviewed this content and used this to develop the recommendations found within this report.

Ethics

Within this research design and implementation there were several processes to respond to potential participant distress, to maintain anonymity of participants, and to ensure voluntary participation. This project was approved by the University of Melbourne Psychology, Health, and Applied Sciences Human Ethics Sub-Committee (Application number: 1852915).

4. FINDINGS

The following section outlines the key findings of this project, beginning with the demographics of the study participants, moving to the strengths evident within the consumer workforce, and the challenging features of consumer work in the mental health sector. Avenues for change evident in the study will be explored with a consideration of survey, interview, and focus group findings.

4.1. Demographics

4.1.1. Survey

A total of 76 participants completed the survey with four exiting the survey as they had not worked as a consumer worker in the last 2 years. The demographics for the survey are detailed in Table 2 (pg.14).

As illustrated in Figure 4 and Figure 5, part time work is a feature of this workforce. A total of 77.5% of survey respondents reported working part-time and 8.5% reported that they work casually. Almost half (45.1%) reported working in more than one job. This could suggest that the rate of part-time work is not necessarily because workers themselves choose part time positions, but because part time roles are all that is available, requiring them to take on several roles at a time to make up a full wage.
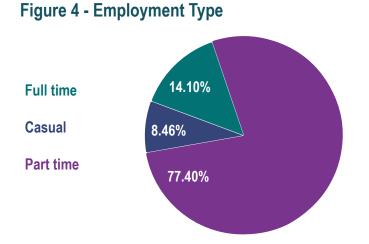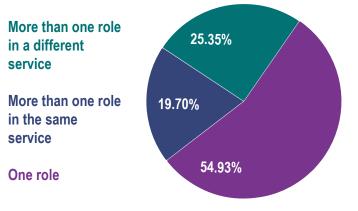
Figure 4 - Employment Type

Full time

Casual

Part time

14.10%

8.46%

77.40%

Figure 5 - Number of roles

More than one role in a different service

More than one role in the same service

One role

25.35%

19.70%

54.93%

Table 2 - Survey demographics

	TYPE	N	%
GENDER	Female	52	72.2
	Male	18	25
	Identifying as another gender	2	2.8
	TOTAL	**72**	**100**
AGE RANGE	18-25	3	4
	26-29	8	10.5
	30-39	21	27.6
	40-49	19	25
	50-59	16	21.1
	60-69	7	9.2
	70-79	1	1.3
	Rather not say	1	1.3
	TOTAL	**76**	**100**
TYPE OF EMPLOYER	Area Mental Health Service	40	57.1
	Mental Health Community Service	18	25.7
	Not for Profit	8	11.4
	Other	4	5.7
	TOTAL	**70**	**100**
TYPE OF EMPLOYMENT	Part time	10	77.4
	Full time	55	14.1
	Casual	6	8.5
	TOTAL	**71**	**100**
LENGTH OF EMPLOYMENT	Less than 1 year	7	10
	1-2 years	23	32.9
	3-5 years	23	32,9
	6-10 years	8	11.4
	Over 10 years	9	12.9
	TOTAL	**70**	**100**
NUMBER OF OTHER CONSUMER WORKERS IN TEAM	Sole consumer worker	13	18.3
	1	8	11.3
	2	13	18.3
	3	7	9.9
	4	7	9.9
	5	2	2.8
	More than 6 consumer workers	21	29.5
	TOTAL	**71**	**100**
ROLES WORKED	One role	39	54.9
	More than one role, same service	14	19.7
	More than one role, different service	18	25.3
	TOTAL	**71**	**100**

4.1.2. Interviews

A total of 14 interviews were conducted with consumer workers. Table 3 outlines the key demographics of this group. These demographics indicate a diversity of participants that is similar to the survey demographics.

Table 3 - Interview demographics

	TYPE	N	%
GENDER	Female	10	71.4
	Male	4	28.6
AGE RANGE	26-29	1	7.1
	30-39	8	57.1
	40-49	2	14.3
	50-59	1	7.1
	60-69	2	14.3
TYPE OF EMPLOYER	Area Mental Health Service	8	57.1
	Mental Health Community Service	4	28.6
	Other	2	14.3
LENGTH OF EMPLOYMENT AS CONSUMER WORKER	Less than a year	1	7.1
	1-2 years	5	35.7
	3-5 years	4	28.6
	6-10 years	3	21.4
	Over 10 years	1	7.1

4.1.3. Focus group

Ten participants attended the focus group. Table 4 outlines the key demographics of this group.

Table 4 - Focus group demographics

	TYPE	N	%
GENDER	Female	6	66.7
	Male	2	22.2
	Queer	1	11.1
AGE RANGE	22-25	1	11.1
	26-29	1	11.1
	30-39	4	44.4
	40-49	2	22.2
	50-59	0	0
	60-69	1	11.1
TYPE OF EMPLOYER	Area Mental Health Service	5	55.5
	Mental Health Community Service	1	11.1
	Other	3	33.3
LENGTH OF EMPLOYMENT AS CONSUMER WORKER	Less than a year	1	11.1
	1-2 years	4	44.4
	3-5 years	4	44.4
	6-10 years	0	0
	Over 10 years	0	0

4.2.   Positive impact of consumer worker roles

While this study focused on the challenges experienced by consumer workers in the workforce throughout the study, there were several themes that related to the strengths of the consumer worker experience. Participants reported that they felt the inclusion of consumer workers in mental health services often had a positive impact on the consumers using the service, the consumer worker themselves, and their non-consumer worker colleagues.

4.2.1. Impacts on consumers

Throughout the interviews and survey participants highlighted the value they felt that consumer work has for consumers utilising mental health services. Participants noted that mutuality and the use of lived experience when engaging with consumers strengthened their capacity to build supportive and healing relationships. Participants particularly highlighted the value of coming from a space of lived experience and how this could be used to connect with consumers in ways that may not be possible from clinicians who do not have a lived experience of mental health service use.

There are some glorious moments, absolutely glorious moments. And I suppose there are times when you know, you think, oh yes, this is just so good, this is what it's all about. When you connect with people and – you know I guess those experiences where you really just, you grow, like you're aware that you are growing and that the other person is also growing. Interviewee 7

Because I had a lived experience, I was I think probably more successful in my role with creating connections and working with people than someone who didn't have that lived experience would have been. Your average clinician who couldn't tap into that resource. I think I was more successful because of that. Interviewee 5

Participants also noted that their roles in representing the interests of consumers in organisational settings had a positive impact on organisational change and that this was appreciated by consumers using the service.

Consumers don't really know what my role is because I don't have a one-to-one contact with consumers unless they are participating in service improvement (presentations, focus groups, forums, advisory group), but when I do explain my role they are very excited that there is consumer representation and expertise at the executive level that covers all aspects of the service from treatment to policy to KPIs and consumer engagement. **Survey participant**

4.2.2. Impacts on self

Participants also noted the personal positive impacts they had experienced working in consumer roles. Participants spoke about the work being a way of turning a difficult experience of distress into something that was positive and could benefit others.

And I think the bottom line is that I'm in mental health work because I want to contribute something positive out of stuff that's been perhaps, for the most part, really challenging and sometimes negative in my life. So yeah, really trying to make a full circle of yeah, making something really good out of tough stuff . Interviewee 14

The one thing this, for me, is like to put a 25 year train wreck just in use is great. What a privilege. Yeah it is a good thing and the consumer thing I did the other night, I was sat bang opposite to the Commissioner and she asked me a few questions and I gave some things and so it's actually really empowering to be of some use after being not for such a long time, you know, just took a while to get there. Interviewee 11

Within these descriptions participants highlighted how supporting consumers from a place of lived experience created opportunities for connection and growth for both the consumer and consumer worker.

I feel like it drives me even more because I'm like the more I can advocate for other people, maybe I will be kinder to myself and I will advocate for myself better in the future. My values are I just want to help people. I just want to make it better and easier for other people. That's all. And it's my whole life. That's what my life has always been about. Interviewee 13

Participants also spoke about the value of working in a role where their lived experience of distress was known as they could inhabit a workplace without needing to hide their lived experience. Participants spoke about their own journey in becoming compassionate towards themselves and their experiences of distress and not wanting to be in a space where they needed to conceal these parts of themselves.

I choose to be in a role because it fits me, it suits me, and I couldn't imagine being in just like a vanilla [job] you know, I could not imagine having to hide such a significant part of myself that I completely embrace and love as much as possible. Interviewee 2

I've experienced mental health issues since I was 18, I didn't ever think that there would be some value in having, or some contribution you could make from having a mental health issue, and when I saw that funding had been made available for people who had lived experience, then I was really keen to explore it and to see whether it was something that would fit with my values and would fit with my skill set. So I was drawn on the basis of the values that I hold in terms of supporting other people, learning together, growing together, and I find that I'm able to communicate well, like I feel very comfortable in that space in my own skin when I'm not trying to pretend that I'm something that I'm not. But I feel very comfortable in that space working with people who in their lived experience, experience disadvantage or more mental health issues as it is currently. Interviewee 7

4.2.3. Impact on other professionals

Participants also spoke about the positive impact they believe they had on other professionals in their workplace. Participants spoke about the value in sharing lived experience as it can encourage their colleagues to share their vulnerabilities.

I try to be open about this and I don't feel shamed by colleagues because they also share their vulnerabilities Survey participant

Participants detailed how their work practice positively influenced the work practices of other professionals. The focus on building connection and rapport, mutuality, and awareness of power were all noted as features of consumer work that positively influenced non-consumer colleagues.

But as they got to know me then they would talk about their stuff more, even the psychiatrist, like everyone. And that was an interesting experience when I finished up there, we had lunch and my team leader said I've learned a lot from you, and I was so surprised, she'd had all this experience and she's going, I learnt it's about rapport, as a peer worker you know it's all about connection and rapport, and that's the first thing – we just naturally, I think most peer workers naturally think about. Interviewee 2

4.3.   Numbers in the workforce

While there were positive impacts of consumer work detailed by participants, there were also several challenges highlighted in the survey and interviews. One of the challenges related to the low number of consumer workers employed within mental health teams. The consumer workforce in Victoria is still relatively small and many consumer workers are hired as sole workers, or work in very small teams. Throughout the interviews and survey participants highlighted the difficulties in working in isolation from other consumer workers and the strengths inherent in working with connection to others in similar roles. Not surprisingly increasing numbers of consumer workers featured as a key avenue for change identified within the interviews and the surveys and was highlighted within focus group discussions.

4.3.1. Isolation

Both survey and interview participants reported feelings of isolation in their workplace. Over a third (36.9%) agreed or strongly agreed with the statement "I feel isolated in my workplace because of being a consumer worker". This isolation is in part related to the fact that consumer workers often work without a team of other consumer workers. Amongst survey respondents 18.3% reported having no consumer worker colleagues and a further 11.3% reported having just one other consumer worker colleague.

The interview and survey participants frequently noted that they felt isolated because they did not feel as if they were a substantive part of the team.

They don't consider you an equal, they considered you as like a token, you're just put there because they have to have a consumer worker on their team and they don't consider you as part of their team. Interviewee 12

I'm not going to work there anymore. I'm happy just to design surveys and consult with - but I'm not going on site. I'm not doing it. I'm not going to put myself into that position anymore. Because I was the only Lived Experience person there. I went there once a week and like I just felt invisible. Interviewee 9

The isolation felt by consumer workers is also a result of non-consumer workers excluding them from social and team activities. Around one fifth (21.4%) of survey respondents agreed or strongly agreed with the statement "I feel that my colleagues exclude me in the workplace because of being a consumer worker". Exclusionary behaviour was also evident in the survey and interviews.

If I go into [a] Adult Acute Ward room nurses are not receptive to me at all. They don't even look at me and because I think it – they're going to perceive me like; okay she's going to come here and cause trouble. She's going to cause us more work. She's going to say we're this wrong, we're doing that wrong, and I mean my role is just to be a voice for a consumer. Interviewee 13

There were some notable exceptions to these experiences of exclusion and isolation. Participants frequently highlighted the value of working in a team of other consumer workers as a means of feeling included in the workplace.

I have felt isolated in my role for the last five years as being the only peer support worker now that they have increased the lived experience team. I have moved across to this team and [I] am feeling supported. Survey participant

Participants also noted many examples of where they did feel included by their non-consumer worker colleagues. A significant number of comments were made about the positive and helpful relationships that were built with allied health. They were described as being the most approachable and receptive to lived experience work. Respondents spoke about

feeling more comfortable speaking with and even confiding in those in the allied health professions. They also reported feeling as though allied health workers tended to have the best understanding of consumer work and genuine intention to support authentic consumer work.

Allied Health in general seemed to be more approachable, more easier. Not so much of a barrier. **Interviewee 4**

I shared an office with the OT [Occupational therapist] and frequently the psychologist, those two people, you know we were like the sort of three musketeers' type of thing, you know fighting against the dark side . So outside of those two people I never felt comfortable in confiding in any of the clinical staff or the assistant manager, so completely different, yeah. **Interview participant 11**

4.3.2. The need to increase numbers of consumer workers across services

One of the most commonly cited suggestions for change in the interviews and surveys was the need to increase the density of the consumer workforce. Participants regularly highlighted the uniqueness of the consumer role and the need to work closely with other consumer workers for support and professional development.

I feel that we've got a good framework around supervision and support for other consumer peers, really if there's ways that the lived experience discipline can continue to grow the kinds of supports of supervision and spaces that peers can comfortably debrief in or have grievances, I think that's a huge thing. **Interviewee 14**

I believe if peers in mental health are really going to thrive, they need other peers and they need good structure and they need a good supervision model where they're with a peer. **Interviewee 2**

Participants also spoke about the need to have a critical mass of consumer workers with an increase in roles across all levels of the service.

Like the numbers, we need strengthening. I don't want to put quotas on it. I hear a lot of people say oh we want 50% lived experience, can we just have more than one? Can we just have more than one please? **Interviewee 9**

Lived experience roles functioning well across the service. **Survey participant**

In order to have consumer workers at all levels of organisations there was a perceived need for strategy and resources to develop consumer leadership. While most of the systemic efforts to support consumer workers has been focused on developing the skills and capacities of peer workers, participants identified that there needed to also be efforts to develop the capacity of consumer workers to take up leadership positions.

We need people to start tapping peer workers on the shoulder going, and having those conversations about where do you see yourself in a year, what do you want to be doing, how do you want to grow you know where do you want to go to, what's the next step in your career? **Interviewee 5**

We need more individuals who have a lived experience background in management roles. People with tertiary degrees/relevant experience who can fulfil those roles, yet are also appreciated due to their lived experience and can weave this into their experience into their role. Opportunities need to be made for the lived experience workforce to step up and grow in their careers, this needs to be publicised to give hope and strength to others with such ambition. **Survey participant**

In the focus groups, participants reiterated the importance of increasing the density of consumer workers and suggested a number of mechanisms that could support this to occur, such as the use of (EBAs) to ensure a minimum number of consumer workers within organisations.

4.4.   Organisational support

Throughout the study there were features of the organisational context of consumer work that can be seen to support or inhibit inclusivity and safety of the consumer mental health workforce. A number of findings suggested a need for improvements in the support and development mechanisms for consumer workers. Over a third (36.5%) disagreed or strongly disagreed with the statement "I feel that I have enough support from my organisation to do my role". There were several issues identified by survey respondents and interview participants relating to supervision, professional development, and formal support mechanisms.

4.4.1. Supervision

Throughout this study supervision was highlighted as an important feature of a supportive workplace. As detailed in Table 5, the majority of supervision accessed by survey respondents was provided by a person employed within the respondent's organisation who was not employed in a consumer role.

Table 5 - Type of supervision

TYPE OF SUPERVISION	N	%
A person who is not employed in a consumer role within your organisation	32	45.7
A person who is employed in a consumer role within your organisation	14	20
A person who has consumer lived experience and is not employed by your organisation (paid by the organisation)	10	14.29
Formal support activities facilitated by consumer workers within the organisation (i.e.: group supervision)	6	8.56
Group supervision	3	4.29
A person who does not have consumer lived experience and is not employed by your organisation (paid by the organisation)	2	2.86
A private supervisor without consumer lived experience (a person that you pay for)	2	2.86
A private supervisor with consumer lived experience (a person that you pay for)	1	1.43
TOTAL	70	100

The majority (68.9%) of survey respondents reported that they found supervision either helpful or very helpful. Interview participants reported several features of helpful supervision. Receiving supervision from supervisors working from a lived experience perspective was frequently highlighted as a helpful practice in consumer work.

I believe [if] peers in mental health are really going to thrive they need other peers and they need good structure and they need a good supervision model where they're with a peer. **Interviewee 2**

The lack of good lived experience supervision was highlighted as a particular problem for consumer workers. Participants noted the uniqueness of the lived experience role necessitating specific lived experience supervision and reported significant difficulties when this was not available.

I often wish I had more day-to-day support when I first started my role, by someone who understood peer work - it was overwhelming to be thrown into an IPU[Inpatient unit] environment without feeling as though I had space to unpack the complexities of this, and I didn't receive ANY monthly supervision for the first four months of me being in my role. **Survey participant**

Almost a third (29.2%) of survey respondents reported that they did not receive regular supervision. Employers were often unwilling to pay for external supervision, so consumer workers were left to resource their own, which was often difficult with the low paid/part time nature of the roles.

So I was trying to find an external supervisor but I only work 4 days a week and get paid $27 an hour, which is only $2 more than to work at Aldi or something, where am I going to find 120 bucks a month, I can barely pay my rent, I'm a working poor person essentially. Now I'm on Newstart but anyway. So yeah like I just, it wasn't – it was highly unrealistic for them to expect me to pay for my own external supervision. **Interviewee 12**

4.4.2. Other support

Survey respondents reported utilising a range of formal support mechanisms when requiring support at work. As indicated in Table 6 the most common mechanisms utilised were Employment Assistance Programs (EAP) and internal mediation.

Table 6 - Formal support mechanisms

SUPPORT MECHANISM	N	%
Employee Assistance Program (EAP)	24	36.92
Internal mediation	15	23.1
Workplace Health & Safety	10	15.38
I'm not aware of these processes in my organisation	6	9.23
I have not used any process	4	6.15
General human resources	2	3.08
Other external agency (Police, Centre Against Sexual Assault (CASA), Critical incidence counselling service)	2	3.08
Workcover	2	3.08
TOTAL	65	100

The experience of these support mechanisms was mixed. A total of 31 survey respondents commented on their experience using these mechanisms. Out of these responses 11 were coded positive, 17 negative, and 3 mixed. Under half (41.9%) of respondents said that they often or always received adequate support from their organisation when they have been involved in, or associated with, distressing incidents in the workplace.

I was dismissed and cut off when attempting to seek support for a difficult situation where I had to accompany someone to hospital who was in a psychotic state. I was not given any opportunity to debrief, quite the opposite, I was perfunctorily dismissed and told to go home. **Survey participant**

Having seen altercations escalate on the ward and been notified of [a] consumer death after they have been discharged, I feel time after time these events are managed poorly, from the point of notifying to ongoing support. **Survey participant**

A strong theme relating to these support mechanisms involved staff in these roles having an inadequate understanding of lived experience roles.

When I called HR it was in relation to discrimination within my workplace and I felt they were not equipped to support me with this. The discrimination was in regards to my diagnosis being mentioned as a reason for me being unsuccessful in gaining a permanent contract in my role and HR didn't understand how this was discrimination as they knew I was in a LE role and suggested I just talk to the person who said this. Upon discussing it with my supervisor, they too didn't understand how this was discrimination. **Survey participant**

At one stage I tried to contact OH&S at my workplace to let them know that my job was not a safe one, along with other consumer roles. I was ignored, never followed up, treated poorly on the phone. I wouldn't try it again. **Survey participant**

A majority of survey participants (64.5%) reported that they had raised concerns about their treatment while at work. Of the 38 responses that detailed how their organisation had responded to their concerns, 11 were coded as positive, 10 were coded as neutral, and 17 were coded as negative. Almost half (45%) responded that they felt the organisation responded badly or very badly when they raised concerns. This was also reflected in the interviews.

I'll never do it again, you know they all say to you that there is a formal grievance procedure and you're welcome to use it, I would never ever do that again, just in terms of what the outcome was for me. **Interviewee 7**

4.4.3. Reasonable adjustments

Utilising reasonable adjustment processes was another feature of support evident in both the surveys and interviews. A total of 58.7% of survey respondents reported having a conversation with their manager about making reasonable adjustments at work because of their lived experience. Of those who commented from this group, 65.5% reported they received a positive response in relation to this request, 20.7% reported a negative response, and 13.8% reported a neutral response. Over half (56.8%) reported that they found this response helpful or very helpful.

Participants spoke positively about workplace measures that offered flexibility to enable their self-care strategies and out of work demands to be met.

I find there's a lot of flexibility around being able to attend to self-care needs, it might be that your appointments at the end of a working day, you have to leave a little bit early to attend something like that. **Interviewee 14**

The use of reasonable adjustment processes is in contrast to the practice of mandating care plans for consumer workers which was evident in this study. Almost one fifth (17.4%) of survey participants reported that they were required to develop a care plan as part of their employment. This practice can be seen as discriminatory, as it places a blanket condition specifically on the employment of consumer workers, which does not apply to other colleagues. Reasonable adjustment processes on the other hand can enable organisations to effectively respond to the unique needs of each individual consumer worker that is based on opt-in principles.

4.4.4. Professional development

There was a range of findings in the surveys and interviews relating to professional development mechanisms. Throughout the interviews and survey the importance of good quality training was evident. Participants specifically highlighted the importance of lived experience led training. This was seen to be integral in developing consumer worker identities, learning skills to work within the unique role of a consumer worker, and to learn from other consumer workers.

The IPS training is great, the training we deliver is great, any peer training you can do, even if you feel like you've done something similar, it's connecting with other peers, so if you can link yourself in to peer support, but you know getting that support from other peers and learning how to be a peer worker, and developing your identity as a peer worker. Interviewee 2

It's about my own personal feeling of being powerless and or my own personal experience of being powerless within a system, and that's – and when I did that training just sitting comfortably with that feeling of vulnerability and not pretending that I've got it all together(…) I was just myself and that felt fantastic and it made sense, it made sense of everything. Interviewee 7

My view is that peer work training often needs to look different than clinical training.. I feel like peer work trainings need to be more reflective spaces on the topic, with information provided within the training space, but also a lot of time and opportunity to think and talk and share ideas and grow. Without adequate opportunities to do this I find it really hard to keep growing in the work that I do. Interviewee 1

While the value of training was highlighted there was some evidence that consumer workers did not have enough access to good training opportunities. A third (33.3%) of survey respondents disagreed or strongly disagreed with the statement "I feel that I have received enough training to be successful in my role". Several participants commented that they were not resourced well enough to obtain the training they felt they needed to complete their job.

It's quite frustrating because I'm only three days a week in hours. So, I can do three PDs a year. So, they have the cluster of in-services that they do at different sites. So, let's say I do three of those, once I hit three. So, I can't do more than I want, even though it's not costing the service money and even though it's free. They restrict me to three a year. Interviewee 4

Others commented that they were not supported to develop skills to participate in certain work activities. For example, one interview participant detailed being asked to sit on a committee but not having the training to support them in the role, particularly given the unique power relationships that may be present:

I used to be part of an executive committee called the Lived Experience Advisory Group at the hospital and the head of psychiatry used to sit on that committee and that doctor had assessed me one time when I was in hospital, and I felt very uncomfortable working with them in the committee setting, and I had no formal induction or training into that committee. Interviewee 10

A consistent theme was the unique training needs of consumer workers as compared with other professionals. Lived experience work is a discipline in its own right and this knowledge is required alongside a consumer's personal lived experience to undertake a consumer role and maintain their unique values base in the mental health service landscape. Unlike other health professionals, there is no formal qualifications in 'consumer perspective' that can be obtained by consumer workers. Therefore, many consumer workers require a more expansive investment in professional development utilising the various offerings that are available and that do align with their unique values base. Additionally, they may need to acquire more general skills to facilitate their specific position in the field such as; creating documents and reports, presentation skills, chairing meetings, people management, and delivering training.

Peer workers are very siloed, they don't have training, if you're a social worker you get four years and you get two placements. Peer workers, if you're lucky, in mental health you get the five days or you get the peer work cert, you don't get any placement, you don't get mentoring by other peer workers. Interviewee 2

I see peer work as a profession, this is my personal view, I see it as a profession just like my social work is a profession and as with any profession you need some kind of framework around how to do that and that's

why you know I really like Intentional Peer Support. I know that there's a Certificate IV and there's some other programs out there but it's about giving you a framework about how to maintain your skills, how to form good relationships but also how to have conversations that are useful and of benefit to yourself and to the other person, and how to not make it also about your own individual recovery. **Interviewee 5**

Beyond training, participants detailed a lack of structures to help them develop in their careers. A total of 41.3% disagreed or strongly disagreed with the statement "I get given feedback that enables me to grow in my profession". Participants commented that there was limited capacity to progress their careers. Often there was a lack of opportunities in management or in higher levels of the organisation.

I found it to be a bit of a dead end actually. There's no career progression either. Like the most I could earn is maybe like 32 bucks an hour or something in the hospital system, maybe a bit more in the community system. You know there's not really anywhere you can go. **Interviewee 12**

There were a few examples where participants felt they received good support in terms of their career development. One participant detailed their experience of having leaders within their workplace encouraging their greater involvement in workplace decision making and scaffolding their career development:

So and like I said earlier, having a voice at the higher leadership level being the consumer representative for our workforce and for our program, yeah like I'm just starting to feel now after 12 months at that level that I've got other directors of the program and leaders actually trying to encourage me to speak up and asking opinions that I might have in different spaces so that they're, like they're, it's sort of starting to get a bit of understanding of my personality as well and who I am, not just being the representative but me as a person and how I function and stuff like that. **Interviewee 14**

4.4.5. Promoting support and development for consumer workers

A frequent suggestion for change was the need for well-resourced supervision and training for the consumer workforce. There was a focus on the need for good, detailed approaches to orientation, and induction of new consumer workers employed within organisations.

Well they could start to address it by giving the consumers more orientation and inductions to different committees that they're on so that they get some background information before they attend the meeting. **Interviewee 10**

So you have to have a lot more organisations to take up peer workers and take them on to train them, and invest early on, and give a lot of support, otherwise people will just drop off, and that happens all the time. **Interviewee 6**

There was also the recognition that training opportunities needed to be ongoing so that workers could continue to develop and get support for their role.

I suppose my confidence in my role was waning so much that I was you know certainly considering leaving because it was impacting on me enormously, but as I said until I did that training in Melbourne where I just got a better handle on my work as a peer worker, it's made a big difference to how I approach things. **Interviewee 7**

The need for specific training and development opportunities was a key point of discussion in the focus group. Participants in the group stressed the need for a variety of training opportunities to match the education levels of consumer workers along with their career trajectory. The idea that there should be a "baseline" qualification was strongly

critiqued by participants. There were concerns about the current Certificate IV in Mental Health being the prioritised training option, and while some participants noted the benefits of this certificate, others suggested that there should be a range of other options at vocational, tertiary, and non-accredited levels. Participants suggested that tertiary education options could be utilised to learn theory and practice skills related to consumer work at an advanced level, as well as offering education targeted at policy development and management. They also suggested that TAFE or other training pathways could better focus on skills such as consultancy and advocacy, grant writing, and team management.

The focus group participants also highlighted the importance of organisational and sector scaffolding to ensure that consumer workers had access to appropriate professional development opportunities. At an organisational level, participants suggested that consumer workers should have access to regular professional development, and planning and review meetings, that could be used to help them to progress towards career milestones. From a sector point of view, improvements to EBAs were discussed with a focus on mandating that employers provide time and resourcing for consumer workers to attend professional development opportunities. Another sector development suggestion was the option of an internship model that linked employers with training providers to offer tailored training for entry level consumer workers as they progressed through their first years in the workforce.

Beyond formalised training opportunities focus group participants also stressed the importance of having access to good quality peer supervision, mentoring, and networking opportunities. They again suggested that changes to EBAs could mandate the provision of peer led supervision for consumer workers as well as allowing consumer workers to attend conferences or networking events. Focus group participants suggested consumer workers would benefit from more opportunities to network with other consumer workers, with a particular focus on connections between consumer workers in different roles and within different parts of the mental health system.

4.5. Safety, bullying, and discrimination in the workplace

Throughout the interviews and surveys, participants detailed experiences of discrimination, bullying, concerns with confidentiality in the workplace, and a lack of safety in the workplace.

4.5.1. Being treated differently

Throughout the surveys there were reports of consumer workers being treated differently than their non-consumer colleagues. A total of 59.1% of respondents agreed or strongly agreed with the statement "I feel like I am treated differently in my workplace because I am a consumer worker." This experience of being treated differently manifested as different workplace conditions, discriminatory behaviour due to consumer status, or as a response to the unique position of consumer workers in organisations.

A total of 65.2 % of respondents reported that they felt the conditions of their employment were different to that of their non-consumer colleagues. As detailed in Table 7 (pg. 26), respondents reported a range of different workplace conditions such as; being paid less than non-consumer colleagues, only having part time positions available, not having access to the same workplace resources, and being required to develop a care plan or wellness strategy.

Table 7 - Workplace conditions

CONDITION	N	% OF 69 RESPONDENTS
I get paid less than my non-consumer colleagues for doing work of equal skill level or experience	28	40.1
I only have part time positions available to me	23	33.3
I don't have the same access to the same workplace resources as my non-consumer colleagues	15	21.7
I have been required to develop a care plan as part of my employment	12	17.4
I have been forced to take annual leave as a wellness strategy	11	15.9
I am not allowed in certain areas of the workplace	10	14.5
I have not been allowed to take study leave	8	11.6
I am employed on a fixed term contract when my non-consumer work colleagues are on ongoing contracts	6	8.7
Other	17	24.6
TOTAL	130	100

This sense of differential work conditions to non-consumer colleagues was also evident in the interviews. Participants spoke about a range of instances where they felt they were subject to different workplace conditions due to their position as a consumer worker. Interview participants spoke at length about the pay differences between themselves and other workers, as well as the frustrations relating to only being offered part time positions.

I think there is a slight tension between this idea of a clinician with clear career pathways and you know if you've been a clinician for this amount of years you'll get paid this amount you know. At my service they don't have a lived experience or any kind of pay scale, so I'm an administrator on my payroll. Interviewee 9

Being treated differently was not always considered a negative experience by consumer workers. Interview and survey participants commented that the nature of the consumer worker role necessitated differential treatment in order to support the developing workforce.

I think they should put in some extra effort with me, but they don't, so I think they try and just be like; oh you're just a normal worker, we won't treat you differently, but I kind of would've liked to be treated differently, yeah, in the way of extra support or extra resources– yeah I would've liked to be treated differently. Interviewee 6

Being able to access reasonable adjustment processes, having access to specialised training, and having access to consumer supervision were ways in which respondents felt they should be treated differently from non-consumer workers.

4.5.2. Discrimination based on lived experience status

Participants in both the surveys and interviews reported discriminatory practices based on their lived experience status. Over half (53%) of respondents to the survey agreed or strongly agreed with the statement "I feel that others in the workplace make judgements about me based on my disclosed lived experience".

In the interviews and surveys participants commented that these judgements involved negative interpretation of their performance of workplace behaviour through the lens of their lived experience status. Participants commented that they were often labelled as "sensitive" or "triggered" when they expressed dissatisfaction or disagreement in the workplace.

My feedback is seen as me being triggered or over-sensitive, whereas my non-consumer co-workers are passionate and dedicated. **Survey participant**

I had a manager continually 'remind me' that I am "overly sensitive to feedback" when I got angry with him for making decisions about my role when he is not my manager. I've also had the same manager ask me "is that what you perceive is happening or is really happening?". **Survey participant**

Participants also described several instances where they were explicitly discriminated against due to their lived experience status. For example, one interview participant detailed management restricting their work due to their specific diagnosis.

Like there's been times when I've had management utilise my diagnosis as a reason for me not to be able to do something. **Interviewee 1**

The experience of discrimination has a significant impact on consumer workers. Almost half (45.5%) of survey respondents agreed or strongly agreed with the statement "I anticipate being treated differently which impedes my confidence in putting myself forward or expressing my opinions with my team".

Interview participants spoke about second guessing themselves and closely self-monitoring due to concerns that they would be misinterpreted because of their lived experience status. This is a unique feature of the consumer worker role. A consumer worker is hired to specifically utilise their lived experience of often painful and difficult experiences. This lived experience is often highly stigmatised within society, a reality that can be replicated within mental health services. Participants described being aware of this stigma and monitoring their own behaviour to mitigate the risk of stigmatising attitudes being applied to them.

But I also find it really, I find it tricky to hold conversations with the correct people, and hold it in a way that looks like I'm trying to address an issue, about the way that my colleagues speak about consumers, but not look like a consumer myself who is just being overly sensitive. **Interviewee 1**

For ages I said nothing to the nurse who'd characterised that person's behaviour as being part of the diagnosis that I had. Because I thought if I tried to raise it with him I'd burst into tears or yell or something. I was certain I was going to get it wrong if I tried to speak about it, have the difficult conversation, I was terrified of getting that conversation wrong and making things worse, so I said nothing for ages yeah. **Interviewee 3**

Participants reported that that this high level of self-monitoring caused a significant stress in their day to day working lives.

4.5.3. Bullying

Experiences of bullying were frequently detailed in both the surveys and the interviews. Half (50.8%) of survey respondents reported being verbally abused in the workplace and 41.5% reported feeling threatened by others in the workplace. This was reflected in the interviews and the open-ended questions in the survey.

It was quite aggressive the way she spoke to us, treating us like little children in a crisis rather than treating us like adults and letting us follow the proper procedure that we knew to follow. **Interviewee 12**

Unfortunately, myself and my Peer Worker colleagues were subjected to the most insidious workplace bullying, by not only non-lived experience colleagues, but also the CEO. **Survey participant**

Participants commented that such experiences were particularly difficult due to past experiences of abuse or distress and highlighted the emotional impacts of such behaviour.

Yes, well I mean she'd already set up this precedent of yelling at me and pointing a finger at me while I'm sitting down like in a corner, like already making me feel like I'm a little child. You know who knows, she might've spoken to nurses like that or I don't know doctors like that, I don't know, maybe she speaks to everyone like that, but you know like she shouldn't speak to anyone like that let alone a person that's been traumatised maybe from yelling of other people in their, maybe with complex trauma that have been yelled at their whole lives by their family, or you know like you just don't act like that. **Interviewee 12**

And her behaviour was relentless and it was just, I wasn't the only one that was experiencing it, but I was the, because of my mental health condition you know stress really, really exacerbates what I go through, I couldn't handle it. **Interviewee 5**

4.5.4. Confidentiality

As consumer workers have used mental health services there were concerns about how the information about their service use was kept confidential in relation to their work. One fifth (23.1%) of survey respondents reported that they did not feel confident that their privacy around their personal use of services would be respected.

Participants detailed experiences of management accessing their health records, being in contact with their treating professionals, and sharing their personal details about mental health amongst their colleagues.

Ethical perspectives on issues like service user record retention, privacy, confidentiality and storage have been overridden by senior management on the basis of my mental health condition. **Survey participant**

The service that I am using, that is linked to the same network of hospitals where I work, hasn't protected my privacy and have made contact with a senior colleague of mine in regards to my mental state. There was no duty of care issue involved in the decision to make this phone call and I was told that I do not have the right to refuse the phone call happening. **Survey participant**

Participants commented on the difficulty in accessing services whilst maintaining privacy when they are employed in organisations associated with their local mental health service. This is a particular concern for consumer workers employed in regional settings.

"Well do you need to go to the ER?" I was like, "Well you can't send me there because I work at Allied Health Services and said you – I will literally hate you to the ends of the earth if you send me to the ER because it's a small town". People can be like "Oh why was she in the ER?" "Oh, you know, she was thinking about committing suicide." Oh, now everybody in the ER knows and then it gets around the whole system – and to me – I'm a very proud person. I'm so proud that with those sort of things - that I come to work, and I want people to see this me. I don't want people to know about that me unless I'm ready to talk about it. **Interviewee 13**

4.5.5. Emotional Labour

Participants also spoke about working from a lived experience perspective being a form of emotional labour. While they often spoke of this as a strength, several participants pointed out that working from this perspective can be emotionally challenging, something that necessitates good support structures around consumer workers. Part of this labour related to the impact of participants using difficult aspects of their life in their practice.

No, no there was no recognition in that organisation and still isn't, of the sort of how re-living your life in your role can impact on you, there's a very real appreciation of that where I am now. Interviewee 11

Participants also talked about the emotional impact of having a dual identity within the workplace. They spoke about their identity being both a worker, and a consumer or former consumer of mental health services. Participants described feeling distressed at witnessing how consumers were treated by their colleagues, as well as how their colleagues would talk about consumers.

A lot of the people were just burnt out and lacking empathy anymore. And just – and a lot of the time there'd be all these assumptions about oh yeah they're probably just, you know they're probably doing sex work to get drugs or anything, it's like you don't even know that, you haven't even asked them or you know. Yeah I would just be so angry, I would just like end up having to, well I just eventually would just start disassociating and just be sitting there and just like going someplace else in my mind, and I was just like I can't keep working like this because it's horrible. Interviewee 12

Participants spoke about aspects of the consumer worker role that necessitates forms of resistance. Participants frequently described a core part of their role as challenging colleagues and management when representing consumer perspectives. This can also be seen as a form of emotional labour, or resistance labour, that is present in the role of the consumer worker. When this wasn't supported by organisations it also threatened the emotional safety of consumer workers.

I constantly am feeling like I'm sitting on the outside and saying no to things and staying in the bad books with my manager, rather than them really understanding the work that I'm doing and supporting me to not step outside of peer work values and championing that work. Interviewee 1

I just feel like that's a constant, like just weighing that up every day. Like every single day is like do I speak, and yeah I don't know, it's like every day I probably face that multiple times. Interviewee 3

4.5.6. Safety

The experiences of discrimination, bullying, breaches in confidentiality, and emotional labour were related to a range of impacts felt by consumer workers. The most cited impact was that consumer workers did not feel safe in their workplace. For example, one interview participant spoke at length about feeling unsafe in the workplace:

I've put in a formal grievance, I had to take you know quite a long time off work, on stress leave, and that grievance was formally dealt with and aspects of it were upheld, but subsequently I had to leave the work, well I felt I needed to leave the workplace that was no longer safe for me emotionally, I felt threatened because I had taken the course of action that I did. And I needed to continue to work, so I needed to continue there for about three months until I got a new job, but it was certainly an experience of feeling very, very unsafe. Interviewee 7

Another highlighted that the ways in which consumers were treated was central to why they did not feel safe in the workplace.

I said that what makes it dangerous to us, the job, is what's dangerous to the consumers. And what will make us feel better about our job is when the treatment of the consumers is you know good, is really good. Like we're there, we're almost there to fill the tension between the consumers and the clinical world and find a way to communicate that. You know like I feel like that's part of our value to the organisation. But also that's what makes it incredibly painful to be there. So, the only thing that's going to make it better for us is when it's good for consumers. Interviewee 3

In a number of cases this lack of safety in the roles and culture has led consumers to leave their positions. A total of 25% of survey respondents reported leaving consumer roles because they felt unsafe or felt discriminated against. A further 60.9% reported that they had remained in roles where they felt unsafe or discriminated against as they felt that they needed the job. This was reflected in interviews and the open-ended questions in the survey.

It then really started to impact on my family life and that's why I've moved away from the role because I can't, it's not sustainable for me and my family anymore. Interviewee 5

I used to be really proud of it, but it just feels so - I feel so undermined and yeah, I want to leave. I don't want to give up on the consumer consultant profession, but I don't want to work for the organisation anymore. Interviewee 9

The industry is destroying talented workers, there are many people who have been so badly traumatised, discriminated and abused in the workplace and have never worked again because of the bad experience. Survey participant

The discrimination, bullying, and threats to emotional safety indicated in these findings point to an urgent need to create a safer workplace for consumer workers.

4.6. Mental health system

Beyond the behaviour of individual colleagues or organisational structures, participants also identified systemic barriers in the mental health system itself which impeded the development and sustainability of a consumer workforce. Participants noted that the dominance of the medical model and consequent undervaluing of lived experience expertise, power and hierarchy, and the poor treatment of consumers were challenging features involved with working in the mental health system.

4.6.1. Dominance of medical model and undervaluing of lived experience expertise

Participants regularly noted the dominance of the medical model within mental health services and how this frequently served to minimise the influence of other approaches, including consumer work. The values of consumer work were often seen at odds with the medical model, which participants believed impacted on their ability to contribute meaningfully to work being done within mental health services. For example, one interviewee detailed the clash of values between the medical model and consumer work that resulted in a disregard of the potential benefits of consumer work.

And he's also coming strictly from the medical model, so the only thing he is concerned about is whether someone's on the right medication, and or changing the medication or what their behaviour is in relation to medication that they are taking. And so he has no regard, absolutely no regard for peer support at all, so he just continually says oh don't waste your time, or that that person wouldn't benefit, or he makes constantly makes comments of that nature. Interviewee 7

One of the most common themes throughout the interviews and surveys was the perceived lack of understanding of the consumer worker role within workplaces. Participants felt that their colleagues lacked a clear understanding of what consumer workers were employed to do.

I don't know that they (clinicians) could really turn around and say this is the work that we do and how it fits into the support the consumers receive within our service. Interviewee 1

I don't think they really understood what it was that I did, even though the coordinator had done presentations every so often saying this is what we do, this is the program. So hardly anybody referred, and sometimes they, when they did refer it was a really inappropriate referral and the person was just not interested in talking to you. Interviewee 12

Participants commented that this lack of understanding often led colleagues to hold low expectations of the consumer worker role, frequently leading them to direct consumer workers to do menial tasks that fall outside of their role.

Clinicians expect lived experience workers to be a taxi service or to drop off a script without purpose. Survey participant

Almost a third (32.3%) of survey respondents reported they often or always get asked to complete work that was not related to their role. Participants also commented on being asked to do work that was at odds with their lived experience values. Almost a quarter of survey respondents reported often or always being asked to perform work that violated their lived experience training, values, or ethics. Participants noted that this conflict was a source of distress.

I think to hold onto your values really tightly makes the work more pure, but it can also make the job more distressing at times, especially when you work in organisations that, their values are almost opposite to some of what peer work values are. Interviewee 1

I work very hard to keep myself out of clinical reviews, handovers etc, but then the other peer worker is happy to be in these spaces and it makes my manager view me as someone who keeps saying no and avoiding certain tasks - she's started to ask my colleague to do non-peer things behind my back and not include me in the conversation. Survey participant

Not surprisingly one of the most common suggestion for change was to have clearer position descriptions that spelled out what is to be expected of consumer workers.

4.6.2. Power and hierarchy

Themes pertaining to the level of influence, respect, and power an individual felt in relation to their employed position were common in the interviews conducted with consumer workers. Many of those interviewed spoke about the impacts of working in teams where they felt a sense of unevenly distributed power between colleagues.

I think that at the end of the day the power imbalance is the thing, is the kicker. Like it doesn't really matter what else you change. Interviewee 3

I think it's just a culture thing, they're not used to consumers being part of their workforce, their used to a top down model of treating people who are unwell without sort of (…) valuing the lived experience. Interviewee 10

A number of interviewees made reference to a sense of 'hierarchy of power' within their workplaces. In this structure consumer workers, in comparison to other professions, were at the lowest rung whilst psychiatrists were spoken of as having the most power in teams. There was also a sense that this meant that often their expertise was dismissed or not heard.

It's a very hierarchical system and the psychiatrist is at the top of the tree and when the psychiatrist doesn't even acknowledge you saying hello to them in the hallway, it's very hard to kind of feel like anything you say is valid… it's hard when you're meant to be in a team with people that don't consider you part of their team. Interviewee 12

A few interviewees spoke of feeling a lack of power particularly around the level of influence felt in the consumer worker role and how this was constructed and maintained by non-consumer colleagues.

You don't feel like you're an equal (...) I sat down at the table once and the, one of the senior nurse practice whatever he was, sorry I can't remember his title, he said oh the pharmacist usually sits there, indicating I should get out of the way you know like, you have to know your place. And you know so I kind of had to sit further and further in the corner of the table. Like I didn't even feel like I could put my piece of paper, like a notepad down. Interviewee 12

Whilst acknowledging that the consumer workers had it worst, it was not the only profession mentioned that seemed to have limited or less access to power on the team underneath psychiatry. Several interviewees noted that a feeling of powerlessness permeates many professional groups within mental health services.

I also feel as though other professions have more of a voice in the team setting, in that where I work there's a treating team, and on the treating team there's doctors and nurses and Allied Health staff. Within those workforces not all of them are always going to feel heard and get their way, and it does mostly fall back on psychiatrists. Interviewee 1

That's how I think the Allied Health feel and that's how you know, that's actually one thing that was a real eye opener to me was that I used to think we're on the margins, we're on the bottom rung, no one cares about what we're doing, no one blah blah blah, then I heard the OTs saying the same thing, then I heard the social workers saying the same thing. Then I heard the nurses saying the same thing. Interviewee 3

This adds weight to the idea that it is the structure or culture of these environments themselves that creates feelings of 'being lesser than' professionally. One interviewee linked their experience of being dismissed in this way to their experience of being dismissed as a consumer.

Unfortunately, I would probably say it fits with my world view in that like I do – as a consumer worker I kind of feel like of course the doctors aren't going to talk to me, do you know what I mean? I don't expect it to be otherwise, but that's probably a sad thing rather than – do you know what I mean. Like it kind of fits with my world view that I belong on the bottom rung [this is] reinforcing that. Interviewee 3

4.6.3. Poor treatment of consumers

Participants reported on the difficulty of encountering poor treatment of consumers and how this had a negative impact on their experience at work. Participants reported frequently hearing colleagues discuss consumers in derogatory ways. Over half (53.3%) of survey respondents agreed or strongly agreed with the statement "I have heard my colleagues talk in a derogatory way about consumers or in relation to certain diagnostic categories". Participants detailed feeling shocked hearing this derogatory language.

They'd just be talking about medication the whole time and maybe making some dark humour or like really rude comments about certain people, like you know certain consumers and stuff. Interviewee 12

But then when I was on the ward I was like oh my God I can't believe the language they use, I can't believe they walk out into the office area and like bitch about a consumer in the most disrespectful way possible in front of a room full of people. Interviewee 3

Interview and survey participants commented that their own lived experience made it particularly difficult to hear this derogatory or stigmatising language. This was particularly the case when hearing a colleague disparage consumers with whom they shared the same diagnosis.

He was saying to me oh look they think he's done all this because he has da-da-da traits and I was like, and that was my diagnosis and it was just a really, really horrible moment. Interviewee 3

Throughout the study participants argued that part of what makes consumer work difficult was the fact that consumers continue to be poorly treated within mental health services. Several participants suggested that this was a key feature of why they felt unsafe in their workplaces. Not surprisingly this featured in participant suggestions for change.

If clinicians didn't bitch to me about people with my diagnosis. If clinicians didn't bitch about consumers generally. Survey participant

If consumers' human rights were not routinely walked all over by the service I work for. Survey participant

4.7. Embedding rather than tolerating the consumer workforce

Throughout this study participants highlighted the need to better embed consumer workers into organisations and the sector more broadly. To do this effectively there was a perceived need for better approaches to organisational readiness, an approach to accountability to ensure that organisations are implementing measures to support and develop the consumer workforce, and the involvement of organisations to advocate for the working conditions of consumer workers.

4.7.1. Organisational readiness

Participants spoke at length about the need for a greater focus on building organisational capacity to incorporate consumer workers in a safe and meaningful way into the workplace.

I wish there was a lot more workplace readiness trainings and things like that available, because it's really hard, especially where I work. I'm one of two employees but I was the first ever employed consumer worker in the organisation, so I'm then starting in this role, having to learn the role myself as well as having to educate other people on what my role is, and it would've been really nice if other people just knew what my role is so I could just focus on learning it myself, rather than having to learn and educate at the exact same time. Interviewee 4

Better development of role and preparation of organisation, including policies put in place prior to hiring me. Better education of staff at all levels as to the work of peer workers. Survey participant

Participants stressed that the focus of organisational readiness work should involve building up a better understanding of consumer work within organisations. Linked to the finding outlined in 4.6.1. (pg. 30), participants noted that they entered into workplaces grounded in paradigms and values that were often at odds with the principles of consumer work, which were often poorly understood by their colleagues. For this reason, participants highlighted the need for targeted efforts to support non-consumer workers to develop their understanding of the consumer work, its various functions, and its value base.

Being able to give clients or other workers a standardised piece of information regarding what peer work is about rather than having to come up with it all by myself. I realise that all peer work is different but even just a starting point would help. Give me an info pack or something. **Survey participant**

I have to pull staff off tasks to organise an education system and get them to spend time for half an hour to listen to a presentation. I can't do that off my own bat and that's not kind of a line management relationship challenge, that's kind of like you know the lived experience workforce needs to be able to say hey we need some time here, we need you to understand where we're coming from, and why it's significant that you listen to what we say. **Interviewee 7**

Participants also suggested that a clearer definition of consumer roles was needed, and this definition needed to match closely with lived experience values and ethics. For example, many participants commented on the difficulty of sitting in clinical reviews and how this was at odds with lived experience values as it was done without consumers in the room. Some participants reported that they refused to attend such meetings and that this was looked down upon by non-consumer colleagues. One participant argued that an avenue for improvement would be to clearly stipulate that attending such meetings was not in the consumer worker role.

Yeah, well look I think maybe, you know like even if we could just skip the whole going to the clinical review, because you don't get to contribute in it anyway, and you hear the way people talk about consumers and it just makes you angry. And it's not productive, because they're not letting you contribute anyway. So, and you don't need to hear about their medications and all that jazz, like all you need to know is what the consumer tells you. So I think maybe a ban on, I don't know, some people like going to clinical reviews, I don't want to say if you're a peer worker and you really want to go to clinical review and sit at the table and go right things are going to change around here, but maybe that's just not my personality. Like I shouldn't have to be just like yelling to get a space at the table, I don't even want to sit at the table like you know, I just want to be with the consumer. **Interviewee 12**

Other participants spoke of the need for organisations to regularly review their approach to incorporating consumer workers into the workforce. One participant spoke highly of an organisation that did an evaluation of the consumer roles within their organisation with a focus on quality improvement.

I thought it was excellent, I thought that the whole approach was excellent, the fact that they were doing evaluation of their consumers roles at the organisation and yeah I just thought it was fantastic. **Interviewee 10**

Participants in the focus group highlighted the importance of cultural change within organisations to better incorporate and support consumer workers. One suggestion was to ensure that policies and procedures relating to consumer workers be informed by the perspectives of consumer workers themselves to ensure that these more successfully respond to the unique role of consumer workers in mental health services. For example, position descriptions should be written by people with consumer work experience to ensure that they accurately capture consumer work values and perspectives.

Focus group participants stressed the importance of a whole of organisation approach to cultural change and that training around consumer work needed to focus on executive and management levels of the organisation, along with HR departments and other front-line staff. They also suggested that key stakeholders such as EAP's, unions, and Fair Work also should be targeted for training focused on how to best support the consumer workforce.

Participants highlighted the role of allies within the workplace- non-consumer workers who had a good understanding of, and appreciation for, the inclusion of the consumer worker within mental health services. They suggested that such allies be supported to champion the role of consumer workers and co-produce initiatives to help their colleagues to gain a better understanding of the consumer worker role.

4.7.2. Accountability for organisations

Focus group participants highlighted the importance of stronger accountability measures for organisations hiring consumer workers. This was identified as the most preferred long-term solution by focus group participants. Participants noted that there are currently no accountability processes for organisations to ensure that they deliver the support, training, and development for consumer workers that they have been funded to provide.

Participants suggested that organisations needed more "carrots" and "sticks" to encourage leadership to make necessary changes to become more inclusive of consumer workers. For example, one participant suggested that organisations could be asked to achieve targets for retention of consumer worker personnel and penalised or rewarded in relation to these targets. Other suggestions included having a benchmark of expectations for mental health services employing consumer workers and a process whereby organisations were assessed against these benchmarks. This could take the form of an accreditation process that could be used to inform consumer workers of employers of choice.

4.7.3. Advocacy and unions

In order to better embed consumer workers into the mental health sector participants suggested the utilisation of organisations external to mental health services to advocate for the interests of the consumer workforce. Such organisations were seen to be beneficial as they could independently address issues faced by both individual consumer workers, and the workforce as a whole.

Government, sector and organisations to seriously back up their claims by resourcing it. I would feel more comfortable if there was a national advocacy body or union, and national standards and accreditation to pressure more action. **Survey participant**

A better understanding of the EBA and union. **Survey participant**

I honestly think that having union support and advocacy would really add a sense of confidence when raising issues. **Survey participant**
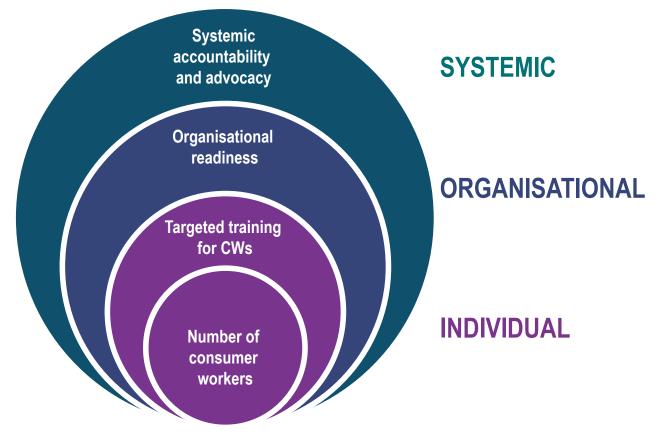
Focus group participants also noted that unions could play an important role in building better workplace conditions for consumer workers. They did note that current health and community unions were not necessarily well equipped to understand the unique issues faced by consumer workers and often focused on heavily representing particular other occupational groups within the sector. Despite this, participants highlighted the important role of unions to ensure workplaces address safety and discrimination issues, to support consumer workers with complaints, and to help improve workplace conditions.

The focus group stressed the importance of effective EBA inclusions to support consumer workers in mental health services. The participants voted this suggestion as the quickest way to address many of the issues identified in this study. Effective union representation of consumer worker issues was seen as essential in effective EBA negotiations.

5. RECOMMENDATIONS

As illustrated in the findings, the features of the mental health sector that create safety issues for consumer workers exists across multiple levels- moving from the unique nature of consumer work, to the ways in which organisations support consumer workers, as well as the limitations of the mental health sector more broadly. Consequently, any efforts to enable mental health workplaces to better include and utilise the consumer workforce must take place over these multiple levels. These recommendations aim to systematically strengthen the capacity of the mental health system to meaningfully incorporate consumer workers in a way that is safe and inclusive. Figure 5 depicts the different system levels of intervention that form the basis of these recommendations. These recommendations are interlinked and ideally should be implemented together as intervention across system levels is needed to effectively address the issues identified in this study.

Figure 5 - Systemic change

1.   Ensure that all new approaches to supporting the consumer workforce are fully co-produced.

There is a wealth of wisdom within the consumer workforce that is often untapped in approaches to mental health reform. This wisdom must be at the heart of any strategies aiming to build a strong, inclusive consumer workforce. Throughout this project there is evidence that approaches to introducing and supporting consumer workers in the mental health services have fallen short in their capacity to meaningfully equip organisations in their inclusion of consumer workers. This is comprised by a lack of resourcing for consumer led supervision, professional development, and training for non-consumer workers. Furthermore, human resources and complaints processes do not take into consideration the unique experience of consumer workers. Often these approaches have not been developed with meaningful consumer worker input.

We strongly argue that all of these strategies must be co-produced with people who have a lived experience of consumer work. Through the use of co-production, the wisdom of the consumer workforce can be at the centre of any initiatives designed to support this workforce and we believe this will result in more effective initiatives that take into account the unique nature of the consumer worker role.

While approaches to co-production often have sound intent, there are many examples where co-production in mental health settings is poorly executed and tokenistic. We suggest that any approach to co-production is informed by Roper, Grey & Cadogan's (2018) approach to co-production in mental health settings.

2.   Build the consumer workforce to increase the number of consumer workers within organisations and across all levels of services, including management and leadership roles.

Participants consistently described the negative consequences of working as a lone consumer worker or in a small team and conversely spoke positively of the support gained from having other consumer workers to reflect with or develop supervisory relationships. Participants at all stages of the project spoke of the importance of having consumer workers employed in leadership and management roles. Having consumer workers in leadership roles will be integral in supporting the cultural shift that is needed within mental health services and to be truly inclusive of the consumer workforce. This will also support the development of a career pathway for consumer workers which is currently lacking.

3.   Provide resources and training, developed by consumer experts, to build the capacity of organisations to effectively incorporate consumer workers into their workplace.

The capacity of organisations to effectively incorporate consumer workers into the workplace was one of largest issues identified by participants. Participants detailed the significant challenges they faced due to the misunderstandings their colleagues held about consumer work and the corresponding lack of value they attributed to the work performed by consumer workers. A strong theme present in the data was the burden of additional labour required to educate colleagues born by consumer workers where the organisations approach was insufficient. There is therefore a need for strategic resourcing to build the capacity of organisations to build safe, inclusive workplaces for consumer workers. We recommend that the DHHS or a commissioned organisation, could play a role in supporting organisations to improve their capacity to meaningfully incorporate consumer workers within services. This could take the form of a two-tiered approach:

Tier 1 would involve working with organisations who have not yet started employing consumer workers but are in interested doing so. Strategic consultancy and training packages would be provided to help prepare organisations to employ consumer workers. This will focus on areas such as the development of policies, position descriptions, recruitment support, human resource support specifically in the area of reasonable adjustments, and the delivery of consumer perspective supervision and management training to non-consumer managers.

Tier 2 would target organisations currently employing consumer workers. These organisations would be supported to self- assess their current approaches relating to consumer workers and to develop action-plans to improve their capacity to meaningfully incorporate and support consumer workers. This could involve guiding organisations to grow and develop their consumer workforce; the sourcing of training for frontline staff and managers to work effectively with consumer workers; providing consumer perspective supervision for managers; and providing advice on the development of the DHHS could play a role in incentivising organisations to undertake such processes. Organisations undertaking self-assessment processes could receive funding to implement relevant action plans to address self-identified need. Ideally this funding would be staggered to ensure that organisations effectively implement their plans and include reporting on measures of success of their programs or improvements.

4.   Resource support mechanisms for consumer workers so that they receive adequate training, consumer led supervision, and peer support throughout their career.

To effectively build the consumer workforce there must be targeted resourcing to ensure that consumer workers receive ongoing professional support and development opportunities. Throughout the findings of this study participants commented on a lack of resourcing to access consumer specific supervision, and tailored professional development opportunities.

What is evident is that consumer workers require a tailored approach to professional development, one that is distinct from professional development opportunities offered to other health professionals. Whilst social workers, nurses, and psychiatrists receive years of education before entering the workforce, consumer workers often begin their careers with negligible training in the mental health sector. While the lived experience of consumer workers is key to their role, ongoing supervision and training is needed to support them to best make use of this lived experience and to thrive within the consumer work profession.

We recommend a stepped approach to supporting the consumer workforce. This would involve different levels of funded training and support for consumer workers in a variety of roles and at different stages of their career. This approach would aim to offer training opportunities for:

- consumers interested in beginning a career in consumer work;
- baseline training for entry level consumer workers;
- specialised training for unique roles such as peer workers, consumer consultants, advocates, and trainers; and leadership training for experienced consumer workers.

As consumer workers enter the workforce with a variety of education and training backgrounds it is important that a range of training opportunities are available to match their learning needs. Figure 6 (pg. 41) illustrates a model of professional development that could be funded to meet these needs. Here there are four tiers of training opportunities available to consumer workers that can be matched to consumer workers at different stages of their careers.

The use of micro-credentialing could open further potential to deliver a range of tailored training options for consumer workers. Micro-credentials are short, certified courses that are often mapped to the Australian Qualifications Framework (AQF) and are designed to meet professional development needs within an industry. They are warranted and can be used to gain credit points towards AQF qualifications. For example, four micro-credentials would equal one university subject which could be used to obtain a graduate certificate.

To meet the training needs of the consumer workforce a suite of a micro-credentials could be developed that target specific skill areas required within the consumer workforce. These could include:

- Peer support
- Counselling and interviewing skills
- Individual advocacy and systemic advocacy
- Supervision
- Management

- Policy development
- Consumer research
- Working with trauma
- Working with AOD issues

Utilising this suite, consumer workers would be able to select the specific credentials relevant to their role or career pathway. Such an approach would also open up further educational opportunities for consumer workers.

This study indicates that consumer workers are often restricted in their ability to access professional development opportunities due to a lack of funding provided by their employer, or employers being reluctant to release workers to attend the training. For this reason, there is a role for DHHS to play in funding consumer worker professional development opportunities. In addition to this, changes to EBAs could be utilised to mandate professional development or study leave for consumer workers. This should also include support for, and access to, professional development opportunities.

Such an approach to developing the consumer workforce may be resource intensive at first but will lead to a stronger consumer workforce moving into the future.

5. **Support the development of consumer led organisations to provide key services within the mental health sector**

Throughout this study there has been extensive discussion regarding the undervaluing of the unique values base that consumer workers utilise and the extent to which this is at odds with the medically oriented core business of mental health organisations, which dominates practice and culture. The impact of this tension on consumer employee's wellbeing is evident in the findings. In addition to this, participants spoke about the difficulty working in environments where they had to bare witness to derogatory and often highly medicalised perceptions of consumers. This was particularly damaging when they encountered their own lived experiences of distress viewed in this way.

While we recommend that work is done to improve the conditions consumers workers face within mainstream mental health services, the dominant discourse within these services may still continue to harm consumer workers. For this reason, we concurrently recommend the development of consumer-led programs and organisations as an alternative employer of consumer workers that would create a supportive workplace that is well aligned with consumer values. Consumer led organisations can also be a source of training, along with opportunities for the exposure to different ways of working, supervision, and support for consumer workers.

Here it is important to distinguish between consumer directed and consumer led programs. Consumer directed programs entail consumers being involved in running programs that are incorporated into mental health services that are not consumer led. Such examples include Voices Vic which is run by the non-government organisation Uniting (Uniting, 2020) and Piri Pono in New Zealand which is run by Rodney Adult Community Mental Health Services (Larsson, 2019). While such programs are a welcome innovation and potentially provide excellent work opportunities for consumer workers, there remains a power imbalance within such services whereby non-consumer leadership retains control. Ultimately the aim should be for the development of consumer led services where consumers wholly lead programs. There are several consumer led organisations in the United Kingdom such as the Leeds Survivor Crisis Service (2020) which is a charity set up by mental health service users in 1999 and provides crisis support delivered by people with lived experience of distress.

6. **Resource advocacy positions within consumer led organisations that can provide individual and systemic advocacy for consumer workers.**

Many participants spoke about the difference in general working conditions compared to colleagues in other professions along with the limitations of traditional organisational procedures to resolve complaints and disputes. They also commented that existing support such as EAPs and health unions are not meeting the needs of consumer workers. Consequently, an advocacy program is needed to provide tailored support to consumer workers experiencing workplace issues. Advocates would ideally be employed by consumer led organisations and would be tasked with supporting consumer workers when workplace dispute or issues arise.

Participants in the focus groups strongly argued for amendments in EBAs to improve the workplace conditions of consumer workers. There were concerns that current health unions are not equipped to best support consumer workers as there is a lack of understanding of the consumer work role. An advocacy program could also play a role in working closely with unions to develop their capacity to support consumer workers and to campaign for the appropriate EBA amendments needed for consumer workers.

7.   Support ongoing research into the experiences of the consumer workforce

While this project was able to capture important experiences of consumer workers in relation to discrimination, safety, and inclusion there is a need for further research into the experiences of consumer workers to support the development of this profession. Research could be utilised to build knowledge in the following areas:

- **Benchmarking –** this would involve developing a clearer understanding of the range of roles within the consumer workforce, whether these roles match well to position descriptions, and a detailed picture of training and development needs.
- **Workforce sustainability -** this would involve building an evidence base that can be used to support the growth and sustainability of the consumer workforce. This should focus on building the capacity of the workforce to be representative of the diversity within the consumer experience.
- **Evaluation of interventions –** this would involve ongoing evaluations of interventions designed to support the consumer workforce.

Such research should aim to ensure that it is representative and captures the full diversity of the sector.

Figure 6 - Internship Model

	TIER 1	TIER 2	TIER 3	TIER 4
TARGET GROUP	Any person who has used public mental health services and has an interest in beginning work as a consumer worker.	Consumer workers who have recently commenced working in the mental health sector.	Consumer workers who have been working for over one year and wish to develop their skills.	Consumer workers with over five years of experience.
STRUCTURE	A series of one day workshops delivered throughout the year.	A year-long internship where consumer workers from partner organisations receive monthly professional development and ongoing networking opportunities' and where partner organisations agree to release participants to attend training.	A range of professional development opportunities tailored to consumer workers. Consumer workers will be supported to identify their training pathways.	Quarterly reflective practice sessions along with brokerage to spend on professional development opportunities.
CONTENT	Content aimed at introducing key concepts in consumer work including the history of the consumer movement, consumer values, consumer worker roles, and different approaches to consumer work.	Content aimed at developing the necessary knowledge and skills to support consumer workers in their careers. This would include content focused on peer support principles, consumer perspective principles, influencing change, and utilising supervision. Depending on the different roles of participants specific training could be targeted at specific roles such as peer support workers, consumer consultants, or advocates. The internship will also involve the provision of monthly group supervision to support participants to reflect on their learning and how this is translating into practice.	A range of professional development sessions aimed specifically at consumer workers that cover a range of topics for advanced practitioners. These could include: Trauma-informed care Dual diagnosis Reducing restrictive practices Systemic advocacy	Participants will meet four times in 12 months to explore, learn, and share experiences, knowledge, and skills. They will each have a budget to use as brokerage to undertake specific skill and knowledge development to meet their needs. A particular focus will be given to the development of knowledge and skills that will support movement into management positions.
OUTCOME	On completion of workshops, participants will receive completion certificates that will support their movement into the field.	On completion of internship participants will receive a certificate of completion.	Participants will receive certification of training received.	Participants will receive certification of training received.

6.   CONCLUSION

The Leading the Change project has highlighted the value of the consumer workforce within the mental health sector and identified several challenges that may inhibit the sector's ability to meaningfully, and safely incorporate consumer workers. Challenges exist in relation to the low number of consumer workers employed within organisations, leading to experiences of isolation and a lack of career development pathways. Increasing the numbers of consumer workers in the workforce and working to develop the capacity of this workforce to engage in roles across organisational hierarchies will help to address these issues. Beyond building the consumer workforce there is a need for a more strategic approach to building the capacities of organisations to meaningfully include consumer workers. Such an approach must focus on cultural change alongside policies and processes designed to protect consumer workers from discrimination and bullying and to support career development. Finally, changes are required at a sector wide level with a focus on building in accountability for organisations to better support consumer workers. In addition to this, the use of advocacy organisation or unions is needed to address individual and workforce level issues. This study indicates that while there are notable challenges present in the current situation, there is significant scope for improvement. Through a systematic, co-produced approach to organisational and sector level changes there is potential for the full value of consumer work to be better realised within the Victorian mental health sector.

7. REFERENCES

Centre for Evaluation and Research, Department of Health and Human Services. (2019). *"you get what I'm going through" Research report: Expanding post discharge support intiative.* Department of Health and Human Services.

Department of Health. (2013). *Consumer participation in Victorian public mental health services.* State Government of Victoria.

Department of Health and Community Services. (1996). *Victoria's mental health service: Guidelines for consumer participation in mental health services.* Department of Health and Community Services.

Department of Health and Human Services. (2016). *Preparing your organisation for the Expanding post-discharge support intiative.* State of Victoria, Department of Health and Human Services.

Grey, F., & O'Hagan, M. (2015). *The effectiveness of services led or run by consumers in mental health services: An Evidence Check rapid review by the Sax Institute.* Sax Institute.

Happell, B., & Scholz, B. (2018). *Doing what we can, but knowing our place: Being an ally to promote consumer leadership in mental health.* International Journal of Mental Health Nursing, 27(1), 440–447. https://doi.org/10.1111/inm.12404

Ibrahim, N., Thompson, D., Nixdorf, R., Kalha, J., Mpango, R., Moran, G., Mueller-Stierlin, A., Ryan, G., Mahlke, C., Shamba, D., Puschner, B., Repper, J., & Slade, M. (2019). *A systematic review of influences on implementation of peer support work for adults with mental health problems.* Social Psychiatry and Psychiatric Epidemiology. https://doi.org/10.1007/s00127-019-01739-1

Larsson, L. (2019). *Piri Pono – a peer-led acute residential service in New Zealand. Centre for Public Impact (CPI).* https://www.centreforpublicimpact.org/case-study/piri-pono-peer-led-acute-residential-service-new-zealand/

Leeds Survivor Led Crisis Service. (2020). *Leeds Survivor Led Crisis Service.* Leeds Survivor Led Crisis Service. https://www.lslcs.org.uk/

Mead, S. (2005). *Intentional Peer Support.* Interntional Peer Support.

Orr, K., & Bennett, M. (2012). *Public Administration Scholarship and the Politics of Coproducing Academic–Practitioner Research.* Public Administration Review, 72(4), 487–495. https://doi.org/10.1111/j.1540-6210.2011.02522.x

Repper, J., & Carter, T. (2011). *A review of the literature on peer support in mental health services.* Journal of Mental Health, 20(4), 392–411. https://doi.org/10.3109/09638237.2011.583947

Roper, C. (2003). *Consumer perspective employment in the psychiatric service system: A Victorian view on safety issues.* Australian E-Journal for the Advancement of Mental Health, 2(1), 56–61.

Roper, C., Grey, F., & Cadogen, E. (2018). *Co-production—Putting principles into practice in mental health contexts.* University of Melbourne.

Stewart, S., Watson, S., Montague, R., & Stevenson, C. (2008). *Set up to Fail? Consumer Participation in the Mental Health Service System.* Australasian Psychiatry, 16(5), 348–353. https://doi.org/10.1080/10398560802047367

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences.* Sage Publications Inc.

Uniting. (2020). *Voices Vic.* Uniting. https://www.unitingprahran.org.au/ourservices/voices-vic/

Victorian Mental Illness Awareness Council, Centre for Psychiatric Nursing, & Department of Health and Human Services. (2018). *Consumer perspective supervision- A framework for supporting the consumer workforce.* Department of Health and Human Services.

Watson, S. (2013). *Peer Workforce Development.* CEPS Peer Conference, Melbourne, Australia.