Private Mental Health
Consumer Carer Network (Australia)

engage, empower, enable choice in private mental health

Towards Professionalisation

Final Report

A Project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia

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Project Manager

15 January 2019

Private Mental Health Consumer Carer Network (Australia)

Community of Peers Project

Acknowledgements

We acknowledge consumers past, who helped shape the current landscape but didn't have the opportunity to be a part of a mental health peer workforce.
The Project Team wish to thank all those who contributed to the Project, in particular peer workers, those with a lived experience, people who support them and family members. Many were forthright in offering their views, hopes, encouragement, innovative ideas and their passion for change.
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We have also been informed by the content of a '***Statement of Intent***' and wish to acknowledge the following people who developed this. Eschleigh Balzamo - General Manager, BrookRed; Jenna Roberts - Consumer Participation Officer, St Vincent's Hospital; Sage Green - Acting CEO, Being; and Tim Heffernan – Mental Health Peer Coordinator, South Eastern NSW PHN (former Chair, New South Wales Public Mental Health Consumer Worker Committee). The *Statement of Intent* was supported by Sherry Tucker - Executive Director, Georgia Mental Health Consumer Network and Gary Parker - Executive Director, Kansas Consumer Advisory Council for Adult Mental Health. This document appears at Appendix B.
We would also like to acknowledge the September 2018 release of the book: ***Peer Work in Australia***. This book goes hand in hand in many ways with this Project, with the book 'featuring a panoramic review of peer work in Australia' by foremost consumer rights advocates Janet Meagher AM, Anthony Stratford, Erandathie Jayakody, Fay Jackson and Tim Fong from Mind Australia and Flourish Australia. Other contributors include NDIA mental health advisor Dr Gerry Naughtin, and other advocates, service providers, academics, funding agents and policy makers. The book has been created by two of Australia's leading community mental health support agencies in Mind Australia and Flourish Australia.
Our work on the Project in putting this report together would not have been possible without the many views and opinions that we sought and value. We trust that we have done justice to the input we received from many perspectives.
The Project Team also acknowledge and thank the ***Project Reference Group*** who met formally on three occasions and provided expert advice and feedback:

Susie Adam	Peninsula Carer Council, Carer Consultant (Victoria), National Register member
Shandy Arlidge	Project Manager, Lived Experience Workforce and Senior Policy Officer, Mental Health Coalition of SA
Irene Gallagher	CEO, Being
Patrick Hardwick	Deputy Chair, Private Mental Health Consumer Carer Network (Australia)
Tim Heffernan	Mental Health Peer Coordinator, COORDINARE – South Eastern NSW PHN
Daya Henkel	Snr Policy Officer, Mental Health Reform Team, National Mental Health Commission
Jae Radican	State Wide Mental Health Peer Workforce Coordinator, Clinical Service, Mental Health Branch (NSW)
Sharon Lawn	Professor, Director, Flinders Human Behaviour and Health Research Unit, Department of Psychiatry, College of Medicine and Public Health, Margaret Tobin Centre.
Anthony Stratford	Principal Advocate Lived Experience, Mind Australia Limited

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This work was funded by the National Mental Health Commission and we thank them for their contribution.

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Summary of Tables

Recommendations

The Project Team has made the following Recommendations for consideration and action. These recommendations have been informed by the various sections throughout this Report.
In order to build upon the momentum of this Project and the hope expressed by peer workers for a national member-based peer workforce organisation, the Project team proposes the following recommendations be actioned and implemented as quickly as possible.

Primary Recommendation:

The Project Team recommends the following:
Establish a national member based organisation in Australia for all peer workers including those in a volunteer or support capacity.

Recommendation 1: Data on the Peer Workforce

The Project Team recommends the following:

The National Mental Health Commission liaise with the Australian Institute of Health and Welfare and Mental Health Information Strategy Standing Committee to:

- Add data on peer workers as a requirement to all new data fields including the Mental Health Establishment National Minimum Data Set.
- Survey or stock-take current activities through:
  - Services and organisations;
  - various networks including those contacts obtained through this Project.

Additionally, the Project Team recommends:

- clearly define role descriptors and functions of peer workers;
- adopt annual collection of data on peer workers from community managed organisations and the private sector.

Recommendation 2: Literature Review

The Project Team recommends that the National Mental Health Commission approves the public release of the Literature Review including posting onto the Project site of the Private Mental Health Consumer Carer Network's webpage http://pmhccn.com.au/PeerProject.aspx and if appropriate, the NMHC website.

Recommendation 3: National Consultations

The Project Team recommends that the National Mental Health Commission approves the public release of the responses to the online survey in full, including posting onto the Project site of the Private Mental Health Consumer Carer Network's webpage http://pmhccn.com.au/PeerProject.aspx and if appropriate, the NMHC website.

Recommendation 4: Governance

The Project Team recommends the establishment of a national member-based organisation for the peer workforce's legal structure as a Company Limited by Guarantee.

Recommendation 5: Model

The Project Team recommends the following:

Adoption of Model 3

Model 3 could be established to provide the ability and flexibility to move to the establishment of jurisdictional branches (Model 1 – gold standard) as the organisation expands in the future and as more funding becomes available.

Recommendation 6: Funding support

The Project Team recommends the following:

That the National Mental Health Commission progress or commission the:

Development of a business case or formal funding proposal which details the funding sought and other critical requirements. This would be provided to the entities which have indicated an interest in receiving a formal request for potential funding contributions.

Or

Develop a business case or formal funding proposal for the Mental Health Principle Committee:

1) Seeking funding via the established formula for states and territories funding requirements for a three-year funding commitment.

2) Provide additional funding beyond the population-based funding formula or an adjustment to the formula to the smaller states of WA, TAS and NT where additional work is required to establish the peer workforce.

Once the funding has been secured, the National Mental Health Commission to progress or commission the:

3) Development of a formal proposal seeking in-kind support from the organisations who have indicated an interest.

4) Establishment of a Steering Committee of peer workers and other relevant experts including legal to oversee:

    - Legal documentation required including a Constitution to establish the Company Limited by Guarantee.

- Recruit the CEO, and Policy and Governance Officer to further the work required for the establishment of the organisation

- Explore, approach and establish the Secretariat and Peer Liaison Specialists within appropriate entities

Recommendation 7: Future work for the NMHC

The Project Team recommends the following:

The National Mental Health Commission advocates for or influences the uptake or introduction:

In relation to data collection:

1) Develop or engage an entity to determine a nationally consistent definition of a peer worker including their role.

2) Advocate for the implementation nationally through the AIHW & MHISSC of the Non-Government Organisation Establishment Data Set OR the Mental Health Non Government Organisation National Best Endeavour Data Set

In relation to Peer Workforce Guidelines:

3) Finalise the development of the Peer Workforce Development Guidelines with due consideration to those already undertaken by other organisations.

In relation to the national qualification and other training:

4) Advocate for the greater role out and uptake of the **Certificate IV in Mental Health Peer Work CHC43515** national qualification.

5) Seek to influence the introduction within the training sector of this qualification into the Northern Territory.

6) Advocate for the uptake of other professional development or as an introduction to peer work through things such as Intentional Peer Support (ISP), introductory courses, traineeships, internships or scholarships across jurisdictions.

Foreword

Mr. Chris Burns CSC

'Nothing about us without us' is a phrase that resonated with me early in my time as South Australia's Mental Health Commissioner. It is also a message that was reinforced repeatedly in our consultations to develop the State's mental health strategic plan.

The powerful message this phrase sends is that the voice of lived experience must be listened to when considering the mental health and wellbeing of all Australians. The facts are that almost half of us are going to experience a diagnosable mental illness in our lifetime. That means the other half are going to be carers of Australians experiencing a diagnosable mental illness.

To not listen to those who experience mental illness or care for those that do, is folly. More importantly, to not capitalise on the extraordinary experience those consumers and carers offer and employ them as peer workers is naïve in the extreme.

I find it difficult, to find a place in our society that would not benefit from peer workers. Be it supporting new parents, building resilience in our kids, enhancing the mental health of our workforce or fostering the wellbeing of older Australians.

Peer workers have the unique ability and capacity to walk side-by-side with those experiencing mental health difficulties, sharing their experience and understanding to guide them on their recovery journey.

What is lacking is the acknowledgement and recognition of this powerful capability as a functional and effective workforce. We need to look at how we 'professionalise' our peer workforce. How do we select them, train them, supervise them, grow their skills and provide them with a career structure? Just as we do for every other workforce!

I believe this report addresses those issues, identifying the key issues associated with peer workforces and providing constructive solutions for the way ahead. I congratulate Janne McMahon and her team for the exceptional work they have undertaken to develop this enlightening and insightful report.

Chris

C.M.Burns CSC | Commissioner

SA Mental Health Commission

December 2018

Executive Summary

In February 2017 the Private Mental Health Consumer Carer Network Australia (PMHCCN) submitted a Proposal to the National Mental Health Commission seeking funding to undertake a national 'Community of Peers Project'.

At the same time, peer work leaders from Queensland, Victoria and NSW and colleagues from the USA participated in an International Initiative for Mental Health Leadership in Brisbane (February 2017) to develop and later issue a 'Statement of Intent' that would communicate their intention to form a national professional association for the mental health consumer peer workforce in Australia. This demonstrated the currency of need to explore the feasibility of establishing a national member based organisation for the peer workforce in Australia. A member of these peer work leaders was invited to join the Project Reference Group to ensure there was a shared understanding and focus, and together drive the work of this project, complementing, acknowledging and drawing on each initiative. PMHCCN subsequently received funding from the National Mental Health Commission in 2017 to undertake this project throughout 2018.

The Project looked at the feasibility of establishing a national member based organisation to support peer workers and attendees at the consultations were asked the critical question as to whether this is something they wanted. The resounding response was yes, although there were some differing views as to whether it should be for consumer peer workers and carer peer workers as one organisation, and also whether the organisation should admit peer workers from other areas eg alcohol and other drugs, volunteers, peer academics, peer educators etc.

Through a consultative process, and with reference to national and international literature, the Project sought to examine where the sector is now and what it sees as the need for peer worker support, and a model for such an organisation. Our consultations and research have identified that the establishment of a peer workforce organisation in Australia will be a significant catalyst for change and a major contributor to the mental health reform agenda.

While there are currently professional bodies available for other mental health professions and disciplines such as social workers, general practitioners, psychiatrists, nurses, psychologists and occupational therapists, there is no such entity available to promote, provide support, training and advocacy for the mental health peer workforce in Australia.

The essence of peer work is in the unique and personal experiences that individuals bring to the role, specifically the experience of mental illness, treatment, hospitalisation and the recovery journey, or as a family member or carer supporting someone with mental illness.

Peer workers are required to advocate for the consumers and carers they walk alongside, which can lead to further discrimination and harm through re-traumatisation if the staff and management of the organisation they work for do not fully understand the purpose of their role. A peak entity would provide standards and guidelines to be implemented by services and organisations employing peer workers to eliminate further harm, increase understanding of this unique role and maximise the benefits that peer support workers can provide by improving outcomes for consumers and carers.

The following project tasks were undertaken:

1) **An Australian and international literature review**

A review was undertaken identifying current best practice in relation to the peer workforce, including methods to best support the workforce. The results provided further expansion of understanding during the national workshops and online survey. Six key themes were identified from the review which were used to inform and support the national consultation process and to propose possible models suitable for Australian mental health peer workers.

2) Understanding the peer workforce

Obtaining current data on the numbers of peer workers employed within the community managed sector, was difficult and therefore the extent or growth of the peer workforce over the next decade is difficult to predict. The very limited data available demonstrated an average increase of 10.8% in mental health consumer workers from 2011-2012 to 2015-16 per 10,000 FTE mental health care providers. Over the same period, the rate of mental health carer workers employed decreased by 1% per 10,000 mental health FTE staff. In terms of the community managed organisations, only WA and QLD are collecting this data, and this has seen a 4% increase over the last few years in WA.

The Project Team has been reluctant to make projections based on these figures obtained from the only Report of this kind from the Australian Institute for Health and Welfare which make these figures doubtful and could be seen as more speculative rather than providing clarity or validity.

3) National Workshops

Workshops were conducted in all Australian capital cities with 184 attendees. A further 165 participants completed an online survey which sought to further distil the key issues highlighted from the workshops. The key messages indicate that a member based national organisation for the peer workforce was strongly supported. Key themes were consistent with those identified in the literature review and included an organisation:

- Should represent both consumer and carer peer workers as well as all lived experience workers
- Would have a national base that includes individual state/territory representation at that level
- Would have both a CEO and Board Members with the required necessary skills, expertise and experience in addition to lived experience
- Provide professional development, education, training and support services
- Provide systemic advocacy
- Would develop standards, a code of ethics, a code of conduct, and promote the profession of peer work
- Develop national guidelines for the peer workforce
- Support and promote opportunities to further career pathways for peer workers
- Promote and provide factual, consistent information about the peer workforce

It must be acknowledged that a strong view was expressed during the Victorian Workshop that any national organsiation should represent consumer peer workers exclusively. A similar view was expressed in the NSW Workshop regarding the view was that having both consumer and carer peer workers would not be an insurmountable barrier. This view was not represented more broadly however it was raised in some workshops that the two roles of consumer peer workers and carer peer workers are quite specialised and different. These conversations did not identify insurmountable barriers to the establishment of an organisation that is for the whole mental health peer workforce.

4) Developing a model

The Project Team explored two main types of governance for an organisation, Incorporation as an Association or a Company Limited by Guarantee. Given the clear directions from the national workshops that connections at the state and territory level was critical, the Project Team have recommended the organisation be established as a Company Limited by Guarantee, to enable possible branches or other connections.

A model has been recommended which would see a 'Secretariat' and Peer Liaison Specialists co-located within appropriate entities within each jurisdiction. The entity would require careful consideration before a formal approach was made as to the appropriateness of fit.

5) Collaboration and communication with other organisations engaged in supporting peer workers

A critical component of this was to ensure collaboration and cooperation with existing peak consumer and carer organisations. Not all organisations responded to our invitation to provide input. Further, engagement with Mental Health Commissions, PHNs, peak CMO members of Community Mental Health Australia, and other organisations currently supporting peer workers was undertaken.

6) Supporting contributions

The Project Team approached all four Mental Health Commissions, some philanthropic and private providers, peak community managed organisational members of Community Mental Health Australia, other peak consumer or carer organisations, state and territory mental health directorates to identify potential support for a national organisation, including an indication of potential financial or 'in kind' support that could be provided.

Most responded positively to this request identifying their willingness to consider a business model or funding proposal or opportunities for in-kind support such as office space. All these points are further expanded upon in the latter sections of this Report.

This Report has been put together in a sequential manner, a 'road map' if you like with each section following a pathway.

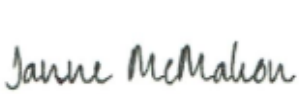
We have set out an introduction of the project, the policy content, what a peer worker is and a definition for lived experience etc. This is followed by what data is currently reported and what we can gain from this or not as the case may be, in determining what the peer workforce will be in 10 years' time. We then looked at training and the national peer work qualification, a literature review informed the national consultations and these results are documented including what peer workers wanted from a national organisation, governance, models, and financial or in-kind support.

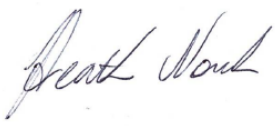
Additionally, we have detailed information on resources targeting employers and workplaces and future work the National Mental Health Commission could undertake.

There are two Appendices, one containing a compilation of notes of each workshop, the other referencing the 'Statement of Intent'

We hope this Report is of interest to Governments both nationally and at the state and territory levels. We are recommending action be taken as promptly as possible to build upon the momentum of this Project and honouring the perspectives and hopes of peer workers expressed throughout our consultations. It has been a privilege to undertake this crucial work.

Project Team





Janne McMahon OAM	Lyn English	Heather Nowak
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Section 1

Introduction

Peer work is a growing occupational group in the mental health workforce and has been reported to be growing at a faster rate than other disciplines in recent years.[1] Increasingly, peer workers are being employed within the public mental health system and community managed organisations (CMOs); however, the private sector lags behind in this regard.

Not unexpectedly, however, as a relatively new occupational group, there is still a lack of shared understanding across the mental health sector more broadly of the definitions, values, skills, practices and challenges in peer work. As a relatively new workforce, and with understanding of their role and potential contribution still limited, there is a need to consider how to best support individual workers and to promote the role, including embedding peer workers within mental health services.

Policy Context

The increase in the employment of peer workers has been supported by the articulation of peer workers as a legitimate workforce firstly within the 4th National Mental Health Plan - *Increase consumer and carer employment in clinical and community support settings*[2] and the National Mental Health Commission's 2014 National Review of Mental Health Program and Services. These actions were further expanded within the 5th National Mental Health and Suicide Prevention Plan.

5th National Mental Health and Suicide Prevention Plan

There are several actions articulated within Priority Area 8 of the Implementation Plan that relate specifically to the peer workforce:

Action 20: Governments will ensure that the Peer Workforce Development Guidelines to be developed in Priority Area 8:

- Create role delineation for peer workers that provide opportunities for meaningful contact with consumers and carers and grassroots based advocacy; and
- Identify effective anti-stigma interventions with the health workforce.

Action 29: Governments will develop Peer Workforce Development Guidelines consistent with the recommendation made by the National Mental Health Commission's 2014 National Review of Mental Health Program and Services, and the commitment made at Action 20.

Action 30: Governments will monitor the growth of the national peer workforce through the development of national mental health peer workforce data including data collection and public reporting.

[1], *Peer Work in Mental Health*, IIMHL January, 2013

[2], Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014, Priority area 4: Quality improvement and innovation

What is a peer worker?

It is helpful therefore to define who a peer worker is.
Not everyone with a lived experience of mental illness will necessarily make a successful career as a peer worker. It is important when noting and describing the peer workforce that carer peers are also included within this framework. Carer peer workers are providing increasingly important and much needed support for families and carers, especially in acute mental health settings.

It is important to acknowledge that clear definitions and role clarity around the peer workforce are not consistent. For the purpose of this project we have referred to the following text which has been taken from the recently launched ***Peer Work in Australia,*** *(Meagher, J, Naughtin, G., September 2018)*

Consumer Peer Worker *is an occupational title for a person in a paid role, who has had personal experience of living with a disabling, traumatic, health or living situation. Through their processing and learning from their own personal experience they are able to offer empathetic support, empowerment and validation to other people with comparable experience.*

Mental health Peer Workers are employed to work solely within their focus area. The focus area in particular is:

- *People with personal experience of mental health recovery working alongside people living with mental health issues in order to enable those people to move towards recovery.*

There are many tasks performed by Peer Workers; these may include such tasks as assisting people in articulating their goals for recovery, helping people to monitor their progress, assisting them to manage personal wellbeing, modelling and articulating effective recovery strategies based on the worker's own learning and experiences, supporting the person to obtain appropriate and/or effective services and helping them to understand different pathways to recovery.

Carer Peer Worker *is an occupational title for a person in a paid role, who has a lived experience of having been a primary carer for a person with enduring mental health issues.*

Carer Peer workers bring a range of experiences to better assist families and carers in undertaking their role in supporting someone close to them with mental illness.

Peer Support: *Are Individuals with a lived experience of mental illness who support others by offering hope, empathy and practical support in a voluntary role.*

Peer work, peer workers and peer workforce include all workers in mainstream or alternative mental health services or initiatives who are employed to openly identify and use their lived experience of mental distress or as a carer supporting someone with mental illness as part of their work. As this workforce develops, there is a greater need to create new roles and define the boundaries between them.

The peer workforce roles include but are not limited to:

- **Peer workers** work in a paid role and provide support for personal and social recovery to people with mental health problems, including in acute mental health services, housing, supported employment, community support etc. and provide support to their families and carers.

- **Peer advocates** empower individuals or groups of people with mental health problems or their families and carers to advocate for their rights and needs on a range of issues in a variety of settings.

- **Peer educators** provide education from a lived experience perspective for other peers, mental health workers or community members.

- **Peer consultants** work in partnership with mental health service providers to give consumer or carer perspectives at all levels of planning, implementation and evaluation, and provide feedback to service users.

  Note: Peer support is also provided in a voluntary role.

  Note: The term *Lived Experience* has been raised through the consultations and we have extracted two definitions below for the purpose of this Report. The second however does not acknowledge the distress that siblings and children experience, referring only to the 'primary' carer but this has been extracted from paragraphs from the Peer Workforce in Australia referenced below.

- Lived Experience refers to the experience people have of their own or others' mental health issues, emotional distress or mental illness, and of living with, and recovering from, the impacts and consequences of their own or others' mental health issues, emotional distress or mental illness[3].

- **Lived Experience** refers to a person who has personal experience of dealing with and managing emotional distress or a person who has experience of being the primary carer for a person with enduring mental health issues. These two roles are quite specialised and intrinsically different. They must not be confused.[4]

National Qualification

Public and private mental health services and community managed organisations deliver programs across a range of service types, including family and carer support and education, and are increasingly looking to the peer workforce as an effective adjunct to their existing workforce.

In part, the growth in the peer workforce may also be attributed to the development of the Certificate IV in Mental Health Peer Work for people with lived experience to become trained under a Nationally Accredited Training Scheme.

A major initiative for a nationally recognised qualification has been the development of training and assessment resources for the **Certificate IV in Mental Health Peer Work CHC43515** (which includes and elective unit of either a consumer stream or a carer stream) designed specifically to support the emerging peer workforce. This qualification is designed for consumer peer workers and carer peer workers who are seeking employment within the mental health sector in government, private, public or community managed services. This qualification is specific to workers with a lived experience of 'mental illness' as either a consumer or carer and who are looking to work in roles that support other consumers or carers.

This qualification consists of 15 units of competency (8 core units and 7 elective units). This training provides an opportunity for peer workers to build upon their lived experience which contributes to

[3] MHCC Foundations 1 Mental Health Peer Work 2015
[4] Peer Work in Australia: A New Future for Mental Health, Meagher, J., Stratford, A., Jackson, F., Jayakody, E., & Fong, T (Eds.) 2018. Sydney: Richmond PRA and Mind Australia

the acquiring of a nationally recognised qualification in mental health. Details can be accessed here (https://training.gov.au/Training/Details/CHC43515)

Private Mental Health Sector

As the demands on the clinical mental health workforce within Australia grow, there is an increasing opportunity for peer workers to provide services inclusive of their unique lived experiences and now, supported by their qualifications.

There is a growing evidence base that suggests there is a place for increasing the peer workforce across all sectors but particularly in the private sector. Private hospitals, for example, in the main, have not embraced the broadening of their workforce to include peer workers. Whether this is because of a lack of understanding or preparedness to engage peer workers by management and corporate entities or related to employment issues or a lack of openness to change is not known. Whatever the reason, the current void in the private mental health sector should be tackled; and, given the nationally accredited qualification, it is timely to seek to do so now.

Scope of the project

Project Team

A Project Team was formed consisting of a Specialist Peer Consultant whose role was to advise and consult on the Project and to assist in the facilitation of the national workshops. A Senior Peer Project Officer was engaged to undertake the roles and responsibilities required for this Project including facilitation of all national workshops and other consultations with relevant stakeholders. The Project was managed by the Private Mental Health Consumer Carer Network's Executive Officer.

Consortium formation

At the commencement of the Project, the Network formed a Consortium with the National Mental Health Consumer & Carer Forum and the National Mental Health Commission.

Australian and international review

A review was undertaken to determine what constitutes current Australian and international best practice in relation to the peer workforce, including methods to best support the workforce.

Understanding the peer workforce

This component of the project enabled the Project Team to better understand what is required to support and sustain the peer workforce to deliver best practice. The Specialist Peer Consultant sought to ascertain the current number of peer workers employed in Australia, the number undertaking recognised qualifications, and the projected growth in workforce availability over the next decade. This proved difficult as data has been difficult to obtain and, in many cases, is not available. Please note the lack of current data collection has been recognised in the 5th National Mental Health and Suicide Prevention Plan. Please see the following Section 3 in this Report that relates to this issue detailing what has been learned in this regard.

Developing a model

The Project Team considered options for the development of a member-based organisation that focused on the potential functions of such an organisation, as well as legal and corporate considerations, and sustainable funding has been explored.

Collaborate and communicate with other organisations engaged in supporting peer workers.

A critical component to support the successful implementation of the peer workforce through all settings in Australia is to create an entity which can collaborate, communicate, cooperate and support various activities being undertaken. Close liaison with Mental Health Commissions and other

organisations at the local jurisdictional level that are engaged in supporting the peer workforce and/or that are creating material specific to the peer workforce has been critical.

The Project Team sought to undertake a scoping of what existing policies and procedures currently exist and to define what local supports are currently available.

Educational material focussed on the employer

An additional component of the Project was to promote the educational resources focused at the *organisation* or *employer* through the Peer Work Hub, undertaken by Craze Lateral Solutions and the NSW Mental Health Commission. These educational resources are currently under review but provide an understanding of the role and responsibilities of peer workers from an employer perspective.

National Workshops

To support the knowledge captured and the development of model options, effective consultation has been required. The Project Team conducted a half-day workshop in the capital city of all states and territories for peer workers, services, organisations and employers. The workshops were facilitated by the Specialist Peer Consultant or Project Manager and the Senior Peer Project Officer.

Teleconferences were also conducted to receive information regarding peer workers in major regional, rural and remote towns across all jurisdictions except the ACT.

Booth at the TheMHS Conferences

Exposure of the Project was expanded by securing a dedicated booth at the 2017 TheMHS Learning Network which was held in Sydney, on the 29th August – 1st September 2017 at the Hilton Hotel. This was manned by the Senior Peer Project Officer. The Project was again promoted at the TheMHS 2018 Learning Network, held in Adelaide on 28-31 August 2018 through the Network's booth with the Senior Peer Project Officer in attendance.

Supporting contributions

The Project explored options for organisations such as private psychiatric hospital corporate providers, departments of health, mental health commissions and philanthropic organisations to support any national peer organisation either in the short term for the duration of this project or for the entity once established (e.g. via a direct funding contribution or in-kind support).

Section 2

Peer Workforce

The Project Team sought data on the peer workforce through a number of different avenues; however, what has become evident is that, currently, there are no accurate or routine data collection sources available across all service delivery sectors to capture this information consistently across jurisdictions or within the CMO sector where the majority of peer workers are currently employed.

Two of the requirements for the Project to address were to:

1) Scope current peer workforce; and
2) Scope projected peer workforce to 2027-2028.

The Project Team investigated the following three data sources on the current peer workforce:

1) **Mental Health Services in Australia 2018**
   Mental Health Services in Australia (MHSiA) includes consumer and carer staff in the denominator 'mental health care provider' – consumer and carer workers and reports per 10,000 FTE.
   https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-cre-facilities

2) **Report on Government Services 2018**
   This report (RoGS) uses the term 'direct care staff' and reports per 1,000 FTE

   https://www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/mental-health-management/rogs-2018-parte-chapter13.pdf

3) **Mental Health Non Government Organisation National Best Endeavour Data Set**
   The Western Australian Mental Health Commission has established and recorded data since 2014-15 on the community managed sector, formerly known as the non-government sector. This set and resources have been shared with Queensland which the Project Team understands has recently established a similar process for recording data.

The NMHC commissioned the AIHW to undertake a 'quick review' on the numbers of peer workers in Australia. This February 2016 Report was made available to the Project Team. This showed that:

- There are limited data sources available to report on the participation of mental health peer workers across the various activities they may undertake, including advocacy, service planning and/or delivery, health promotion, and so forth.
- The only national data set which currently collects data on consumer and carer participation is the National Mental Health Establishment Data Set, which is limited to state and territory specialised mental health services regardless of setting (i.e. this includes inpatient, community and residential settings). What is also noted are the definitions of consumer and carer workers employed on a part-time or full-time basis.

The Commission has previously funded Health Workforce Australia to undertake a one-off analysis of the mental health peer workforce.

- There is currently no routine data source available to report on peer worker participation outside of the state and territory specialised mental health services, such as the CMO (as mentioned formerly known as the non-government sector) or within the private sector.

There are known definitional issues relating to the ability to identify mental health peer workers from administrative data systems across jurisdictions.

Other publications of note are the Health Workforce Australia (2014) Mental Health Peer Workforce Literature Scan and Health Workforce Australia (2014) Mental Health Peer Workforce Study.

Summaries are:

Health Workforce Australia [2014]: Mental Health Peer Workforce Literature Scan

> *'The literature suggests that peer workers can provide an important and useful complement to the traditional teams delivering mental health services. Particular benefits of using this workforce can include improving the recovery orientation of services; better engagement with people using services; reduction in hospital admissions; and reduced load on other practitioners. For some people using services and their families and carers, peer workers offer an improved experience of treatment, care or support.*
>
> *America, Britain and New Zealand are among the countries making more use of peer workers than Australia. Further developing this workforce is not without its challenges, however, it appears that considerable benefits would follow from a well-supported broad implementation of peer workers in the mental health sector'.*

Health Workforce Australia [2014]: Mental Health Peer Workforce Study

> *'Mental health peer work is a relatively new approach to service delivery. Internationally, evaluation has lagged behind implementation of peer workforce roles, however, it is important to consider the available evidence regarding the utility of the peer workforce. Many studies are qualitative; however, some randomized control findings are available.*
>
> *The limited quantitative and qualitative evidence available suggests that the peer workforce can be as effective as the professional mental health workforce in some roles, and may offer particular benefits to consumers, carers, peer workers and service providers.*

It is clear that Australian research in this area is essential in the future.

Scoping of current workforce

During the Project, data on the current peer workforce has been difficult to collect. Some of the members of the Project Reference Group sought to obtain this information from their jurisdiction with some success and the Project Team contacted a number of organisations at the state level in an attempt to find more information. A consistent response was that this information is mostly not documented. This highlights the need for a national entity and registration of peer workers to be able to gain a better understanding of the current peer workforce and planning for the future.

The information on the number of peer workers from the respective states and territories that we have been able to source, though unsubstantiated follow:

1 South Australia

Public sector

25 Peer Specialists (Working approx. 18.5 hours per week)

8 Carer Consultants

Community Managed Sector

Approx. 50. Some contracts have expired due to Personal Helpers and Mentors and Partners in Recovery moving to the National Disability Insurance Scheme.

2 Victoria

Public sector

211 peer support workers of which 52 are carers and 159 are consumers

41 are full time and the remaining 170 peer workers are employed 3 days per week or less

Community Managed Sector

Whilst data has been sought, at this point in time, the Project Team is not able to provide this information.

3 Western Australia

Public sector

Response from the WA Peer Supporters' Network 2018 Report '*The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services,* http://www.comhwa.org.au/wapsn and the Western Australian Association for Mental Health's recommendations to the WA Mental Health Commission Draft Workforce Strategy indicated that data on the peer workforce in Western Australia was difficult to obtain.

From: The Peer Workforce Report - Uptake of the Peer Workforce in Western Australia

'There is a shortage of statistical information on the size and characteristics of the peer workforce for mental health and alcohol and other drug services. Peer workers are not recognised as workers by the Australian Institute of Health and Welfare (AIHW) for health workforce data collection purposes, and thus peer workforce rates are not available for primary care or private hospital settings. The current workforce data analysis tool being used by the disability services sector to measure NDIS related workforce changes also does not collect peer workforce data. AIHW mental health workforce data sets include peer workers but are restricted to public specialised mental health services and thus do not capture mental health workforce data within private and community mental health services. Where data is available, it highlights that peer workforce uptake has been limited in Western Australia. For the 2013-14 financial year, less than 5% of the total Western Australian Mental Health Commission funded community managed mental health service delivery workforce were peer workers24. In 2014-15, peer workers accounted for less than 0.2% of public clinical mental health service delivery workforce'.

Community Managed Sector

Approximately 102 peer workers employed part time.

4 New South Wales

Public sector

The Project Team believes there are approximately 90 positions (full time, part time and casual) in the NSW public sector, however data is not publically available.

Community Managed Sector

'Flourish Australia' has 163 peer workers (full time and part time).

'New Horizons' has 7 consumer peer workers.

Across South Eastern NSW PHN there are over 60 peer workers working in public and CMO services.

5 Queensland

Public Sector

Data not publicly available.

Community Managed Sector

Unable to source the data. However, there was a view that there is a real need for visibility of where positions are for the peer workforce positions in Queensland.

6 Northern Territory

Public Sector

1 peer worker

Community Managed Sector

2 carer peer workers

7 Tasmania

Public Sector

4FTE (2 carer and 2 consumer) another 6 to be advertised soon.

The Tasmania Government announced on 10th October 2018 that they are providing funding over two years to partner with the Mental Health Council of Tasmania to deliver the state's first ever comprehensive Peer Workforce Strategy.

Community Managed Sector

Unable to obtain this data currently within the NGO or private sector. However, it is hoped that the initiative mentioned above will provide this.

8 Australian Capital Territory

Public Sector

The Project Team has been unable to obtain this data.

Community Managed Sector

The Project Team has been unable to obtain this data.

Gaps and current challenges

In discussions with the Australian Institute of Health and Welfare on 7th September 2018, we noted the peer workforce is a valuable and meaningful role taking place across Australia; however, there is variation and variety in activity and data collections. What data is available is fragmented and there are currently no nationally agreed definitions other than those for a consumer worker and a carer worker, so little has changed it would seem from their 2016 brief report at this time.

This can be attributed in part to different models of care being developed, local circumstances, and the challenges both nationally and at the state and territory levels around nationally consistent definitions, description of activities and collection of data which would be crucial in making decisions about the current and future mental health peer workforce. This data also has the potential to influence policy. It will be crucial to have processes which provide a better view of the activities undertaken by peer workers.

As mentioned previously, the sources of data for the peer workforce in public mental health services are:

1) The Australian Institute of Health and Welfare's Mental Health Services in Australia 2018
2) Australian Institute of Health and Welfare's Report on Government Services 2018

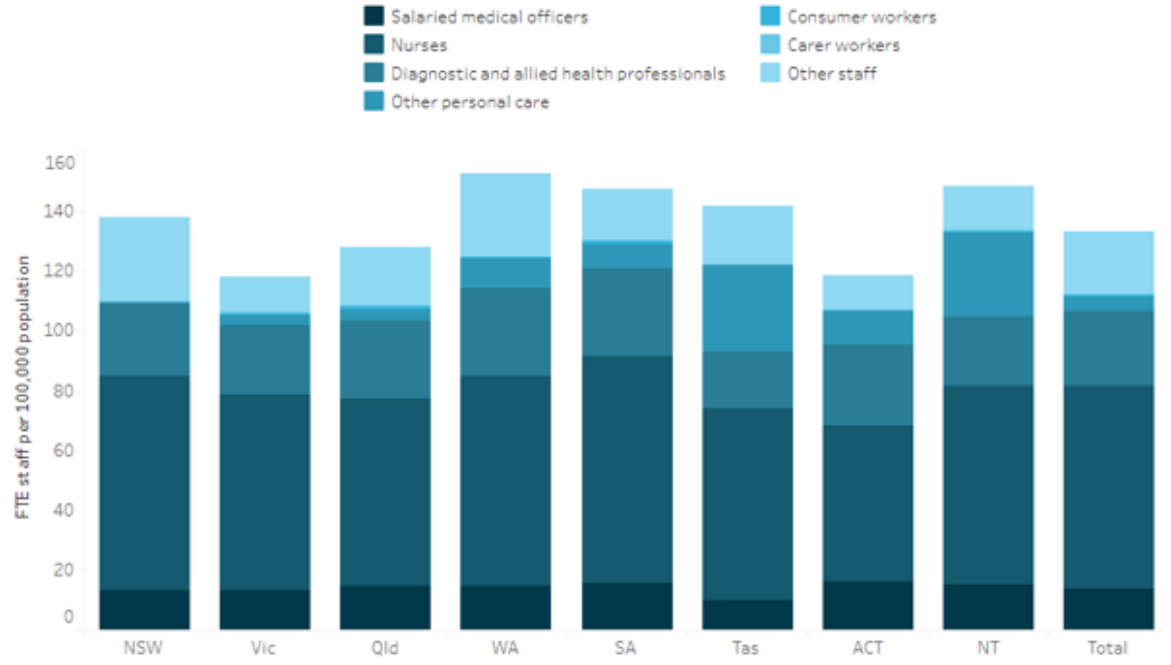
The data underlying these reports is the same in that both are derived from the Mental Health Establishment National Minimum Data Sets. The difference is that the Mental Health Services reports per 10,000 FTE and the Report on Government Services reports per 1,000 FTE.

1. Australian Institute of Health and Welfare's Mental Health Services in Australia 2018

This publication includes the number of 'Mental health consumer and carer worker employment' and reports per 10,000 FTE. The latest data shown in the graph below is extracted directly from this source. From this Report, the following has been extracted:

Consumer and carer involvement: Specialised mental health organisations employ mental health consumer workers and mental health carer workers; an indicator of the engagement of consumers and carers in the delivery of mental health services. The definition used to describe this workforce changed for the 2010–11 collection to better capture a variety of contemporary roles. Caution is therefore required when interpreting time series data for this workforce. See the key concepts for further information. In addition to reporting the number of employed workers, specialised mental health organisations also report the extent to which consumer committee representation arrangements are in place.

Table One: Full time equivalent staff per 100,000 population by staffing category, states and territories 2015-16



Source: National Mental Health Establishments database; Table FAC.36.

From the same Report the following information has been extracted.

Mental health consumer and carer worker employment

The data for 2015-2016 shows that, of the 170 specialised (public) mental health service organisations reported nationally in 2015–16, 79 (46.5%) employed mental health consumer workers and 42 (24.7%) employed mental health carer workers.

Nationally, the rate of mental health consumer workers employed increased from 29.4 FTE per 10,000 mental health care provider FTE staff in 2011–12 to 44.3 FTE in 2015–16; an annual average increase

of 10.8%. Over the same period, the rate of mental health carer workers employed decreased from 18.2 FTE per 10,000 mental health FTE staff in 2011–12 to 17.5 in 2015–16; an annual average decrease of 1.0%. This is a small change and caution is required when interpreting the data since small numbers of mental health consumer and carer workers may have a relatively large impact on the reported rates.

2. Australian Institute of Health and Welfare's Report on Government Services 2018

This publication includes the number of paid FTE consumer and carer staff per 1000 paid FTE direct care staff. The latest data shown in the graph below are extracted directly from this source.

Box 13.7 Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is defined by two measures, the number of paid FTE:

- consumer staff per 1000 FTE direct care staff; and
- carer staff per 1000 FTE direct care staff.

High or increasing proportions of paid FTE direct care staff who are consumer or carer staff implies better opportunities for consumers and carers to influence the services received.

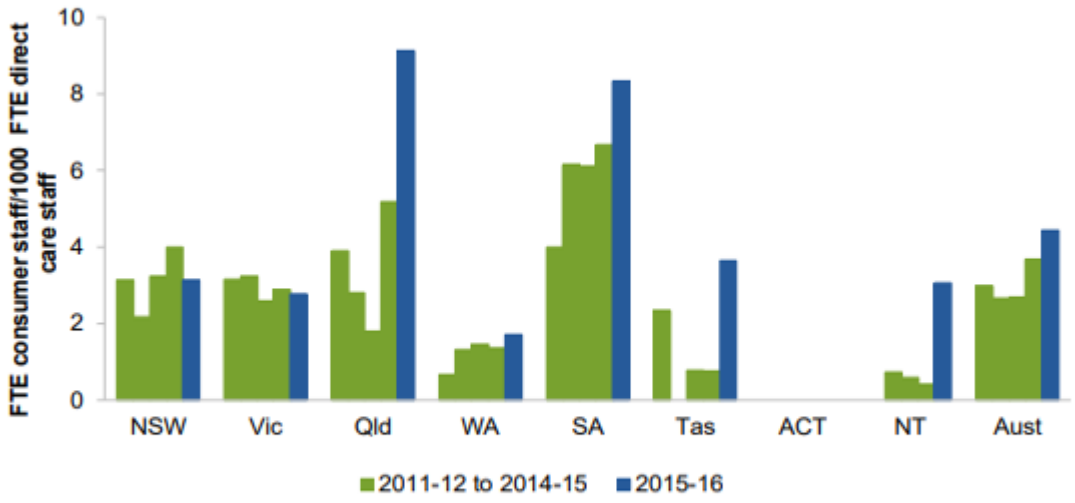
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data from 2010-11 are not comparable to data for previous years

- not complete (subject to caveats) for the current reporting period. Data are not available from the ACT.

Table two: The number of paid FTE consumer and carer staff per 1000 paid FTE direct care staff are reported in figures 13.6 and 13.7 respectively

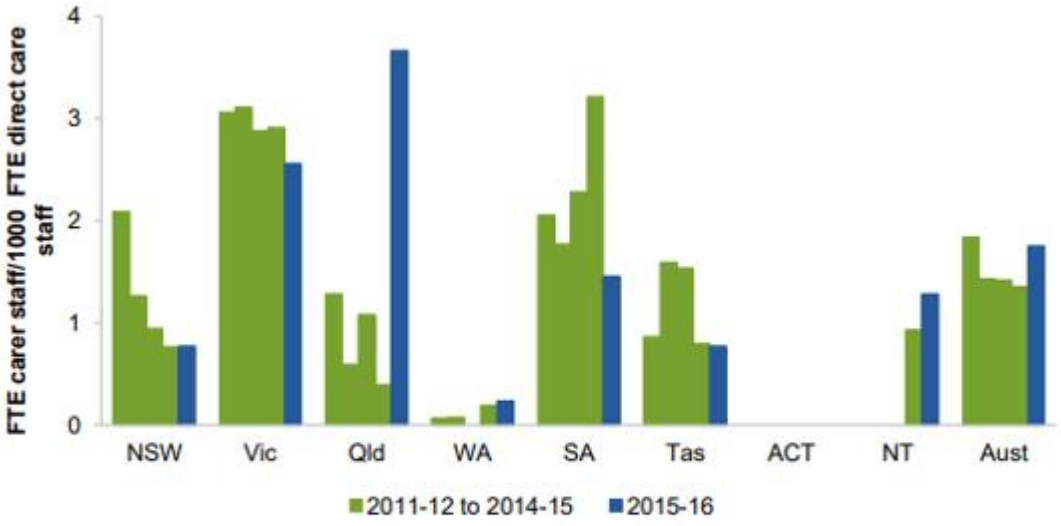
Figure 13.6 **Paid FTE consumer staff per 1000 paid FTE direct care staff[a, b]**



[a] See box 13.7 and table 13A.21 for detailed definitions, footnotes and caveats. [b] Tasmania did not employ consumer staff in 2012-13. Consumer and carer staff could not be separately identified in the ACT. The NT did not employ consumer staff in 2011-12. The Australian total excludes the ACT.

Source: AIHW (unpublished) MHE NMDS; table 13A.21.

Table three: Paid FTE carer staff per 1000 paid FTE direct care staff a,b



[a] See box 13.7 and table 13A.21 for detailed definitions, footnotes and caveats. [b] WA did not employ carer staff in 2013-14. Consumer and carer staff could not be separately identified in the ACT. The NT did not employ any carer staff in 2011-12 to 2013-14. The Australian total excludes the ACT.

Source: AIHW (unpublished) MHE NMDS; table 13A.21.

Community Managed Organisations

Work is being undertaken in the routine collection of data from the CMO sector by the Western Australian Mental Health Commission using nationally agreed definitions from the Mental Health Non-government Organisation National Best Endeavours Data Set (NGOE NBEDS).

In terms of a projection of growth of the peer workforce in Western Australia with the limited data, it suggests that the trends seem to be around 4% pa.

The WA Mental Health Commission has shared their resources with Queensland Department of Health which the Project Team understand are currently implementing this within their system.

This will be the first opportunity to have accurate figures from these jurisdictions about the extent of the employment of peer workers within the CMO sector.

Scope projected peer workforce for the next 10 years

The second part of this Section deals with the projection of the peer workforce and what this may be in 2027-2028. In terms of the growth in peer workforce, the data presented previously shows the increase is not consistent across Australia. There has been a considerable jump in consumer workers in Queensland and South Australia[5] in the last few years, which is largely driving the national figure of 10.8%. The numbers can still be quite volatile so again caution is required when extrapolating a growth trend which we have done, both referred to in the following tables.

The *National Mental Health Report 2013* noted the growth in rates of employment of consumer and carer workers in the early stages of the National Mental Health Strategy. Noted within that Report was a requirement since 2002-03 for mental health services to quantify the investments made in the employment of consumers and carers by reporting salary expenditure and numbers of full-time equivalent staff employed.

[5] Australian Institute of Health and Welfare's Mental Health Services in Australia 2018

The *Fourth National Mental Health Plan* advocated for substantial growth in the consumer and carer workforce and included a specific indicator to monitor the extent to which this is occurring, and this data is captured in the Australian Institute of Health and Welfare's 'Reports to Government'.

The table below shows the national full-time equivalent tally for consumer and carer workers employed in state and territory mental health services from the end of the *Second National Mental Health Plan* to the middle of the *Fourth National Mental Health Plan* (i.e., between 2002-03 and 2010-11). It shows that the number of full-time equivalent consumer workers has fluctuated over time, at its lowest at 54 in 2002-03, and peaking at 69 in 2012-11. It also shows that the number of carer workers has risen steadily and in 2010-11 reached about two thirds of the number of consumer workers. The numbers for both consumer and carer workers are still very low when comparing these figures to 1,000 FTE direct care staff for the same period; particularly given that that there was an increase over this period of 33% per 1,000 FTE in direct care staff.

Caution is required when interpreting these and the following data.

Source: National Mental Health Report 2013

Table four: Number of full-time equivalent consumer and carer workers employed in state and territory mental health services, 2002-03 to 2010-11.

	Carer workers	Consumer workers
2002-03 End 2nd plan	9	54
2003-04	9	60
2004-05	14	55
2005-06	15	61
2006-07	23	57
2007-08 End 3rd plan	27	64
2008-09	31	65
2009-10	27	65
2010-11 Mid 4th plan	43	69

The following table five shows that the number of consumer and carer workers employed in 2002-03 was 3.5 per 1,000 full-time equivalent direct care staff. By 2010-11, this had risen to 4.6 per 1,000. Although this represents a 33% increase, the penetration of consumer and carer workers into the overall workforce remains small.

Table five: Consumer and carer workers employed per 1,000 full-time equivalent direct care staff 2002-03 to 2010-11

	Carer workers (%)	Consumer workers (%)
2002-03 End 2nd plan	0.05	0.30
2003-04	0.05	0.32
2004-05	0.07	0.29
2005-06	0.07	0.30
2006-07	0.11	0.27
2007-08 End 3rd plan	0.12	0.29
2008-09	0.13	0.28
2009-10	0.16	0.28
2010-11 Mid 4th plan	0.18	0.28

The Australian Institute of Health and Welfare's '*Mental Health Services in Australia 2018'* shows the following figures per 10,000 FTE. This does confuse figures considerably given that the '*National Mental Health Report of 2013'* relates to 1,000 FTE. The purpose of looking at the figures has been to see the actual growth over time, which we have used to calculate the figures for the carer workers.

Mental Health Services in Australia 2018

From the Australian Institute of Health and Welfare's *Mental Health Services in Australia 2018,* the following statistics are noted:

> **Mental health consumer and carer worker employment**
> *Of the 170 specialised mental health service organisations reported nationally in 2015–16, 79 (46.5%) employed mental health consumer workers and 42 (24.7%) employed mental health carer workers. South Australia had the highest proportion of mental health organisations employing consumer workers (68.2%), while Victoria had the highest proportion of organisations employing carer workers (51.7%).*
>
> *Nationally, the rate of mental health consumer workers employed increased from 29.4 FTE per 10,000 mental health care provider FTE staff in 2011–12 to 44.3 FTE in 2015–16; an annual average increase of 10.8%. Over the same period, the rate of mental health carer workers employed decreased from 18.2 FTE per 10,000 mental health FTE staff in 2011–12 to 17.5 in 2015–16; an annual average decrease of 1.0%. This is a small change and caution is required when interpreting the data since small numbers of mental health consumer and carer workers may have a relatively large impact on the reported rates.*

Projection for the next ten years based on this would see:

Consumer workers

'*Mental Health Services in Australia 2018'* per 10,000 FTE
The average annual increase in consumer workers over the 4 years 2011-12 to 2015-16 was 10.8%. It could be estimated, therefore, that at an annual increase of 10.8% over the next 10 years until 2027-

2028 would see 150.78 FTE employed by then. Given exponential growth is probable, as cultural and policy changes lead to increasing adoption of peer workforce approaches, this represents a very conservative growth figure.

Table six: Projections for Consumer Workers to 2027-28

Year	Cumulative add if 10.8% growth each year	Outcome
2011-12		29.4
2012-13	3.17	32.57
2013-14	3.52	36.08
2014-15	3.89	39.97
2015-16	4.32	44.39
2016-17	4.79	49.08
2017-18	5.30	54.08
2018-19	5.84	59.92
2019-20	6.47	66.39
2020-21	7.17	73.56
2021-22	7.94	81.50
2022-23	8.80	90.30
2023-24	9.75	100.05
2024-25	10.80	110.85
2025-26	11.97	122.82
2026-27	13.26	136.08
2027-28	14.70	150.78

Carer workers

'*Mental Health Services in Australia 2018'* per 10,000 FTE
The average annual increase in carer workers over the 4 years 2011-12 to 2015-16 decreased; however, the Project Team noted during their consultations that, as of 2017-18, this does not seem to be the case. Given the 2013 Report shows the number of carer workers began at a lower base rate but has risen steadily to reach about two thirds that of consumer workers, and given the point of caution, we are noting a potential increase of roughly two thirds for carer workers, which would equate to an annual increase of 7.2%. It could be estimated that, at this rate of annual increase, 2027-28 would see 40.31 FTE carer workers employed (see Table seven below). The Project Team is reluctant to make these projections based on one Report which make these figures more speculative and no doubt seen as lacking validity.

The Project Team does not consider the figures we have extracted below will be representative of the carer peer workforce in 10 years' time, (2027-28) because we believe the growth rate will be much higher. If we are to maintain the carer workforce at two thirds that of the consumer workforce, this figure will no doubt be more like 100.52 FTE and not that indicated in Table seven below.

Table seven: Projection for Carer Workers to 2027-28 based on 7.2% Growth per year

Year	Cumulative add if 7.2% growth each year	Outcome
2011-12		18.2
2012-13		
2013-14		
2014-15		
2015-16		17.5
2016-17	1.26	18.76
2017-18	1.35	20.11
2018-19	1.45	21.56
2019-20	1.55	23.11
2020-21	1.66	24.77
2021-22	1.78	26.55
2022-23	1.91	28.46
2023-24	2.05	30.51
2024-25	2.20	32.71
2025-26	2.36	35.07
2026-27	2.53	37.60
2027-28	2.71	40.31

Community Managed Organisations

As mentioned previously, WA seems to be the only jurisdiction which has data from the previous few years, i.e. beginning in 2014-15. This shows an annual increase of 4% in paid peer workers' FTE. It could be estimated that, at an annual increase of 4%, we would see 44.71 FTE by 2027-28.

5th National Mental Health and Suicide Prevention Plan

The Commonwealth has recognised the need for greater clarity of the peer workforce across Australia. Within the 5th National Mental Health and Suicide Prevention Plan: Implementation Plan there is a recommendation under Priority Area 8: Action item 30. This articulates that 'Governments will monitor the growth of the national peer workforce through the development of a national mental health peer workforce data including data collection and public reporting' The Implementation Plan notes that commencing in mid-2018 and ongoing, the Mental Health Information Strategy Standing Committee (MHISSC) will take carriage of this Action by:

- Continued development of data sources to monitor the growth of the national peer workforce in public sector mental health services; and
- Identifying opportunities for reporting of employment of peer workers in the non-government sector, including PHNs.

The second part of this Action relates primarily to the community managed sector.

Summary

The Project Team has endeavoured to gain statistics and insight as to the current peer workforce and what could be a projected number of peer workers in 10 years (2027-28). It is evident that work is required to formalise definitions and roles in order to capture more accurate data.

The number of peer workers within the mental health sector for the next ten years is impossible to predict given the current and planned expansion of the peer workforce across various sectors and in various jurisdictions. What is reasonable to deduct, is the growth of the peer workforce will be far in excess of that of the last ten years.

Whilst data is collected from specialised mental health services (public), private sector data is not collected and the data for the community managed sector is just emerging, with WA having data since 2014-15 and Queensland hopefully collecting that data currently.

Recommendations

The Project Team recommends the following:

The National Mental Health Commission liaise with the Australian Institute of Health and Welfare and Mental Health Information Strategy Standing Committee to:

- Add data on peer workers as a requirement to all new data fields including the Mental Health Establishment National Minimum Data Set.
- Survey or stocktake current activities through:
  - Services and organisations;
  - various networks including those contacts obtained through this Project.

Additionally, the Project Team recommends:

- clearly define role descriptors and functions of peer workers;
- adopt annual collection of data on peer workers from community managed organisations and the private sector.

Section 3

Training

A requirement of the Project was to research the current training available for peer workers and gain an understanding of the number of trained peer workers in Australia.

The Project Team focused on those registered training organisations which provide the accredited Certificate IV in Mental Health Peer Work course. However, it is acknowledged that a number of organisations across jurisdictions also provide various short-term courses, for example the Intentional Peer Support (ISP), Wellways one day introduction to peer work and Recovery Colleges' introductory training. Of interest is the 2-day course offered by the Mental Health Coordinating Council 'Management of Workers with Lived Experience' aimed at creating a supportive and safe workplace for lived experience workers.

Initially the National Mental Health Commission provided funding to Community Mental Health Australia which contracted the Mental Health Coordinating Council to develop the resources for the accredited Certificate IV Mental Health Peer Work course. A National Management Steering Committee, National Technical Reference group and National Carer and Consumer Peer Work Qualification Reference Group was established.

This was followed by a Champions initiative to enable 30 peer workers to be trained in the Certificate IV Mental Health Peer Work and Cert IV Training and Assessment if required, to boost the trained peer workforce in Australia in order to train others.

After the initial release of the Certificate IV Mental Health Peer Work qualification, the course was modified in 2015 which meant that champions needed to update their skills. This was also funded by the Mental Health Commission but unfortunately resulted in a reduction of the number of trainers, in that not everyone elected to do the update. Access to updated materials became challenging in that those peer trainers already providing training could access them through the goodwill of the Mental Health Coordinating Council. These materials are now no longer available and so those trainers who have not been delivering training no longer have access to resources.

This background information has been provided to gain an understanding of some of the complexities surrounding the delivery of the Certificate IV Mental Health Peer Work qualification.

The Project Team initially gained information in relation to the Registered Training organisations (RTOs) that had the qualification on scope, through the Australian Government Department of Education and Training National Register of Vocational Education and Training.

The following RTOs were identified as having the Certificate IV Mental Health Peer Work qualification on scope, see Table eight below.

The RTO's were contacted in March 2018 by email and phone and followed up in, May, June, October and November where a response had not been received. Gaining information in relation to the delivery of the training and the numbers of peer workers trained was problematic for various reasons. Firstly, organisations had a specific contact person who held information about the course who in several instances never returned contact. Secondly, the organisations would not share information given the competitive nature of training providers and confidentiality and privacy; and thirdly, many

RTO's had the course on scope initially but after the update to the qualification they had not updated resources and were therefore not able to deliver the course.

Information gathered was also reliant on the organisation contact person to hold and provide accurate information.

Table eight: RTOs which have the Certificate IV Mental Health Peer Work qualification on scope

RTO	Training delivery status	No of students training delivered to	No of students obtained the qualification to date
VICTORIA Wodonga Institute of TAFE	Provide corporate training only	Not willing to divulge due to privacy	
Melbourne Polytechnic	Course has not yet been delivered		
Goulburn Ovens Institute of TAFE	Course has not yet been delivered		
TASMANIA Tasmanian Health Service		2014- 9 commenced (Students paid 5-10% of costs) 2016- 12 commenced (Fully funded) 2018- 34 places (32 funded positions)	6 0
WESTERN AUSTRALIA SMR Learning Services Pty Ltd trading as TrainSmart Australia	Course not yet being delivered		
AMA Training Services	Course being delivered	2018 - 6	
Health Training Australia (Inc)	Course not yet being delivered		
North Metropolitan TAFE	Course being delivered	2017- 10 2018-7 Have gained funding for 20 scholarships	10
SA Australian Institute of Social Relations	Delivered 2017- no longer delivering	2017- 2	0
TAFE SA	Course currently being delivered	2017 – 14 2018 - 11 + (2 continuing from 2017)	9 2
ACT Canberra Institute of Technology (CIT)	Course currently being delivered. Current	2017 - 9	

	students to finish mid-2019.		
QUEENSLAND Health Industry Training Queensland	Course currently being delivered	2016 - 7 students commenced online. 2018 - 5 continuing and have 24 months to complete	2
Jobtrain	Have not delivered as unable to find a qualified trainer		
Spectrum Training	Course currently being delivered	2016 - 1018	50
TAFE Queensland	Would not provide information due to privacy		
TAFE Queensland East Coast	Course delivered in 2017 Did not respond to request for numbers		
NSW MDS Training	Not delivering mainly due to students not being able to meet the cost of the course		
Mental Health Coordinating Council Inc	Currently delivering	2018 Currently studying 82	Original qualification CHC42912
	Scholarships provided to students		47 New qualification CHC43515 92
TAFE New England	Course not yet being delivered		
TAFE NSW - Illawarra Institute	Course not yet being delivered		
TAFE NSW - North Coast Institute Coffs Harbour & Kempsey	Currently delivering		
TAFE NSW - South Western Sydney Institute	No response		
TAFE Nowra	Currently delivering		
TAFE Wollongong	Currently delivering		
NT No RTO's on scope	No one qualified to train the course		

Some of the reasons reported for not delivering the course were:

- Students unable to afford the course fees
- Low number of students interested as no jobs available
- No-one qualified to deliver the course; of particular note is Northern Territory which no longer has a 'champion' available to provide training
- Unable to gain placements for students

Some of the reasons reported for students not completing the course were:

- Students become unwell
- Students struggle to do assessments

Other issues noted through discussions were:

- Course being delivered by trainer without the relevant Cert IV Mental Health Peer Work Qualification. E.g. Professional without lived experience
- Course being delivered by a carer with no trainer identifying as a consumer and vice versa
- No one to write the course material
- No access to the course material
- Course material requiring to be updated and adjusted for each state
- Lived experience not necessarily acknowledged by management staff of RTO and led to "burn out" of peer trainer.
- Low confidence in the RTO.

Summary

Due to the complexities in gaining information from RTOs, it is almost impossible to draw conclusive evidence of the number of trained peer workers in Australia who have gained the qualification.

The Project has, however, highlighted a number of issues pertaining to RTOs in delivering the qualification, as outlined above.

Information obtained through the consultations is reflective of how a national entity for peer workers may assist in resolving several of the issues identified:

- Setting standards for the peer workforce and peer trainers; and
- Providing support to Registered Training Organisations employing peer trainers.

Further roles may be:

- registration of peer workers will ultimately provide much more accurate data. This will allow better planning for supporting and training the peer workforce.
- Access to updated course materials.
- Identification of organisations willing to undertake student placement, mentoring by peer trainers or peer champions.

Section 4

Literature Review

An Australian and international Literature Review was undertaken titled: 'Toward Professionalisation', Exploration of best practice models in mental health peer work to inform the establishment of a national professional organisation [Literature Review]. This was delivered to the National Mental Health Commission on the 9th March 2018.

The literature review explored Australian and international best practice standards for mental health peer workforce development to inform the professionalisation of the peer workforce in Australia through the establishment of a mental health peer workforce membership organisation.

Given pre-existing literature reviews similar in nature undertaken in 2011, this literature review focused on peer reviewed journal articles and grey literature published between 2011-2017. A systematic search for peer reviewed journal articles across multiple electronic journal databases was undertaken using keywords "peer" and "mental health" with 30 journal articles meeting the inclusion criteria for further analysis. In addition, a google search for grey literature using the same key words was undertaken, with 34 resources selected meeting the selection criteria for further analysis.

A thematic analysis was undertaken on all literature identified with each item being analysed for common themes and coded accordingly.

Based on the results from analysing the literature, six common themes were identified which can be used to inform professionalisation of the mental health peer workforce in Australia and the development of a professional membership organisation for mental health peer workers. The common themes identified below are ordered by a) considerations for organisations and non-peer worker; b) considerations at individual peer worker levels; and c) considerations of the broader peer workforce. Each theme includes an associated recommendation to inform the development of a national membership organisation.

Theme 1: The importance of recovery oriented practice within services offering peer support and exploration of organisational culture to support the successful integration of peer support services.

Recommendation 1: ***Provide access to resources to support recovery oriented practice, trauma-informed care, organisational culture and best practice guidelines for peer work.***

A national peer support membership organisation in Australia could provide access to resources and training exploring recovery orientation, trauma-informed care and organisational change, and provide example policies and best practice guidelines to support organisations seeking to implement peer support initiatives. Education, training, guidance and advice on quality delivery of peer support services and effective leadership could be made available for those who manage or are considering offering peer support services within their organisation. Further training for social workers and mental health nurses on recovery oriented practices and their role in supporting peer work within mental health would assist in successful integration of peer workers in mental health settings.

Theme 2: Issues of stigma and discrimination and the impact this can have on the peer workforce, effective integration and delivery of peer support services. There is an identified need for education of non-peer staff on the functions, values and role of peer workers.

Recommendation 2: ***Provide access to training for non-peer workers to reduce stigma, discrimination and increase understanding of the value of peer work.***

A national peer support membership organisation in Australia could provide access to training, delivered by lived experience facilitators, to support non-peer workers' level of understanding and to support integration of the role, particularly within traditional mental health services. This could be extended to include co-facilitation by peers working with educational institutions, such as those delivering qualifications in health services e.g. mental health nursing, social work, psychiatry, psychology, etc.

Theme 3: The need for role clarity and a clear identity for peer workers and to support broader organisational and consumer and carer understanding of the peer worker role.

Recommendation 3: ***Provide role clarity and constructing identity for peer worker roles.***

This could be achieved through provision of example peer worker job descriptions, access to resources to support a deeper understanding of the role for peer workers, non-peer workers, organisations, and consumers and carers. The professional peer membership organisation could also support professionalisation of the peer worker role to increase credibility and demonstrate the value of peer work within mental health settings.

Theme 4: Exploring boundaries and self-disclosure in the peer worker role.

Recommendation 4: ***Provision of support, training and specialised supervision to navigate boundaries and self-disclosure***.

A professional peer membership organisation could support peer workers in navigating boundaries, self-disclosure and protecting their own health and wellbeing by providing access to communities of practice with other, experienced peer workers in addition to offering access to specialised supervision and training. Providing training and mentoring for non-peer staff and managers to understand the unique role of peer work could support their understanding of the different nature of boundaries for peer workers. The professional organisation could also provide example policies and procedures that organisations could adapt for their unique settings.

Theme 5: Supporting the ongoing health and wellbeing of peer workers.

Recommendation 5: ***Support and promote the mental health and wellbeing of peer workers through policies, resources and access to communities of practice.***

A professional peer membership organisation could provide example policies for wellness planning and access to specialised training, professional supervision, and communities of practice for peer workers to support their personal mental health and wellbeing. The professional organisation could also provide training and support to assist non-peer workers to have a deeper understanding and appreciation of the peer worker role.

Theme 6: Training, development, certification and professionalisation of peer workers.

Recommendation 6: ***Provide access to training, supervision and certification to professionalise the peer workforce.***

A professional membership organisation in Australia could develop and provide a core set of guiding principles and values for mental health peer work and an ethical code of conduct for peer workers. This professional organisation could also advocate for professionalisation and certification of the peer workforce including recognition through parity of remuneration for the specialised nature of the role. Offering access to specialised training, supervision and communities of practice would also support the ongoing development of the peer workforce in Australia.

The Recommendations from the Literature Review assisted in refining the Agenda for the face to face consultations and the on-line survey.

The Network is keen to promote the report on the Peer Project page of the Network's website; however, we are awaiting a response as to when and if the Literature Review can be made public. In the meantime, we have received permission to distribute the report to the Queensland Mental Health Commission and the NMHCCF in confidence. There have also been further requests as entities such as the PHNs are embedding or expanding their peer workforce.

Recommendation

The Project Team recommends that the National Mental Health Commission approves the public release of the Literature Review including posting onto the Project site of the Private Mental Health Consumer Carer Network's webpage http://pmhccn.com.au/PeerProject.aspx and if appropriate, the NMHC website.

Section 5

National consultations

The Project team conducted consultations with a representative sample of interested peer workers and other key stakeholders via workshops in each capital city, by email and telephone contacts for those peer workers located in major regional areas, mental health commissions, local level jurisdictional organisations supporting peer workers and an online survey.

During the consultations, the Project Team sought copies of policies and materials specific to the peer workforce. A number were received and are listed at the end of this Report.

People were advised of the consultations via the Private Mental Health Consumer Carer Network (Australia) website and directly to their 1200 'friends'; through Mental Health Commissions, community managed mental health peaks and member organisations. The survey link was distributed throughout consumer and carer networks through the National Mental Health Consumer & Carer Forum and National Register members, people who had registered their interest with the Network to receive Project information (Project Interest Register), and respective jurisdictional connections.

There was a strong view expressed during the Victorian workshop that any national member based organisation for the peer workforce should be representative of consumer peer workers exclusively. A view was expressed at the NSW workshop that whilst many were in agreement with this view at the consultation there was a feeling that the differences were not unsurmountable. A feeling expressed by a carer peer worker at the workshop was that both have more in common with each other than differences and whilst the workforce is still evolving, combining learnings would add strength to both. There are fewer carer peer workers in paid positions with limited job opportunities currently across Australia but having joint representation at the national level may support a focus on working toward rectifying this.

A narrow view has also been expressed as to whether peer workers employed within alcohol and other drugs, NDIS, other areas or volunteers engaged in a peer support capacity should be eligible for membership. These views were not representative of what the consultations highlighted. In terms of applicability of a national peer organisation to peer workers in the alcohol and other drug area, it should be noted that the National Qualification Certificate IV in Mental Health Peer Work CHC43515 is the same for A&OD peer workers with AOD electives.

Further, given this strong view from the Victorian consultation, the Project Team determined that a question as to membership should be included within the online survey which asked people:

***Membership: If we have an organisation who should it represent*?**

129 individuals responded to this question with 36 skipping it. Respondents believe that any organisation should represent all lived experience workers 48.8% (n=63 of 129) and both consumer and carer peer workers 29.4% (n=38 of 129) with only 9.3% responding to applicability for consumer peer workers exclusively (n=12 of 129).

ANSWER CHOICES		RESPONSES	
consumer peer workers exclusively		9.30%	12
carer peer workers exclusively		0.78%	1
both consumer and carer peer workers		29.46%	38
all lived experience workers		48.84%	63
Other (please specify)	Responses	11.63%	15

Given the sensitivity of whether an organisation should be exclusively for consumer peer workers, all comments received via the online survey in relation to this question are detailed below:

Comments

Everyone has lived experience from both sides of the fence and when I hear the perspective from a carer - it is enlightening, engaging because it opens the conversation to hear their voice and share mine. It provides a space to be safe and feel vulnerable without shame of having mental distress or a diagnosis. Its peers learning from each other and the arh ha wow moments in the conversations is powerful. It drives me to want to keep going and learn more about mental health from all sides.

All lived experience paid and not paid people

all consumer lived experience workers including peer educators, peer advocates, peer leaders

All 'identifying' peer workers. It could have streams for the more specific types. Consumer, carer consultants and lived experience workers could be welcomed to join as well. Liaison with interested non-lived experience workers could occur too.

Community-based ('non-clinical') rehabilitation and recovery workers. Note: We are at risk of losing this workforce that has been hard fought for with the NDIS.

I think all lived experience workers should be covered. It would be challenging to be a carer peer worker and not have your own issues too. Although there may be some issues with the approach of some who have a carer role. Nevertheless, this is a challenging role, and allows a different insight into mental health and the related issues and effects on those surrounding and supporting consumers. Looking at my circumstances, it would be helpful to have an organisation which supports and advises on career paths and how to engage with the system and consumers in a professional and ethical manner, considering my lived experience (in my case complex PTSD). I think that it would be good to have an organisation which advocates for consumers (isn't this already done by CoMHWA? and other organisations in other states??) and also lived experience people entering and engaging in 'formal' careers in mental health. However, I hope that 'formal' careers would not be seen as better or preferential to consumer peer workers. It would be good to have a place, value and voice for all and to honour the different choices, capacities and contributions we can all make.

Consumer Peer workers (paid & voluntary) Carer Peer workers (paid & voluntary) All Lived Experience workers (paid & voluntary)

2 specific sub-divisions which individually focus on the lived experience workforce (client)and those with lived experience (carer) to ensure lines are not blurred.

Represent all lived experience workers - consumer and family/carer peer workers - those in an advocacy/representative role and those who are employed as peer support workers, to provide one on one or group based peer support to consumers to support them on their recovery journey. I'd also like such an organisation to support managers/supervisors of lived experience workers to build their capacity to adequately support and develop peer workers within their organisation.

I believe that consumers and carers have such different experiences and needs that there should be two groups

peer workers

I think everyone

Lived experience workers and those training and employing peers.

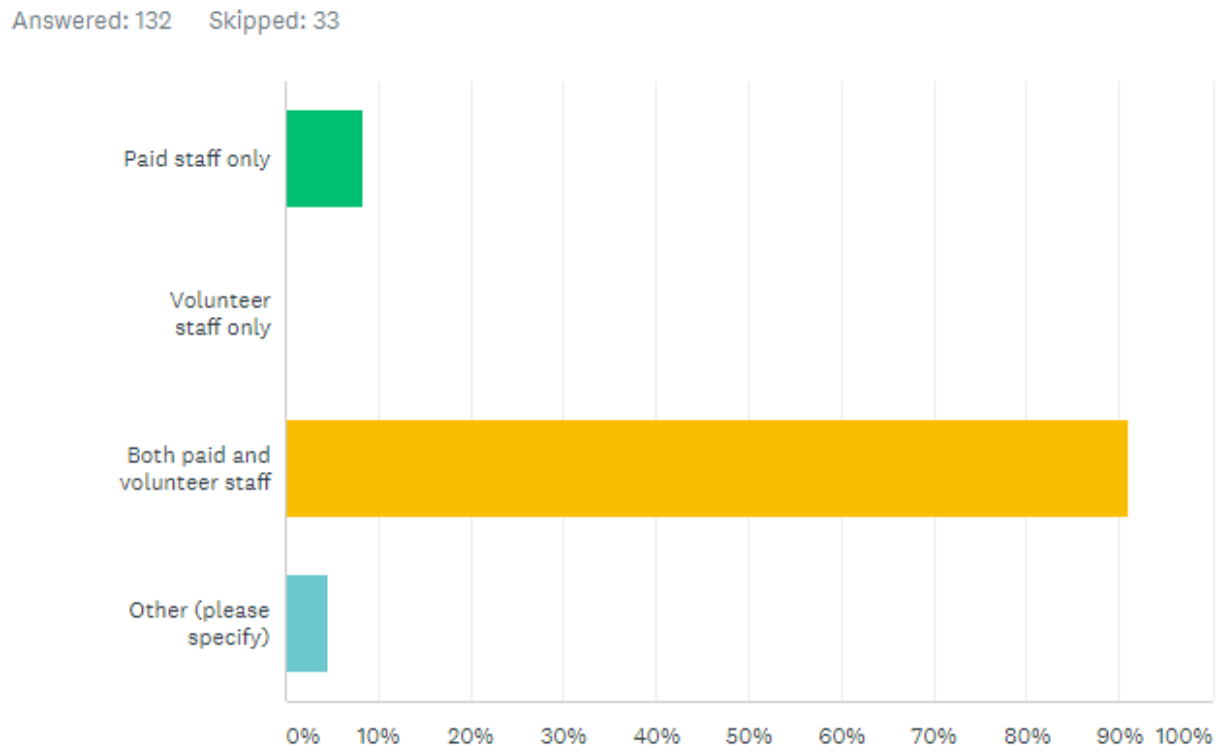
People with lived experience

Peer workers is a narrow term. I think carer specific and consumer specific organisations are appropriate, with collaboration between the two. I would not like to see people employed in declared roles not being invited to be part of either national organisation. For example, consumer and carer consultants, family peer workers, consumer and carer academics in declared roles, folks who work for mutual support self help (MSSH) sector such as Grow Australia. Grow employs many fieldworkers who have lived experience, but their role is not called peer. Also, the MSSH has many peer volunteers. There are also roles such as consumer or carer engagement roles.

Representation

A further question was included within the online survey in terms of whether an organisation should represent paid or volunteer staff. Given this sensitivity this question was also included within the online survey.

Respondents overwhelmingly endorsed both paid and volunteer staff being eligible for membership 90.9% (n=120 of 132)



Comments

Both are valid and valuable roles, which may fluctuate in people's lives and careers.

Again, sub-divisions. One for paid and one for volunteers. Volunteers have very different expectations and roles responsibilities than paid staff. Providing specific support to each I feel is very important. E.g. I would hope that volunteers are not 'used' within their roles as a substitute for paid staff to save organisations money!

Represent all lived experience workers - consumer and family/carer peer workers - those in an advocacy/representative role and those who are employed as peer support workers, to provide one on one or group based peer support to consumers to support them on their recovery journey. I'd also like such an organisation to support managers/supervisors of lived experience workers to build their capacity to adequately support and develop peer workers within their organisation.

Volunteers according to the National Standards are to be treated exactly the same and should be valued exactly the same as paid staff so this question shouldn't even be asked.

I also believe its time to pay all those who work in peer support - our work is worthwhile and important, even if done by volunteers.

Engagement with key stakeholders

This engagement is detailed hereunder.

TheMHS 2017 – A booth was set up and staffed for the full 4 days of TheMHS Conference in Sydney 2017. Contact was made with a wide variety of consumers, carers, people who identified as peer workers and representatives from organisations, including executive staff from consumer and carer peaks, expressing their delight that this feasibility study was being undertaken.

The most frequent comment was 'it's about time, we need something'. This view was also expressed repeatedly during the national consultations. Peer workers and those working in mental health expressed a real need for the peer workforce to have formal and professional representation at a national level with a view to providing a formal and 'professional lead' for the peer workforce. It was hoped that having a national entity would offer a contact point, a recognised educational resource and a source of factual, consistent and reliable information outlining what the mental health peer workforce is and is NOT. People who approached members of the Project Team during TheMHS offered encouragement to move ahead with the Project, expressed interest in being kept informed about the progress and looked forward to the proposed national consultations. There was concerns raised by many people that although there was a genuine need for an entity for the peer workforce, this may be stifled by other disciplines currently already established and with recognised roles and financial surety. Clinical mental health disciplines are well represented, both at a state and national level, and by some the peer workforce is seen as a 'threat' to potential future funding of clinical services. This view and a lack of understanding of the role and purpose of peer workers and the extent to which they contribute to improved connections and better outcomes for consumers supports the importance of a national entity.

TheMHS 2018 – The Community of Peers Project used the Network's booth to promote the Project. The Project banner was displayed, the promotional resources were made available together with the flyer promoting the 'Employers Guide to Implementing a Peer Workforce', Peer Workforce Hub, NSW Mental Health Commission. The distribution and promotion of this resource through TheMHS 2018, the Network contacts, National Mental Health Consumer & Carer Forum, National Register, Mental Health Australia and their members satisfies the requirement of the Project.

People were interested in the current status of the Project and were encouraging and hopeful the Project may lead to a national organisation for, and to represent the peer workforce.

The Senior Project Officer actively networked and utilised the opportunity to connect with a number of peer workers at the Conference and had more conversations (in particular) with peers from regional areas. The Senior Peer Project Officer also chaired a number of peer work sessions which outlined further aspects of the extent and variety of work that is undertaken by this workforce.

Workshops

The following workshops were held, and a total of **184** people were in attendance.

Adelaide	Thursday 7 December 2018
Melbourne	Thursday 15th February 2018
Sydney	Monday 26th February 2018
Perth	Monday 26th March 2018
Hobart	Tuesday 10 April 2018
Canberra	Monday 23 April 2018
Brisbane	Monday 30 April 2018
Darwin	Thursday 10 May 2018

The compiled notes of each of the workshops appears in full at Appendix A. These notes were provided to attendees of each workshop with an invitation to amend or correct any inconsistencies. Responses were extremely positive with little or no amendments received.

Telephone contact

Telephone contact was offered to people in regional areas, telephone calls were arranged and conducted, this included people from smaller towns. Feedback generally was that peer workers find it even more challenging and experience less support or understanding of their work. The teleconferences were mostly undertaken during the months of June and July but continued throughout August 2018. Every opportunity was utilised to speak about peer work, including during the Senior Project Officer and Peer Specialist attendance and participation at the National Suicide Prevention Conference in Adelaide in August 2018.

Direct phone contact was made with **28** regional peer workers.

A comment was made by a regional organisation which expressed serious concerns for the future of the mental health peer workforce, given the competing fiscal priorities and perceived lack of genuine commitment to this workforce.

Those interviewed included peer workers and consumers working in voluntary roles.

NSW: Port Macquarie, Coffs Harbour, Nowra, Shellharbour, Central Coast/Illawarra, Southern Highlands

NT: Darwin and Alice Springs

QLD: Mackay, Cairns, Rockhampton, Hervey Bay, Bundaberg

VIC: Shepparton, Mornington Peninsula and Bendigo

SA: Whyalla, Mt Gambier, Port Lincoln, Gawler and the Adelaide Hills

WA: Kalgoorlie and Albany (a poor response from WA)

TAS: Launceston, Burnie and Smithton

ACT: Nil – most of the ACT would not be considered regional

There were some understandable differences identified by peer workers based in regional areas, and this varied according to the size of the regional area in which the peer worker was working. These differences included the following:

- Isolation
- lack of connections to colleagues
- lack of resources and availability of training and professional development
- Limited opportunity
- Lack of appropriate supervision and the understanding for that need
- Lack of 'local' mentoring opportunities
- Potential for stigma was expressed as more obvious in regional areas with less support from senior/management staff
- Organisational 'ignorance' particularly in public mental health services
- Expressed concern by peer workers who feel there are particular barriers to understanding of the peer role and how peer workers can work effectively within a service in a 'local' community without being 'biased' towards people they may know
- The impost of travel, both time and expense
- The travel can be isolating and impact on a persons' emotional wellbeing
- Peer workers are often expected to cover their own cost and then have to 'fight' for reimbursement

Project Interest Register

From the outset of the Project, a register of interested persons was established. As at 30 November 2018 this numbered **310** people.

In order to further distil the information gained from the national consultations and phone contacts, an online survey via survey monkey of key issues that were identified and emerged was distributed to all attendees, through the Project Interest Register, our Network data base, through the NMHCCF and National Register. This saw a further **165** individuals provide direct input into the Project.

The Project Team believed that this approach best informed the Project as to delivering this part of the Project requirements. We are seeking agreement from the National Mental Health Commission to make the full responses from **On Line Survey** publicly available through our peer project link on the Network's website, with the section below containing the key responses**.**

Several themes emerged from the consultations which were consistent across Australia, with many aligned with the 6 areas identified within the Literature Search.

Main themes

- An organisation should represent both consumer and carer peer workers as well as all lived experience workers (except for Victorian consultation)
- An organisation would have a national base that includes individual state/territory representation
- The CEO would have both the right skills, expertise and experience and lived experience
- Board members should have professional skill set and lived experience
  An organisation would:
- Provide professional development opportunities
- Provide education and training
- Have a role to promote and provide factual, consistent information about the peer workforce

- Provide both individual and systemic advocacy
- Develop standards and promote the profession of peer work
- An organisation should support opportunities to further career pathways for peer workers
- Development of both a code of ethics and a code of conduct were strongly supported
- Development of national guidelines for the peer workforce was strongly supported
- Numerous support services an organisation could provide were identified

Some themes or specific issues emerged within the different consultations. These are captured in the following table.

Table nine: Details of national workshops

Compilation of notes of all Workshops appear in Appendix A.

Date	where	No	themes
7.12.17	Adelaide	29	• Staffing – the topic which generated the most discussion. • Most people were of the view that if possible, they would prefer staff to have a lived experience. • But the majority agreed that they consider the skills, expertise, attitude, character and understanding of the issues for peer workers and the value & importance of a MH peer workforce were the most important features to have in the staff, particularly a CEO. • Systemic advocacy for the profession of peer work is the key • Overarching standards including remuneration/awards and management/leadership training • Membership to comprise paid peer workers, volunteer staff and carers • Have respect for different perspectives and diversity • Accreditation of Peer Workers (credential) with recognition for prior learning and experience • Maintaining integrity for what it represents gives the org status. • **Mental Health Coalition of SA** The MH Coalition SA received funding from SA Health, Office of the Chief Psychiatrist for a Lived Experience Workforce Development Project. A small working group of peer workers was established from across the community managed mental health sector. This group has met regularly and has achieved the development of Standards & Guidelines. The standards and guidelines have been piloted by a non-government organisation in SA employing a number of peer workers. This has been very successful and highlighted how the implementation of such guidelines has enhanced the understanding of the organisation in employing people with lived experience and supporting them in their role. Further activities of the project have been a number of professional development days being held for peer workers and leadership for managers and direct supervisors of peer workers. These professional development days combine both public mental health and community managed mental health service peer work staff and volunteers. An excellent example of innovation and genuine collaboration across service sectors.

15.2.18	Melbourne	54	• There was a robust discussion about the differences between carers and consumers and the importance of keeping their representation separate as the perspectives are quite different. • Most consumer attendees expressed the view that they wanted a separate organisation for consumers and a separate one for carer peer workers. They sought a vote. Question: Those who want the organisation to be separate for consumers and carers: Yes 29 No: 1 Not sure: 3. • Mandatory supervision and training for peer workers • Peer internships. • Create unity for same practice within peer work. • Should registration be contingent upon undertaking PD? • Need for debriefing and support. • A national body would legitimise this occupation. • Detailed feedback relevant relevant to a consumer only organisation can be viewed within **Appendix A attached.** **General Comments**: <u>If organisation is both consumer & carer</u> – advocacy would be difficult and probably unethical because of views on some issues are **so** different. • Codes of ethics <u>must be different</u> Lived Experience workforce • <u>consumer</u> workforce – need a professional body at this level • peer work (direct with peers) peer support – individual and group • consultants who work with consumers at service level (these roles are blurred issue) who do systemic advocacy • other consumer workers – volunteers, consumer academics & leaders, advocates, consumer educators & speakers • There is enough complexity here for an organisation (without adding the different perspective of carers) • carer workforce?
26.2.18	Sydney	20	• Good discussions on Governance. • Importance of how the organisation is structured. • Some discussion as to whether the organisation should represent both consumer and carer peer workers. • Discussion on differences between consumer peer workers and carer peer workers. • Did not identify insurmountable barriers. • Saw the potential to have a national organisation with 'branches' or 'sub branches' that represented both consumer & carer peer workers. • Participants were keen to know what the make-up of attendees was i.e. how many peers and how many managers? Question: Who identifies as a lived experience worker – 8, Manager: -11, those in lived experience role and manager:-3 • Should it represent carers and consumers? Statement of intent- need to understand the different skill set and felt that the consumer movement needed its own professional association. Felt having consumer and carer arms may be possible but jobs are completely different. o Change of language would assist in defining the roles o Many carers are employed as lived experience workers in NSW. Carer peer workers are often confused about their role.

			○ If we have an overarching group, it would need to have separate arms. ○ Leadership roles need to be in relation to the number of consumer/carer workers as the majority of peer workers are consumer roles. Having a strong voice is important and we would therefore need to be united. • Staffing - Looked at other bodies such as AMA, are the executive doctors? ○ Ideal would be if they have lived experience and the leadership skills. ○ Skill set for the purpose of the organisation is essential. ○ IMHL were looking to establish a professional association that was consumer run and would be staffed by people with lived experience. ○ People with skill set need to understand lived experience or we nurture people with lived experience to gain the skillset. ○ People with lived experience should be at all levels not just because of their lived experience but because of the roles and other skills that they bring. • An important role for the organisation is to help to define roles of peer workers, provide clarity of roles and may lead to better defined roles. • **General Comments:** Union - Will employers see this as a union-type organisation? Additional detailed comments from a participant sent via email.
26.3.18	Perth	21	• Robust discussion on governance – concerns about equality, how WA would be represented, or if they would have representation at the Board level of any national organisation. • Concerns about: ○ their distance from Eastern states and that evidence is they do not get an equal share of funding ○ A national organisation may be funded to represent states with population-based funding, this would put WA at a disadvantage • Felt it important that where there are existing organisations with established peer networks, or where there is a state-based entity representing MH peer workers, it MUST be linked in with the national entity. • Concern that existing infrastructure and Peer Networks in WA and the potential impact on these as there has been a lot of development work done to date. • The national entity should not be established to the exclusion of any state-based orgs. • Instead of separate branches, capacity build and support local peaks (peer support orgs) to take on this role. • Views divided in terms of CEO and requirement for lived experience. Some felt skill set was most important criteria, others felt strongly that majority of staff should be lived experience and recruitment should be targeted to preference for those with a LE. • Education should deliver intentional peer support. • Link training to that being provided by other orgs. • Peer oriented training – for peers, by peers. • Work with other orgs to deliver training, not compete with them. • Learn from and partner with local organisations

			• Supporting local orgs (in a hub and spoke model) • Promote the value of peer workforce, capabilities of peer workers, inclusion of peer workers and how peer workers are different to clinicians. • Have standards for rates of pay, leave, benefits. • Need both code of conduct and code of ethics but who develops these? **General Comments** o A number of participants felt strongly that the wheel should not be reinvented. o Local organisations that may be consumer peaks, or have established support networks/training for peer workers should be supported to capacity build. o Avoid alienating of local organisations/services.
9.4.18	Hobart	17	• Participants were very enthusiastic about the possibility of this potential entity towards the professionalisation of the peer workforce. • Some similar concerns to Perth in their isolation and being represented adequately or equally. • Important to have local representation with reach into the national entity or to have a Tasmanian rep in the national organisation – someone who spoke with or on behalf of Tasmanian peer workers. • Org should only be for peer worker members • National org to represent peer workers • Do not want orgs to be members • Need to offer both training and professional development • Org cannot provide individual advocacy • Systemic advocacy promotes peer workforce with the intention of reducing stigma • Standard rates for pay • Set it apart from other disciplines. • Should be code of ethics for peer workers and a different one for employers • Looked more broadly for how peer workers could be utilised e.g. housing, Centrelink, justice, etc.
23.4.18	Canberra	11	• Entity independence is vital. • Preference for individual state/territory representation at a governance level. • Coordinate training. • Provide all professional development, education and training. • Mentoring for staff with a lived experience in the organization in HR policy. • Equip peer workers to oversee training – educate community and health professionals. • Importance of establishing a Code of Practice similar to those of other professional bodies. • A clearing house of information on the peer workforce. • Provide phone support for peer workers and industrial advice as needed. • Provide an information source for organisations, service providers. • Coordinate ongoing training opportunities, oversee an annual conference for peer workers. **General Comments** One of the participants:

			○ asked if we would accept written comments. ○ Stated that PMHCCN need to make sure every effort is made to contact peer workers – advised about planned survey after the consultations
30.4.18	Brisbane	14	• Lead organisation should be for carer and consumer peer workers. • Something like the ASW or AMA • Could have sub-branches in states or those that already exist • May not have funding to set up a representative in each state • CEO needs to be a role model for people living with mental illness. • This lead organisation needs to be for carer and consumer peer workers. • It could have sub-branches in states or utililise those (networks or orgs) that already exist • Could be co-hosted in the Mental Health Commission. • Must have independent roles that are paid by the entity and should be co- located to minimize costs e.g. staff could sit within a peak body. • Very important that the peer workforce needs a national entity to represent them. • All attendees felt very strongly that staff at all levels needed to have a lived experience and should lead by example. • Strong views that the entity be responsible for establishing guidelines and standards. • Must have the capacity and resources to advocate at a system and individual level. • Needs to lead by example, provide employment for those with a lived experience. • Promoting asset value of having people with lived experience and benefits. • Diversity of peer workforce • Contact point for organisations. • Central advisory body. • Clearing house of information – self- care etc. • Education and development. • Dispelling myths associated with lived experience. • Showcasing lived experience work and sharing success stories. • Professional development opportunities.
10.5.18	Darwin	18	• Despite 18 in attendance, only 3 peer workers present which shows the lack of focus on the peer workforce in the NT and the lack of formal training etc • Attendees very keen for an organisation that may assist in formalising a peer workforce in the NT. • No current training in the NT – pathways, no workforce structure • Important to reducing stigma and discrimination. • Value of importance of the peer workforce in the NT. • Representative from peak body needs to be based in the NT (they need to access broader body of remote voices) • Help to connect, establish and promote the value and embed the peer workforce in the NT. • Provide a formal structure and guidance for the peer workforce. • Would assist organisations to understand what they need to have in place to employ and support peer workers.

			• Cultural diversity – understanding the local context. • Advocating for National training to be available in the NT. • Provide an awareness of peer worker and the lived experience value add.

Engagement with Mental Health Commissions

Whilst members of the Project Team were in the various locations, additional meetings occurred. These are detailed below.

NSW: Met on 26 February 2018, with the NSW Mental Health Commission.
WA: Met on 26 March 2018 whilst in Perth for the WA consultation.
QLD: Met on 1 May 2018 whilst in Brisbane for the QLD consultation.
SA: Met on 2nd August with Commissioner Chris Burns.

Engagement with local level jurisdictional organisations supporting peer workers

Members of the Project Team met with the following organisations:

Table ten: Face to Face engagement with jurisdictional organisations supporting peer workers

15 February 2018	Mind Australia, VMIAC, Tandem
16 February 2018	Dept. Human Services Victoria, Health and Wellbeing Division and the Mental Health and Consumer & Carer Workforce Project Team
16 February 2018	Neami National, Victoria representative
26 February 2018	NSW Mental Health Branch (Ministry of Mental Health)
26 March 2018	Consumers of Mental Health WA, HelpingMinds
27 March 2018	Western Australian Association for Mental Health
27 March 2018	Private Mental Health Consumer Carer Network (Australia) WA
10 April 2018	Tasmania Health MH, AOD Branch
10 April 2018	Chief Psychiatrist, Tasmania
11 April 2018	Mental Health Carers Tas
11 April 2018	Mental Health Council of Tasmania
23 April 2018	Mental Health Community Coalition ACT
24 April 2018	Carers ACT
30 April 2018	Corporate Services, Mental Health Carers QLD
9 May 2018	Team Health
10 May 2018	Mental Health Directorate Strategic Policy and Planning Mental Health Directorate, Department of Health
10 May 2018	Carers NT
11 May 2018	Mental Health Coalition NT
11 May 2018	Industry Skills Advisory Council of NT.

Engagement with the Community Mental Health Australia (CMHA) member peak community managed organisations

The CMHA member peak community managed organisations were contacted, responses are detailed below to the following:

Please advise if you provide:

1. *Support/networking opportunities for peer workers*
2. *Training for peer workers*
3. *Promotion of the peer workforce*

1) Mental Health Council of Tasmania

- Peer workers attend triannual Regional Mental Health Group meetings, held around the state for front line/team leaders in mental health
- Peer workers can become members and attend MHCT events/training throughout the year
- Do not offer any specific training to peer workers
- Promotes the peer workforce where needed in enews, social media posts, and throughout networks when attending meetings and relevant events.

2) Mental Health Community Coalition ACT

- Believe a national organisation should have responsibility for monitoring training and registrations and accreditation. The professionalisation of the lived experience workforce would be strongly supported if there were a national organisation and this would be a significant step in building the credibility and professional status of this workforce.
- See a role for the MH Community Coalition ACT in working with a national peer workforce organisation, particularly in the area of training, supporting and offering networking opportunities to peer workers, and working with member organisations and other stakeholders to contribute to the growth of the peer workforce in the ACT.

3) Mental Health Coordinating Council

- Provides student supports to all of our Certificate IV in Mental Health Peer Work students. Also provides general networking opportunities through our networking event "Meet Your Neighbour" which are run in locations all over NSW (this is not peer work specific though).
- MHCC coordinated the development of the Certificate IV in Mental Health Peer Work (on behalf of Community Mental Health Australia). MHCC now offers CHC43515 Certificate IV in Mental Health Peer Work to peer workers in NSW. To find out more about this project please visit the project page: http://www.mhcc.org.au/project/mental-health-peer-work-qualification-development-project/
- The Certificate IV in Mental Health Peer Work is a qualification that has been developed specifically for peer workers (consumer or carer) to meet the needs of the growing peer workforce. MHCC offers both a standard Certificate IV in Mental Health Peer Work (14 days of face to face training) as well as the Fast Track option (for those with two or more years' experience in a peer work role). MHCC has offered this qualification in Sydney, Newcastle, Wollongong, Wagga Wagga and Queanbeyan. For more information about the Certificate IV in Mental Health Peer Work please visit our website: http://www.mhcc.org.au/learning-development/courses/?search=&course-type=nrt
- MHCC has also run some internal customised professional development to a number of organisations who are beginning to grow their peer workforce including a 2 and 5 day "Induction to Peer Work" program.

- MHCC recognises and advocates for the importance of the peer workforce and the unique and crucial supports that peer workers can provide. As mentioned above, MHCC was a driving force behind the creation of the Certificate IV in Mental Health Peer Work. Further, since 2015 MHCC has been funded by the NSW Ministry of Health to provide funded scholarships for peer workers to complete the Certificate IV in Mental Health Peer Work. This has allowed over 100 peer workers to complete their qualification and get their experience recognised across NSW. MHCC is now offering another round of scholarships for qualifications that will be run across NSW from 2018 – 2020.
- MHCC also promotes peer support groups and links to Peer Worker job advertisements through our weekly e-newsletter FYI.

4) Mental Health Coalition of SA

- The Lived Experience Workforce Program (LEWP) Reference Group has proved to be a powerful network of LE workers and leaders who support each other and lend their expertise to the LEWP project as well as consultation, e.g. meeting with the SA MH Commissioner to peer workforce and opportunities.
- Person with lived experience leads a co-design team that develops and runs regular PD activities for peer workforce - offered to peer workforce in NGOs and SA Health.
- Lived experience leader a co-design team who develop and deliver training for leaders of LEWs - aimed at supporting leaders to recruit, develop and support their LE workforce.
- The co-design teams for both are 100% LE
- LEWP have co-designed Toolkit for Organisations to support recruitment, retention and growth of LEW. Being finalised at present - website revamp in progress and these will be available for download.
- from February 2019 we will have a Community of Practice for NGO Mental Health peer workforce. ToR developed by the LEWP Reference Group and while LEWP will convene the CoP it will be run by the members. First meeting date has been set.
- In an indirect way, the Standards and Guidelines support peer workforce by helping organisations to be fit and ready to recruit, lead and support their peer workforce. Feedback from Uniting SA Executive was that they didn't fully understand their peer workforce or its potential until undertaking the S&G audit process.
- LEWP developed the proposal that led to subsidised places at TAFE for Cert 4 in Peer Work. We also supported the Peer Champions to become trainers.
- PD days for LEWs
- NGO Mental Health LEW Community of Practice (from Feb 2019)
- Sharing training opportunities through the network
- PD opportunities through participating in workshops and forums held by MHCSA. We aim to have as many peer workforce/people with LE as possible in these forums, to give voice and include the collective wisdom of the people with LE.
- Within the NGO sector - Standards and Guidelines - development and implementation support
- Leadership training through LEWP
- Lived Experience Workforce Project and LEWs participating in MHCSA workshops and forums
- SA Mental Health Services Plan – Lived experience manager sits on the Workforce group and is promoting the peer workforce alongside others from Centacare and other LE champions.
- Threading LE through all the work of the MHCSA, e.g. through our workshops, the Human Rights work currently underway, work with the SA MH Commission, OCP.
- Advocating for peer workforce to be named in service contracts - this is definitely WIP
- New project - we have just recruited a Peer Leader as part of the national Reimagine Today website re-design. Will be developing LE networks and undertaking consultation as widely as

possible to influence the website redesign and hopefully NDIS language beyond the skin of the website.

- Sharing project, information through MHCSA membership and LEWP mailing list.
- Advocacy in NDIS work - peer workforce is always advocated for and promoted.
- Presentations to organisations considering LEW (both within MH services and other businesses)

5) NT Mental Health Coalition

- One important role for a member based MH peer work organisation is to be the 'gatekeeper' for a trained, professional peer workforce. The organisation would be responsible for a registration process for members qualifications. There is also the potential for the peek body to offer accredited training to the peer support workforce.
- The organisation should have members who have undertaken the necessary accredited training in Mental Health Peer Work – to then be able to register with a peek body
- Initially membership may be from a broad peer workforce base, and as a future role the organisation could be responsible to ensure that the peer workforce comprised people who have either done their Cert 1V in MH Peer Work, or equivalent.
- See the organisation as having an important role in ensuring that the peer workforce is not only seen as a recognised profession, but that those who work in the roles hold the necessary qualifications and competencies

6) Western Australian Association for Mental Health (WAAMH)

There could be a role for WAAMH. As to what it could look like there are several realistic (and practical) possibilities.

Engagement with the four state peak organisations representing consumers

The four state consumer peak organisations were contacted and the following formal response was received from CoMHWA.

1) Consumers of Mental Health WA (Inc.)

We are concerned that not all states and territories have mental health consumer peaks and there is no national consumer peak. We see the establishment of a national consumer organisation as an essential step forwards and requisite for a peer workforce association, in order to:

- offer guidance and support to the peer workforce as it develops, based on the values, principles and direction for peer work sought by the lived experience movement in Australia;
- provide essential co-production partnerships with consumers at federal level for current and future initiatives to grow and develop the peer workforce;
- ensure access to an essential groundswell of support for peer work from people with lived experience;
- effectively address and manage the tensions between occupational formalisation and ongoing connection to lived experience philosophies, leaders and approaches (the 'professionalisation' debate).

We are of the understanding that significant variation exists between states and territories about their preferences and priorities for peer workforce development. A final report that is made public and which accurately captures the consultative feedback received is essential to support

the project's recommendations going forwards, given the project is with regards to a future occupational, representative association.

As was raised in the Perth consultation workshop, Western Australian members are at risk of disadvantage with respect to national associations as a result of tyrannies of distance and geographic scale that lead to unbalanced resourcing. Members from WA would not be able to equally participate in association activities based in Canberra, Sydney or Melbourne. However, in considering any establishment of a local branch structure to remedy this, there are also risks to WA peer workers in the form of: undercutting of development and capacity building already underway and reduced autonomy of peer workers to set and lead the priorities and direction of peer work at state level. At the same time there is a need for more coordinated peer workforce representation at a national level alongside other occupations in the health and community services industry to support recognition, establishment and growth.

We therefore recommend the following post-project directions:

1. A project to establish a national mental health consumer association;
2. A medium term focus on building and supporting capacity of local peaks to undertake development work towards a future national peer workforce association, and/or federal investment in regional peer workforce capacity building that supports peer workforce groups, networks and organisations to identify, implement and share outcomes of priority workforce development initiatives in their regions;

In terms of CoMHWA provision of services to peer workers, CoMHWA supports and advocates for the growth of a widely available, valued peer workforce. We undertake training (including non-VET training and a VET training partnership), systemic advocacy to promote and support the peer workforce, and innovative peer-led projects. CoMHWA also hosts the WA Peer Supporters' Network, a forum led by and for peer supporters (people offering support on the basis of a shared lived experience and/or identity, across sectors and walks of life, and in formal or informal roles). The WA Peer Supporters' Network exists to promote peer support, build knowledge, skills, connections and access to support for people in peer support roles. CoMWHA and the WAPSN co-host a Peer Workforce Champions' Community of Practice for those involved in developing the peer workforce within their agency or sector to support best practice exchange and collaborations in peer workforce development.

Engagement with a representative sample of state peak organisations representing carers

The Project Team made contact with the following organisations seeking responses to the same questions.

1) Tandem Inc. formerly Victorian Mental Health Carers Network.

Question: Support/networking opportunities for peer workers

In Victoria, people employed in carer lived experience roles come together as the Carer Lived Experience Workforce (CLEW) network, which is a member based network. The executive is elected biennially. This network is the successor to the Carer Consultant Network of Victoria (CCNV), which was established in 2001[6]. The new name reflect the need to incorporate the many types of lived experience workers across a range of peer roles now being established

See history of the lived experience workforce movement in Victoria at http://tandemcarers.org.au/history-of-the-carer-lived-experience-workforce.php, including a timeline of important milestones of peer workforce at http://tandemcarers.org.au/images/Tipsheet-History-of-the%20LEW-v1-20180806.pdf

across the state in DHHS funded roles, public mental health positions and the broader mental health community support services, and particularly incorporates the many peer support workers now in the system. The essential role of the network remains as originally envisaged – to articulate the role of peer work; to support peer workers; to lobby for greater recognition of the value of this workforce in the services; and to work towards a full professional association. Tandem was instrumental in the establishment of the CCNV and continues to provide logistical and secretariat support to the CLEW. Support for the carer workforce is one of the priorities outlined in the Tandem Strategic Plan[7]. Since the inception of the CCNV, supervision of workers has remained a key issue for the lived experience workforce, and meetings have always included a component of discipline supervision.

Question: Training for peer workers

Tandem recognises the importance of training of the carer lived experience workforce and has been involved in the development of training curriculum and standards and delivery mechanisms for over a decade. Tandem has supported the development and delivery of Certificate IV in Peer Work, and has provided subject matter expertise to several of the learning providers that include this course on its scope. Tandem has also worked closely with the workforce division of DHHS to develop the workforce development framework which the department will provide as guidelines for services as they employ lived experience. Tandem has also been closely involved with the adoption of Intentional Peer Support (IPS) as the default training for lived experience workforce members who have been employed in the past three years under the post-discharge workers scheme.

Question: Promotion of the peer workforce

Tandem continues to promote and lobby for the proper recognition and support of the peer workforce as an important mechanism for improvement of the mental health system. Tandem is committed to supporting the CLEW and its development, through auspice of funded projects and organisational support until such time as the workforce is fully embraced by services, has appropriate training, and is a mature discipline. CLEW and Tandem Board members have also been instrumental in the development of the Carer workforce strategy and CLEW, with the support of the DHHS workforce division, have completed work to develop the carer workforce values and principles.

2) Mental Health Carers Tasmania

- Funding resources prevent support/networking opportunities for carer peer workers.
- Have partnership with RTO Connect, which provides 6 FREE places for carers for Mental Health Peer Work Certificate IV Carers
- Promote the value of peer carer workers in everything we do.

3) Carers ACT (Representative of Carers Australia's jurisdictional member organisations)

- Supports a number of carers to enroll in the Certificate IV Mental Health Peer Work
- Doesn't currently provide specific support or training for carer peer workers.
- They do promote the value and need for a well-supported mental health carer peer workforce

[7] http://tandemcarers.org.au/strategic-plan.php

4) **HelpingMinds** (Formerly Mental Health Carers Arafmi WA Inc as a representational organisation for the former Arafmi brand now known as Mental Health Carers)

- Has a role in providing supervision and support for both consumer and carer peer workers and to ensure peer workers received appropriate external supervision
- On reflection; would suggest that having employees of a national peer organisation based throughout each state could potentially not get the desired engagement from all local agencies as many already feel they have peer work covered. Have noticed, of late, a real increase in employment by other agencies of peer workers both government and NGO. A way to co-ordinate and collaborate this nationally is what is required in my opinion.
- At HelpingMinds - We currently have a peer and carer peer workforce. To date the structure has been treated the same as the regular workforce and feel this may not be the best option. We provide separate educational pathways and supervision for our Peer workers. This is continually developing and feel this is crucial.

Engagement with a representative sample of Primary Health Networks (PHNs)

The Project Team made contact with the following sample of PHNs and asked the same questions:

1) Brisbane North PHN

- The Peer Participation in Mental Health Services (PPIMS) Network was established in April 2016, there were 70 attendees, PPIMS Network has monthly meetings held in 2 locations. A regional combined meeting is held on a quarterly basis (Feb, May August and November).

- During 2016, the PHN undertook a Peer Participation Project to develop a regional framework to increase the active participation of people with a lived experience with mental health issues in the development, implementation and evaluation of mental health services in the Brisbane North Region. PPIMS Network was one of the key activities undertaken.
- In August 2018 there were 260 members on the mailing list. The first meeting in April had 70 attend.
  The National PHN Mental Health Lived Experience Engagement Network (MHLEEN).
  Brisbane North PHN was invited by the DoH to manage the project.

  Purpose and Functions:
- The key purpose of the Mental Health Lived Experience Engagement Network (MHLEEN) is to provide support to PHNs in a way that enables them to create an enhanced operational environment that supports not only lived experience and co-design within commissioning mental health and suicide prevention services but also is mobilised from within PHNs themselves.

2) South Eastern NSW PHN

COORDINARE has commissioned services that include peer workers:

- Complex Mental Health – Peer workers working with mental health nurses (Grand Pacific Health)
- Physical Health Coaching – peer workers working as Physical Health Coaches (NEAMI National)
- Suicide Prevention – suicide aftercare for people discharged from ED following an attempt or ideation
- National Psychosocial Support – a commissioning process is underway to develop a peer work service to deliver psychosocial support.

Question 1: Support/networking opportunities for peer workers?

Mental Health Peer Coordinator

My position Mental Health Peer Coordinator is unique amongst PHN's, as indicated in the Position Description: "The Mental Health Peer Coordinator will advocate for consumers across the region in all aspects of the commissioning of solutions in mental health. This person will also assist to develop and provide support for the peer workforce in the region."

One of the Key Accountabilities of the position is to "Contribute to the development of the peer workforce strategy and provide support to peer workers across the region." In this capacity I look to support and develop peer work across the PHN, to provide guidance/reflection/planning advice to individual organisations and to provide supervision and mentoring to individual peer workers

Peer Work Networks

In 2017/18, the SENSW PHN has established and supported three peer worker networks across the PHN. These networks are for all mental health peer workers from LHD's and CMO's (Private will be welcome)

- Illawarra Shoalhaven Peer Worker Network - 32 peer workers
- South Coast Peer Worker Network – 17 peer workers
- Southern Tablelands Peer Worker Network – 13 peer workers

Each network meets quarterly for three hours, followed by a networking lunch. A draft term of reference attached. SCPWN and SCPWN have arranged for a joint meeting in December. The PHN funds room hire and either morning tea or lunch at around $10 per person.

All employing organisations have agreed to release peer works to attend during work time.

Question 2. Training and Development

The networks have proven useful for training

- In commissioning Peer Physical Health Coaching to NEAMI Australia the PHN required NEAMI to provide physical health training to all peer workers. So in September the 'Optimal Health' training program was deliver to peer workers from locations in Kiama, Queanbeyan and Narooma.
- Similarly, the black Dog Institute has been engaged by SENSW PHN to deliver eMHPrac training for peer workers to complete with practice nurses early in 2019.

Commissioned services are required to allocate training and professional for peer workers in their budgets. The most common trainings funded is IPS. Peer workers are expected to complete the Cert IV in Mental Health Peer Work through a scholarship with NSW Health.

The Mental Health Peer Coordinator provides guest lectures to Cert IV Mental Health Peer Work students at Wollongong and Nowra TAFEs.

Question 3. Promotion of the Peer Workforce

Conference presentations

August 2018 – *'Peer Workforce: Challenges & Future'*, Featured Symposium at the 2018 TheMHS Conference.

March 2018 – *'Rural service models and engaging the peer workforce'* Orygen Youth Mental Health in Primary Care Forum

October 2017 – *'Commissioning the Peer Workforce* in PHN's' 9th Australian Rural and Remote Mental Health Symposium.

August 2017 – '*Peer work Utopia-Making it happen'* (Panel, Consumer Day), 'Peer Work and Climate Change' (Paper) and 'Peer Work Ignition! A National Professional Association for Mental Health Peer Workers' (Symposium) at the 2017 TheMHS Conference.

Papers

February 2018 – *'Identifying the role of Primary Health Networks in the development, commissioning and support of the peer workforce'*, Discussion paper written for the NSW/ACT PHN Network (attached)

Media

11 October, 2018 – *'Peer workers, family, friends vital to mental health recovery'*, South Coast Register

'Reconnecting with life – the vital role of peer workers, family and friends in suicide prevention'

Illawarra Mercury 10/08/2018

'Next Steps' program provides peer support for people at risk of suicide COORDNARE Newsletter/ Website 23/03/2018

Question: From your perspective, what would a member based national entity look like:

From my perspective a member base national organisation would significantly enhance the work we are doing in commissioning services that include peer workers. It would compliment the three Peer Work Networks we have established across the PHN by providing further professional development, and it would extend this work by providing peer workers the opportunity to develop structures around their own work and by providing a national network. I envision that each of the 31 PHN's could take responsibility for the development and support of Peer Worker Networks within their boundaries. Peer worker networks provide linkages, communication and continuity of support for mental health consumers in a mental health system that still remains siloed and difficult to navigate.

The peer workforce is currently developing rapidly across the sector, and there is always a risk that peer workers might be co-opted into to practices that are not in line with peer work values. A Professional Association would allow peer workers have significantly improved influence into all services that employ peer workers.

I think a Professional Association could also support the development of consumer-run peer work services. I feel that consumer-run peer work services will evolve as peer work gains a professional identity.

Question: Do you see a role for the SENSW PHN and if so, what might it look?

I believe that PHNs are ideally placed to develop the peer workforce nationally. The National Mental Health Commission is currently developing its National Peer Workforce Development Guidelines as part of the 5th National Mental Health Plan. Much of the implementation of the Plan is being undertaken by PHNs so it is logical that the implementation of the National Peer Workforces Guidelines will also be the responsibility of PHNs. (see Appendix, *'Identifying the role*

of Primary Health Networks in the development, commissioning and support of the peer workforce', Discussion paper written for the NSW/ACT PHN Network (attached)

PHN's could also promote the Professional Association in similar ways we promote the Mental Health Professional Networks and we could harness the Professional Association to contribute to the development of training, supervision, workforce development activities for the peer workforce in primary health. As mentioned in the previous question PHN's are well placed to establish and support place based peer work networks across Australia. These in turn would be supported by a professional association.

PHN's will be essential to the development of relationships between GPs and peer workers for the delivery of low intensity mental health services such as e-mental health and as workforce in the patient centred medical home.

SENSW PHN is well placed to lead and support the establishment of peer work networks across Australia, given our innovative practice in this area. These networks would then provide place-based hubs for a national professional association.

A Discussion Paper has been developed with the purpose being to identify the role of Primary Health Networks in the development, commissioning and support of the peer workforce and the PEER WORK in South Eastern NSW PHN, Tim Heffernan, November 2018

'Peer workers, family, friends vital to mental health recovery'' 11 October, 2018 South Coast Register are noted within the Resources section.

Online survey

A survey was developed by the Project Team to further distil the key messages, themes and issues raised during the face-to-face consultations. The survey was administered through SurveyMonkey with the link being distributed through the Project's Peer Interest Register, face-to-face consultation attendees, the Network's member data base, the National Mental Health Consumer and Carer Forum and the National Register.

A detailed analysis of the survey is not part of the Project; however, we have extracted the information including responses and comments. We are hopeful that at the end of the Project, the full responses can be uploaded to the Project website. However, for the purposes of this section, the Project Team has extracted the key figures and some selected comments.

> *could you please share the resulting report with all who completed this survey? and also circulate through the Mental Health Commission networks?*

A final comment from a respondent is reflected here and demonstrates the enthusiasm for a member based national peer worker organisation.

> *This would be an Australian first for peer workers, if not a world first so much work needs to be done and much of it for the first time, but we could do it very well I think!*

Details

In total **165** people entered the survey and of these 78.3% (n=113) were either consumer or carer peer workers and were from all jurisdictions with one respondent from the NT.

Responses were also received for the governance of the organisation with 59.8% (n=94 of 157) believing that the organisation should have a national base that includes individual state/territory representation.

Responses were received about the CEO position with 84.7% (n=139 of 164) believing that the CEO should have the right skill set and a lived experience.

Additionally, there was strong support for the members of any Board to have both a professional skill set and lived experience 75.3% (n=122 of 162), lived experience 20.3% (n=33 of 162) or lived experience in leadership roles 28.4% (n=46 of 162) In terms of the percentage of board members with lived experience the responses were fairly evenly divided here with 49.0% (n=80 of 163) saying that all board members should have a lived experience and others 46.6% (n-78 of 163) believing that 50% of board members should have a lived experience.

> *Having a mix of lived and non, would bring different skill sets and experiences enriching the board further*

> *I think 50-75%. Often in organisations, there is a minority of people with lived experience, or at least those who are willing or able to disclose this. Part of equity is providing added support and resources for those who don't have the same advantages. Having a board in which people with lived experiences, who also have managerial, professional and/or leadership skills and experience can be valued and included, I think sets an important precedent. However, I don't think this should be at the expense of the sound running of the organisation. Lived experience and good business skills are not mutually exclusive, and there is also the possibility of training and mentoring people for these roles.*

Responders believe that staff members of any organisation should have the right skill set and lived experience 49.3% (n=81 of 164), or a mix of staff with or without lived experience but the right skill set 40.8% (n=67 of 164)

Of note, 98.1% or 161 respondents supported overwhelmingly that any organisation would provide professional development and a mixed response from 164 respondents as to what that would offer with ongoing learning and development 89.0% (n= 146), training for peer workers to be supervisors 82.3% (n=135) opportunities for external supervision 81.1% (n=133), courses for peer workers to effectively deal with stigma and discrimination in the work place 76.2% (n=125) and accredit continuing professional development points 72.5% (n=119)

> *perhaps this could be tendered out to other bodies that they would be happy to endorse/recommend so we have access to standard training that already exists and is endorsed by a national peak body*

> *It is essential for a peak professional body to provide professional development opportunities to its members.*

Education and training

An overwhelming majority of respondents 94.9% (n=149) felt that the organisation would provide education and training; 159 respondents noted the areas which were most important are:

1. Provide employers with education and training around the peer work role; 91.8% (n=146)
2. Provide peer workforce education for community and health professionals; 90.5% (n=144)
3. Educate organisations/unions to understand what a peer worker is; 88.6% (n=141)
4. Provide education to ED's and other mental health settings; 82.3% (n=131)
5. Provide education on reasonable adjustments in the workplace; 78.6% (N=125)
6. Access for people to attain a qualification in peer work by supporting subsidies places; 77.3% (n=123)
7. Develop new units in specific areas relating to peer work (units of competency); 73.5% (n=117)
8. Training for external supervision; 71.7% (n=114)

9. Deliver intentional peer support training; 69.8% (n=111)
10. Training in suicide intervention skills; 64.7% (n=103)
11. Provide auditing training; 49.0% (n=78)

What is of note is these key points reflect education and training to the existing workforce and work places. This supports a number of the common theme findings from the Literature Review.

> *Not necessarily, I see the organisation as being advocates for work place issues and supporting the lived experience workforce as it develops and grows*
>
> *And perhaps link it to the Cert IV Mental Health Peer Work*
>
> *Basic training in counselling, communication, mental health first aid etc. We want the peer workers to be trained to a common standard.*

Of the 159 respondents to this question noted access for people to attain a qualification in peer work by supporting subsidies places as the 6th most important 77.3% (n=123), develop new units in specific areas related to peer work (units of competency) 73.5% (n=117), training for supervision 71.7% (n=114) and deliver intentional peer support training 69.8% (n111) completed this section of the survey.

The survey asked what types of support services the organisation should offer with many of the specific questions being evenly spread. 164 respondents viewed the five main areas being:

1. Networking opportunities
2. Directory of training availability
3. Virtual library with resources on research and information
4. FAQ sheets/brochures for peer workers
5. Referral services for debriefing and support

> *Links for pathways/referrals to other services, not specifically Peer Worker/support services, but demonstrate similar pathways for engaging in community, up skill & training, work experience, mentoring, e.g. NFP community groups who actively have participation activities, events and activities with peer support style involvement.*
>
> *Workshops for organisational leaders/leadership to identify best practice type approaches to implement peer work, identify their understanding of peer work negotiating risk adverse practice To publicly endorse credible L/E research or challenge research and statements that have not included genuine participation by L/E workers and is not published by L/E academics To publicly endorse and challenge government policy, policy implementation & funding announcements*
>
> *Be a voice representing the LE workforce to lead systems advocacy and raise the profile of the LE workforce. Challenge the power systems inherent in the precedence of 'evidence based' approaches (who's evidence; how does evidence based maintain the status quo and impede systems change?)*

Promotion

The survey asked what would an organisation promote. 164 respondents answered this question with 92.0% (n=151) noting promoting policy for lived experience workers as the main activities, with systemic and policy advocacy 89.0% (n=146) and promote the benefits of membership, both personal and professional 80.4% (n=132), liaise with RTOs re promoting training of the Cert IV in Mental Health

Peer Work 79.8% (n=131) research 76.2% (n=125), promote establishment of peer worker run crisis centres 71.9% (n=118) and individual advocacy 70.1% (n=115)

> *Individual advocacy would be great but a huge resource commitment - it would be good to include if it can be realistically resourced.*
>
> *Also having a national organisation that accredits peer workers (though their education/work experience) promotes and strengthens the workforce.*
>
> *Focus should primarily be on systems advocacy representing the views and needs of the LE workforce; facilitating opportunities for LE workers to come together (conferences; forums); influence research policy agendas*

Advocacy

The survey explored advocacy further, and in terms of individual advocacy, 122 respondents answered individual support/advocacy in the workplace as the most important 87.7% (n=107), advocate for professional development 84.43% (n=103), stigma and discrimination in the work place 81.9% (n=100) and appropriate supervision 80.33% (n=98) and partnership with unions for individual advocacy 72.1% (n=88) were the remaining areas thought to be important.

> *I think that in an ideal world, an organisation that has a peer workforce should have the support mechanisms in place to meet the peer workers needs within reason and the funding situation.*

In terms of issues around stigma and discrimination and the impact this can have on the peer workforce, this rated highly, and supports a common theme extracted from the Literature Review. There is a clear need to focus on the value of peer workers, their unique skill set, and the value peer workers bring to settings in which mental health care is provided.

Systemic advocacy

This was also raised as a question in the survey. 151 individuals responded to this question with the top four areas which an organisation should provide being:

1. Benefits of employing peer workers
2. Submissions to governments, providers and relevant others
3. Framework for standards and practice guidelines
4. Showcasing lived experience work and sharing success stories
5. Advocacy in policies, strategies, guidelines, legislation

We can also see some of the responses also align with the common themes emerging from the Literature Review. These specifically are around advocacy for stigma free workplaces and services 84.7% (n=128), position on workforce needs 74.8% (n=113) setting workplace standards 82.7% (n=125)

> *Remember Peer work is not just mental health - include the diversity such as CaLD, AOD & sexual health - look at guidelines for peer review*

Setting Standards

Many individuals felt that an activity for an organisation should be in setting standards. 162 respondents noted the main areas as being:

1. National standards for the peer workforce
2. Standards for organisations employing peer workers
3. Standards and guidelines for peer workers in leadership positions

4. Standards of care – best practice framework
5. Develop, review and accredit education standards for peer workers

The need for role clarity and a clear identity for peer workers including broader understanding of the peer workforce was also highlighted in the Literature Review.

Of note respondents considered that standards for supervision 78.4% (n=127) accreditation of peer workers 77.1% (n=125) standards for recruitment and selection 77.1% (n=125) job descriptions 77.1% (n=125) remuneration/awards 75.9% (n=123) were also of clear importance.

> *Co-reflection / Reflective practice standards and promotion Best Practice Framework is tricky. I personally have a concept of peer workforce best practice but would require extensive collaborative formation and may need to be challenged and reviewed regularly.*

> *Discipline knowledge - what are the principles and codes of ethics all LE workers should sign up to regardless of where their position is/core roles of the position.*

> *Standards are important but competencies measure whether people are able to practice to the standards*

Representing the peer workforce

The survey asked whether respondents see an organisation as representing the peer workforce. Of the 157 respondents to this question, 151 noted 'yes'. The five most important roles envisaged for such an organisation were:

1. Promoting the peer workforce as a profession
2. Guiding principles for the peer workforce
3. Peer leadership
4. Point of contact for the peer workforce in Australia
5. Support and advocacy for all lived experience roles at all levels of services including peer workers.

> *The professionalisation and promotion of the peer workforce is so important to the profession as a whole but also for individual peer workers on the ground.*

> *Peer Work representative perhaps needs to be also mindful of the importance of valuing lived experience in all workers so as to not unintentionally stigmatise.*

> *I believe the strategic plan it's about lived experience participation. It is a standard that promotes excellence in the service delivery.*

Further responses showed 'Hub of Knowledge' for newly created peer worker positions 81.9% (n=127) diversity of peer workforce 81.9% (n=127) recognition of qualifications 78.0% (n=121) strengthening understanding and applicability of the peer workforce within unions 78.7% (n=122) research, data collection 77.4% (n=120) national register of qualified peer workers 74.8% (n=116) and consistent title (for peer worker) rated at 74.1% (n=115)

Code of Ethics and Code of Conduct

The survey asked about whether respondents would see an organisation developing a code of ethics and from 163 respondents to this question, 150 noted yes. The five main points raised by 152 respondents were:

1. Confidentiality/disclosure/privacy
2. Advocacy and empowerment
3. Respect for different perspectives and diversity
4. Skills boundaries: risk/duty of care
5. Recovery principles

> *I think this is important in order to guide and lead the profession and individuals, have validity, set a standard and operate ethically.*

> *Definitely endorse developing a code of ethics which mitigates against peer workers being coopted into medical model approaches and interventions. I am always uncomfortable when I read position descriptions which cite the purpose of the peer role is to prevent re admission to hospital. Peer work is about walking alongside the consumer on their recovery journey.*

> *Inclusion, trauma informed, compassionate, Dignity, Person first, Support and connection, Meaning and purpose, Inclusion and diversity, Recovery, Equity, Collaboration and partnership, Communication*

The need for exploring boundaries and self-disclosure in the peer worker role was a theme which came from the Literature Review and this is consistent with the responses as is the health and wellbeing of peer workers.

Further responses showed that behaviour, expectations, boundaries were important 84.8% (n=129) as was professional development, learning and reflective practice 82.2% (n=125).

The survey differentiated between code of ethics and code of conduct as this was raised quite a lot during the face to face consultations. Of 162 respondents, 132 believed an organisation would develop a code of conduct for peer workers. Areas noted of importance were establishing best practice 90.1% (n=119), role definitions 80.3% (n=114), conflict management 84.0% (n=111) and scope of practice 82.5% (n=109) Other areas of note were boundaries for friendship/peers/colleagues 80.3% (n=106) and supervision by person with lived experience 81.8% (n=108)

> *Yes. Ethics is about the thinking behind decisions whereas conduct is the actions*

> *this would cause conflict with existing codes of conduct for peer workers who span many organisations*

> *Yes. They are similar but different. Code of ethics represents values of the organisation to which members should adhere and agree to. Code of conduct outlines acceptable actions and behavior which members are answerable for.*

> *Code of Conduct makes the 'no' behaviours more explicit.*

> *Yes - The primary difference between code of ethics and code of conduct is that code of ethics is a set of principles which influence the judgement, while the code of conduct is a set of guidelines that influence employee's actions.*

> *They go hand in hand, Ethics are the principals and beliefs underlying the code of conduct. A code of conduct is necessary as it is such a diverse workforce, there needs to be some expectations around what it is to be in this workforce providing a quality service.*

National Guidelines

The survey asked whether development of national guidelines would be a function of an organisation and of 158 respondents, 152 said yes. The five main points guidelines should cover were rated by 156 respondents as

1. Legitimacy of the peer workforce
2. Valuing peer workers and peer workforce
3. Responsibilities in the workplace (peer worker and employer)
4. Quality improvement
5. Flexibility to needs of peer workforce.

Other areas of importance were position descriptions 80.7% (n=126) determining levels of remuneration according to skills/qualification 75.0% (n=117) ratio of clients to peer workers 70.5% (n=110) creation of national award 70.5% (n=110).

> *I feel there should be National Guidelines for all Peer Workers regardless of their State. However, each state may have their own cultural expectations which pertain to each state.*
>
> *Yes, fully developed by consumers and peer workers*
>
> *Guidelines should cover practice, scope and skills; how to mitigate lack of capacity in any of these areas, and scope to be innovative.*
>
> *eligible for membership of allied health profession AHPRA*

Career pathways

The final question in the survey focused on career pathways. 162 respondents reported the five main points as being:

1. Leadership roles within organisations/services
2. Lived experience educators/trainers
3. Advocacy, outreach, mentoring, teaching, training, human resources
4. Specialist skills e.g. BPD, homelessness, addictions, inpatient, youth, community
5. Provision of supervision to peer workers

Career pathways became an important issue to attendees at the face to face consultations and featured equally important to the survey respondents. These covered several areas of importance to peer workers. These are noted below.

> *They should be allowed and included into all organisations, and definitely embraced and utilised in academia, politics, corporate roles and other areas of influence. Mental health issues face far more people than statistic demonstrate. The stats are already high. We need to create a world where diversity is valued and also people are able to utilise their strengths and not be penalised for their 'weaknesses' or rather the different ways they adapt and function.*

Summary

There was an overwhelming positive response to the concept of having a national entity to represent and to promote the mental health peer workforce. This endorsement was widespread and included attendees at the consultations and Community Managed peaks and organisations we liaised with. Having a national organisation that would not only represent the peer workforce, but provide guidance, clarity of what the peer workforce is, what the peer worker does and unique expertise of

the peer workforce. Participants also felt the organisation should be tasked with setting standards and guidelines.

There were some challenges and concerns expressed on how one entity could most effectively represent both consumer and carer peer workers. This created an opportunity for a mature discussion by many with suggestions on how this could work. The views expressed during the Victorian consultation that any organisation should be exclusively for consumer peer workers and that carer peer workers may need their own organisation was not a view expressed more broadly. The importance of the entity representing both consumer and carer peer workers was highlighted and it was agreed this would require consideration and potentially further consultation of peers through the planning, development and governance establishment phases, to ensure the views of all would be understood and represented by the organisation.

A significant issue raised at each consultation was the need to have a representative from each state and territory located within their jurisdiction, who understands the local mental health settings, relevant legislative frameworks and Mental Health Acts, and the services available, these vary markedly across jurisdictions. Participants offered a number of suggestions on how this could be achieved, and it is clear there needs to be jurisdictional connections from and to the national entity. Participants felt strongly about the importance of staff having a lived experience and that a national peer workforce entity should be setting an example in employing those with a lived experience at all levels.

They also expressed the view that the entity must have a significant role in promoting, representing and providing education on behalf of the mental health peer workforce. To ensure this workforce is embedded in all mental health service sectors there is a need to provide a clear understanding and role for the peer workforce demonstrating care that is person centred and focused on the needs of the person more broadly, their social and emotional needs and wellbeing.

A national entity needs to engage with the states, consumer and carer peaks and where work has been done to establish peer networks or organisations, the entity should be working with established networks. Participants do not want the work that has been done to date in the peer work space to be lost and expressed the view that state/territory jurisdictions have strong connections to the national entity. The Model recommended by the Project Team reflect these ideas/concepts.

The importance of validation of the peer workforce being seen and recognised as a profession, rather than a cost-saving measure, and having an entity to represent and promote the peer workforce were consistent, strong messages. The entity should be providing education on the peer workforce to be provided by those with a lived experience.

In cities, states where the population base is spread with smaller regional areas, attendees spoke of the isolation that is often felt and expressed by people living in these areas. This was apparent particularly in Perth and Hobart, where they had a genuine concern that, if an entity was established, states with a smaller population would be disadvantaged. There was a view that if funding was based on population, the eastern states would be at an advantage. The importance of equity of funding, representation and provision of services to all peer workers regardless of where they live is an important component of a national organisation.

Across the consultations there is a consistent and strong view that a national entity for the peer workforce will contribute to stigma and discrimination reduction.

Recommendation

The Project Team recommends that the National Mental Health Commission approves the public release of the responses to the online survey in full, including posting onto the Project site of the Private Mental Health Consumer Carer Network's webpage http://pmhccn.com.au/PeerProject.aspx and if appropriate, the NMHC website.

Section 6

Governance

The Project was asked to recommend a proposed governance model for a member based national organisation.

The main model options, namely a Company Limited by Guarantee or an Association have been explored during the national consultations. A specific governance item for discussion at the workshops has been:

- Should it (the association/organisation) have its own state branches; or
- Should it work with the currently established jurisdictional organisations supporting the peer workforce?

In reviewing these two most common legal structures, the Project Team believe the best model to be adopted from the outset is one that is a Company Limited by Guarantee.

The Project Team referenced the following document for this information.

> *New South Wales Not-for-profit Law Guide*
>
> ***Incorporated association or company limited by guarantee?***
>
> *A comparison between the two most common legal structures for not-for-profit organisations in New South Wales*
> *June 2013*
>
> https://www.nfplaw.org.au/sites/default/files/Incorporated_association_or_company_limited_by_guarantee_0_0_0.pdf

Incorporated association or company limited by guarantee?

We have taken the following text for this section directly from this Resource to better articulate the reasons for our recommendation.

> *An incorporated association is a type of incorporated legal structure made under the NSW Associations Incorporation Act 2009 (NSW). A company limited by guarantee (CLG) is another type of incorporated legal structure made under the Commonwealth Corporations Act 2001 (Cth). Both are suitable legal structures for not-for-profit groups.*

Incorporated associations were originally designed to be low cost to register and reasonably simple to run, particularly when compared with a CLG. However, changes to the laws for both incorporated associations and CLGs mean that the differences between these two entity types, particularly those relating to record keeping, reporting and costs, are no longer so obvious.

For groups that are (or hope to be) registered as a charity, the transition of regulation of CLGs that are registered charities from Australian Securities and Investments Commission (ASIC) to the Australian Charities and Not-for-profits Commission (ACNC) (which commenced in December 2012) means that the regulatory approach for incorporated associations and CLGs is now closer. This is because the ACNC takes a more educative approach as a regulator - meaning it will be less likely to impose fines for technical breaches of reporting requirements. Some reporting fees formerly required to be paid to ASIC by CLGs are waived by the ACNC for charities

In essence the reason the Project Team are recommending a Company Limited by Guarantee (CLG) is primarily because this would be incorporated under the Commonwealth Corporations Act and can be established and carry out activities in relation to a member based national organisation anywhere in Australia; whereas an association would be incorporated under a jurisdictional Associations Incorporation Act which would not allow the flexibility to operate in other jurisdictions or have 'branches' in other jurisdictions.

If the national peer organisation were to Incorporate under a jurisdictional Act, there are two further options available, or the ability to convert from an Incorporated Association to a CLG however the Project Team believes that any national peer organisation should be able to operate or carry out activities from within any state or territory from its formation. The conversion can be costly if this were to be undertaken at a later date.

There is a potential for any peer organisation to apply for charitable status, but that can be undertaken once the legal entity is in place.

It will be crucial for the formation of the peer organisation that this is undertaken with input and assistance from people with good understandings of the running of a CLG, an accountant and to engage professional legal advice.

Please note there are basic fact sheets and other resources available from the ASIC website.

https://asic.gov.au/for-business/registering-a-company/

Recommendation

The Project Team recommends the following:

1) Establish a national member-based organisation for the peer workforce's legal structure as a Company Limited by Guarantee.

Section 7

Potential Models

A requirement of the Project is to propose a potential model of what a member based national organisation for the peer workforce may look like. The Project Team has decided to detail four models as each requires different levels of funding. We did not wish to miss an opportunity of putting forward a prospective model by proposing one model only, which may be dismissed because of funding and other resourcing issues, so several models have been detailed. However, the Project Team in conjunction with the Project Reference Group have determined a recommendation for one specific model.

Outlined below is the Project Team's rationale for choosing each model, as well as identifying what they see as the strengths and weaknesses of each model, relating these to a member based national organisation for the peer workforce. The Project Team have detailed three models below plus a fourth, which is in essence a combination of models two and three, a hybrid model.

The model structure is articulated below, and the functions are detailed at the end of this section.

The Project Team have chosen the models based on the critical components put forward by the attendees at the face to face national consultations, feedback from phone contacts and the online survey results identifying preferences. One of the clear messages from the consultations is that whatever model is ultimately chosen, clear linkages with states and territories are required. This may be in the form of the national organisation establishing jurisdictional branches or forming linkages with existing state or territory peaks or other community managed organisations, or consumer or carer specific organisations currently supporting peer workers. This may hold implications for organisations that do not have an understanding of both the consumer and carer peer worker roles. Mental health commissions or state or territory mental health directorates could also have a potential role, however the Project Team are suggesting a cautious approach to any organisation in case there are real or perceived conflicts.

> *'Having a national base would make the peer workforce more uniformed across the country and having individual state/territory representation would allow for additional targeted support'*
>
> *'National body with centres/branches in each state'.*
>
> *'Local Peaks could support separate branches, but this would be a lot of extra resources which would also require funding.'*
>
> *'Including Regional and Rural areas'.*
>
> *'I think a national body would provide greater advocacy, but maybe lose some of the personal and local connection and specificity. It would be good to have a national body which supports the existing organisations to deliver their services and to remain local and unique'.*
>
> *'National governance is important; however each state and territory need to have local representation. Some states have established peaks or organisations and some don't. Existing peaks or organisations should be supported to transition or blend in to local representation under a national framework. Existing bodies should be supported to maintain and enhance their current processes which are successfully supporting their jurisdiction where possible, whilst embracing learnings and improvements from other jurisdictions and the national framework'.*

Clearly, further discussions will be required beyond this Project to engage with interested and appropriate entities which have indicated a willingness to be considered, or others which may be prepared to endorse the concept of a national organisation for the peer workforce, the chosen model, and whether they have the capacity to provide funding or in-kind support. A proposal would need to be developed with clearly articulated requirements together with detailed funding or in-kind support, commitments and agreements.

The Project Team are very reluctant to suggest or recommend costs because of a number of variables, however we are of the view that a central base for the national peer workforce organisation with staffing requirements of a full time CEO, a full time policy and governance officer, full time administration officer and part time communications officer. Within this section of the Report we will refer to these staff collectively as the **'Secretariat'** encompassing the four positions. In terms of salaries only, this could be based on the following as a very broad guide based on the work level definitions contained in the table below.

Chief Executive Officer: Full time: Australian Public Service; Executive Level 2.7 from 29.7. 2017, the Australian Public Service Commission Enterprise Agreement 2015-2018 Salaried $140,590 which includes superannuation and on costs.

Policy and Governance Officer: Full time: Australian Public Service; APS Level 6 from 29.7.2017 the Australian Public Service Commission Enterprise Agreement 2015-2018 Salaried $125,057 which includes superannuation and on costs.

Administration Officer: Full time: Australian Public Service; APS Level 3.1 from 29.7.2017 the Australian Public Service Commission Enterprise Agreement 2015-2018 Salaried $58,231 which includes superannuation and on costs.

Communications Officer: Part time: Australian Public Service; APS 6.1 from 29.7.2017 the Australian Public Service Commission Enterprise Agreement 2015-2018 Salaried $81,925 which includes superannuation and on costs.

DETERMINATION 5: CLASSIFICATION AND REMUNERATION FOR EMPLOYEES ATTACHMENT 2

EXECUTIVE LEVEL 2 (EL 2.7) **Australian Public Service**	**WORK LEVEL APS6 (APS Level 6)** **Australian Public Service**
Executive Level would generally be required to undertake work with a high level of complexity or sensitivity and operate under broad direction. They exercise a significant degree of independence and perform an important leadership role. Employees at this level will be responsible for influencing and developing strategy, policies, priorities and operational practices in support of agency objectives based on high level decision-making and judgement. EL 2 employees provide a high level of advice to senior management and Ministers as well as coordinating and assuming responsibility for highly complex or sensitive projects or work programs that have strategic, political and/or	Undertake work that is complex in nature, work under limited direction with the opportunity for reasonable autonomy and accountability. Exercise both initiative and judgment in the interpretation of policy and in the application of practices and procedures. APS 6 employees provide detailed technical, professional, and/or policy advice in relation to complex problems and may assist in strategic planning, program and project management and policy development. Employees may have a considerable level of public contact in relation to difficult or sensitive issues and may liaise with a range of stakeholders in a representational role. Work may involve

operational significance. Employees are also responsible for initiating, establishing and maintaining strong relationships with key internal and external stakeholders and may lead a work team or teams. Generally, the work of an EL 2 works with a high level of autonomy, provides strategic leadership and is a decision-maker	management responsibilities requiring the setting of priorities and managing workflows.

Additionally, models 2, 3 and 4 refer to a Peer Liaison Specialist within these models we are suggesting a possible salary could be again broadly based on the following.

Peer Liaison Specialist: Full time: Australian Public Service; APS Level 5.1 from 29.7.2017, the Australian Public Service Commission Enterprise Agreement 2015-2018 Salaried $71,959 which includes superannuation and on costs.

APS WORK LEVEL 5 (APS 5) **Australian Public Service**
APS Work Level 5 employees required to undertake work that is moderately complex to complex in nature and operate under limited direction. They are accountable for organising their workflow and making independent decisions relating to an area of responsibility. Employees at this level provide policy advice within an area of specialisation with advice based on policies and legislation. APS 5 employees undertake specialist or technical research and analysis, conduct investigations, and undertake procedural, clerical, administrative support or operational tasks. Employees may have a considerable public contact role and may be required to communicate with and provide advice to a wide variety of customers and external stakeholders. Work may include supervision of lower level employees and responsibility for managing staff performance, allocating work and identifying opportunities for on-the-job training.

Given there were various views expressed with each having different financial considerations, the Project Team have identified these four models and discussed their respective strengths and weaknesses.

Structure

Outlined below are the structures of the Models being suggested.

Model one:

We consider the 'gold standard' model to be one which is similar in structure to the following examples:

- The Royal Australian and New Zealand College of Psychiatrists
- The Australian Association of Social Workers or
- The Australian Medical Association

Rationale

These organisations are member based and operate to promote the profession they represent and the interests of their members. They advocate on behalf of their members and support their members through a range of services.

All are public companies, have an elected President from their respective profession. They have an elected Board from the profession, a Chief Executive Officer or in the case of the AMA a Secretary General. All have branches in every state and territory, all have committees, a Code of Ethics, and all offer a range of services and benefits to their members. In the case of the RANZCP and the AASW, professional development and education opportunities are offered, with the RANZCP setting the educational curriculum for trainees.

Each organisation accepts membership based on applicants holding respective Australian qualifications or from recognised overseas institutions. The RANZCP offers three types of membership for qualified psychiatrists as a Fellow, trainees (registrars) currently completing their RANZCP training program as an Associate and for overseas trained psychiatrists currently working in psychiatry, Affiliate membership is available. Importantly all organisations charge an annual membership fee and are self-sustaining.

The RANZCP and AASW represent their respective professions, however the AMA is broader in terms of membership, accepting members from doctors across the full range of specialties. Their website states that 'The *Australian Medical Association (AMA) is the most influential membership organisation representing registered medical practitioners and medical students of Australia. The AMA exists to promote and protect the professional interests of doctors and the health care needs of patients and communities*' The AMA could almost be viewed as a 'union' for doctors something which resonates from the consultations with peer workers striving for the peer workforce to become a recognised and respected profession.

Each organisation makes submissions to Government and other entities, and each holds an annual conference. All lobby governments and other entities to improve services to the community, to which their members serve.

Each of these organisations has similar characteristics which we believe would function in the same way for the peer workforce.

Table eleven: characteristics of functions of three professional organisations

	RANZCP	AMA	AASW
Company limited by Guarantee	✓	✓	✓
Represents a profession	✓	✓	✓
Governance: President	✓	✓	✓
Board	✓	✓	✓
CEO/Sec. General	✓	✓	✓
Committees/sections	✓	✓	✓
Holds elections for board positions	✓	✓	✓

Branches: Each state/territory	✓	✓	✓
Code of ethics	✓	✓	✓
Offers PD	✓	✓	✓
Offers Education and training	✓	Through 3rd party partnership	✓
Develops resources	✓	✓	✓
Makes submissions	✓	✓	✓
Holds annual conference	✓	✓	✓

Concept of Model One:

Strengths

The Project Team considers this model would provide all the things identified, based on the direct feedback from the national consultations and online survey results, that peer workers want and therefore represents the 'gold standard'.

The Project Team also feels that whilst these organisations have established branches in each state and territory a national peer workforce organisation could work toward this model with fully established branches.

This model would enable the national organisation via its branches to have a full understanding of the full range of mental health services delivered within that jurisdiction.

Weaknesses

The disadvantages with this model are the costs and resources required to run this model and to sustain it over the long term.

In the case of the three professional organisations mentioned here, each charge substantial membership fees on an ongoing basis and on a sliding scale, each earn substantial incomes particularly from the doctor organisations of the RANZCP and the AMA. Examples of membership fees obtained from the websites showed:

- AMA membership fees: $1,545.60 pa Private Practitioner (Specialist); Private Practitioner (GP) $1546.60 and salaried medical officers $1546.60 for those doctors working in a full-time capacity.
- RANZCP membership fee: $2,344.00 pa for Fellows (approximately 6,000 members with 4,000 Fellows).

With the other professional organisation appropriating the following:

- AASW membership fee: $697 pa for full membership for social workers with an income of above $49,036.

These fees provide substantial financial resources for the organisations and allows the organisations and their branches to be self-sustaining, with the financial income stream being stable but able to be adjusted according to the requirements of the organisations; e.g. fees can be raised on an annual basis, based on CPI or other factors.

High cost membership fees are prohibitive and unrealistic for peer workers at this time and unlikely into the future. It would be unreasonable to compare the incomes of peer workers to that of a medical practitioner or specialist.

Model two:

Given that feedback requires the national organisation to have strong links to the states and territories, a model which could be considered from a **structural perspective** and potentially established at a lesser cost, is that of the Australian Council on Healthcare Standards (ACHS).

The ACHS offers accreditation services, develops standards, clinical indicators, consultancy, and customised reporting and education services. They have developed a core accreditation program which guides organisations through a four-year cycle of self-assessment in order to meet the Australian National Safety and Quality Health Care Standards.

However, what we need to compare to a national peer workforce organisation is how the ACHS is structured.

Rationale

Feedback from the consultations and online survey outlined the functions required of any national peer workforce organisation and the previous Model One which detailed the RANZCP, AMA and the AASW fulfilled those requirements, but at substantial annual running costs. Having branches in each state and territory requires staffing, accommodation, and infrastructure.

Consideration should be made for a model which delivers all of the functions required, for example professional development, education and training opportunities, support services, individual and systemic advocacy, development of standards, code of ethics and conduct and national guidelines. But most importantly, promote and provide resources on the profession of the peer workforce. The Project Team believes that this model two has the capacity to deliver these things.

The ACHS has one office with all staff based in Sydney but the linkages with the states and territories are provided by their designated *customer service managers*. Their task is to know what is happening in each state or territory from a political, clinical service perspective and any other drivers. You will see that the smaller states and territories are grouped together, and the larger states are serviced by one person, totaling six staff for the ACHS. There is of course oversight by Executive Managers.

The following states and territories are currently serviced by:

VIC, TAS and the ACT – 1 customer service manager

SA and NT – 1 customer service manager

QLD – 1 customer service manager

NSW – 1 customer service manager

WA – 1 customer service manager

Private organisations – 1 customer service manager

A model for a national peer worker organisation with staffing by what the Project Team are calling Peer Liaison Specialists rather than customer service managers, could reduce the number of state or territory specific personnel to potentially something like the following:

NSW & ACT - 1 Peer Liaison Specialist

VIC & TAS - 1 Peer Liaison Specialist

SA – 0.5 FTE Peer Liaison Specialist

WA – 0.5 FTE Peer Liaison Specialist

NT – 0.5 FTE Peer Liaison Specialist to coordinate and establish a peer workforce in NT (including Alice Springs)

QLD – 0.5 FTE Peer Liaison Specialist

The key task of the Peer Liaison Specialists located in a central office would be to establish direct links, liaison and partnerships with organisations providing support, training, other services and resources to peer workers, and to understand the roles and functions of the peer workforce in the respective jurisdictions to which they are allocated. They would ensure issues relevant to the 'local' peer workforce are escalated for potential action if needed and to provide advocacy. They would also liaise with the relevant training organisations, clinical services and community managed organisations employing peer workers and jurisdictional government departments. The Peer Liaison Specialist has an important role in establishing and strengthening communication with clinical services, community managed mental health service providers and PHN's to raise awareness and understanding of the peer workforce.

The ability for the Peer Liaison Specialists to travel would be a necessary requirement, as would engaging with peer workers in regional, rural or remote locations.

Concept drawing for Model two on following page.

Concept Model Two:

One Central Office
Located in any jurisdiction

Secretariat

1. **CEO**
2. **Policy & Governance Officer**
3. **Communications Officer – part time**
4. **Administration Officer**

PLUS

5. **Peer Liaison Specialist- NSW & ACT 1.0 FTE**
6. **Peer Liaison Specialist – VIC & TAS 1.0 FTE**
7. **Peer Liaison Specialist- SA 0.5 FTE**
8. **Peer Liaison Specialist- WA 0.5 FTE**
9. **Peer Liaison Specialist- NT 0.5 FTE**
10. **Peer Liaison Specialist- QLD 0.5 FTE**

Strengths

This would provide the required linkages with the states and territories, working in partnership with organisations supporting peer workers, liaising with services and governments. All would fulfil the roles articulated from the national consultations and online survey.

The organisation would comprise the Secretariat plus Peer Liaison Specialists, all housed in one location which could be anywhere in one of Australia's capital cities.

The costs associated with location, would be the one central location rather than several. Given the number of staff we are suggesting, co-location with another organisation would require significant negotiation.

Weaknesses

There is potential for conflict if the jurisdictional organisations currently supporting peer workers see the national organisation located outside their jurisdiction as not fully understanding the issues and needs of the 'local' peer workforce. WA for example, already feels disconnected and isolation from the eastern states, and work would be required to ensure this does not occur. Rather peer workers in WA hope any national organisation would equally represent their issues and needs the same as those of the larger eastern states. Similar comments were expressed in Darwin and Tasmania.

Further conflict could occur if the organisations perceive the national organisation as being in competition with them, rather than working in partnership and collaborating to further strengthen the peer workforce in their jurisdiction.

Travel would be an essential component of this model which would attract costs.

Model three:

As mentioned with previous models, strong links to the states and territories are critical.

One model we would like to explore is that of Community Mental Health Australia (CMHA). This is quite a unique model in that essentially one person manages, drives policy and submissions and engages with the eight jurisdictional peak community managed organisations. The CEO of CMHA is located within one of the eight peak CMO member organisations, currently Mental Health Victoria.

However, the Project Team are suggesting that only one staff member would be unable to meet the requirements of a national peer organisation and have therefore suggested the establishment of the 'Secretariat' comprising the four staff, detailed earlier. We are also suggesting that a Peer Liaison Specialist be co-located within an appropriate state and territory entity, as is CMHA's CEO for example.

Rationale

From a very small base in terms of staffing and office requirements CMHA operates as a coalition of the eight-peak community mental health organisations from each state and territory and their website states they were '*established to provide leadership and direction to promote the importance and benefits of community mental health and recovery services across Australia'.*

From CMHA's website, we also note the organisation provides a unified voice for over 800 community based, non-government organisations who are members of or affiliated with one of the eight coalition members. These 800 organisations working extensively with people with mental health issues and families across Australia provide numerous state and federally funded services.

The goals and objectives articulated by CMHA are to work with all levels of government, community groups and other interested stakeholders at national, state and local levels, and to build a viable and sustainable Australian community managed mental health sector. Also, to influence government decision making, improve funding for community managed mental health services, promote and strengthen the capacity of the community sector, foster effective partnerships, share knowledge and resources, drive innovation, work together to provide leadership and advocacy, to build unity and enable coalition members to be effective in their individual and collective leadership within their respective jurisdictions.

In other words, all the attributes and things peer workers have stated they would want from a national organisation.

The eight-coalition peak community managed organisations already exist, they are operating in their own right and form the support for the ongoing functioning of CMHA. In terms of a national peer workforce organisation, for an adaption of this model to be considered, existing organisations would need to endorse the concept, be prepared to auspice any such organisation and provide funding or in-kind support. This may be in the form of resources, office space for co-location of staff maximising the opportunity for jurisdictional representation and information exchange and collaboration.

This could see the Secretariat located at the most appropriate entity which could house four staff (CEO, Policy and Governance Officer, Administration Officer and part time Communications Officer) This would be a big ask, and again, this is entirely dependent upon the proposed entity having the capacity and willingness to provide this kind of support and subject to a formal proposal.

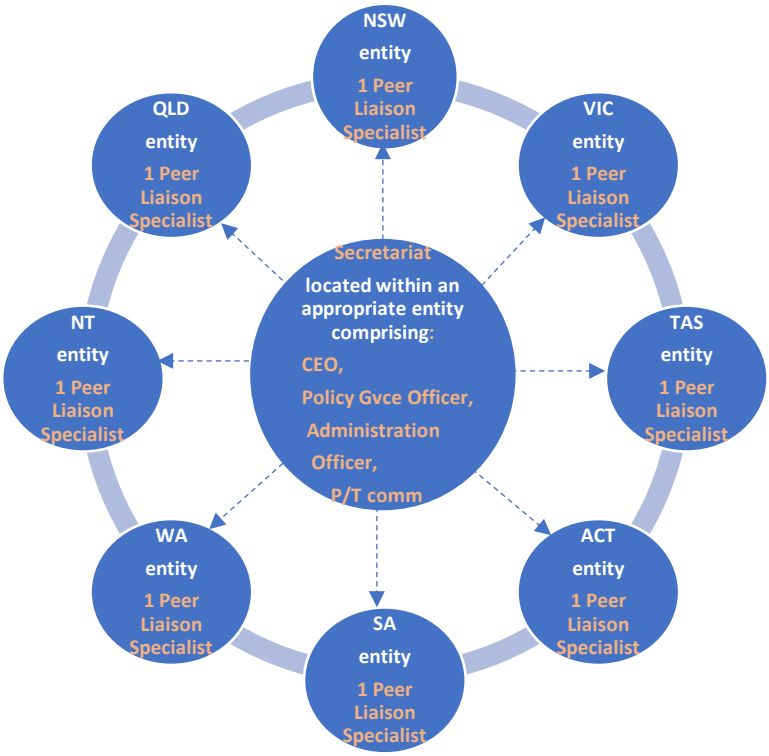
The Project Team are suggesting the eight peak community managed organisations which are members of CMHA, could be best placed as an auspicing organisation for housing the Senior Peer Liaison Specialists given there would not be any perceived conflicts of interest, providing a non-biased, neutral environment. These peak community managed organisations have the interests of people with a lived experience as consumers or carers, not one or the other. Understanding that the roles are different is crucial and the peak CMOs seek to understand and include both roles and all lived experience workers.

However, other organisations could also be considered such as a Mental Health Commission especially to house the Secretariat, PHNs or peak consumer or carer focused organisations such as CoMHWA, Being, VMIAC, Tandem, HelpingMinds or Mental Health Carers Tasmania which currently provide support to peer workers.

The Project Team has been in contact with the CMHA member community managed organisations with most saying they could have a role within a structure such as this model to inform and support the national organisation in their jurisdiction. Additionally, the Project Team has received confirmation from most of those organisations of their willingness to consider co-location of a Peer Liaison Specialist within their organisation. All have advised that this would be subject to the receipt of a formal proposal.

Critically, this would provide that necessary and pivotal link to the states and territories that has been a consistent very strong message from the consultations.

Concept Model Three:



Strengths

The Secretariat would be housed within the most appropriate entity and this could be anywhere in Australia. The Project Team believes strong consideration should be given to locating the Peer Liaison Specialists within the peak CMO organisational members of CMHA which have indicated their willingness to consider a formal approach. Good relationships currently exist within these eight peak organisational members and all support the peer workforce in some way. They would provide that crucial neutral environment which would support either a consumer or a carer who may be appointed as a Peer Liaison Specialist for that specific jurisdiction.

There are several pros in this model. The peak community managed organisations are already well established, have member organisations themselves, and are funded independently. This would provide good partnerships, keep abreast of drivers within the jurisdiction, and have support from the national peer organisation in terms of strengthening their work around the peer workforce.

The national peer organisation through these connections would have the capacity to work with other established organisations and clinical services. They would be well placed to support organisations in employing peer workers and could assist in advocacy at the local level.

Weaknesses

The concept of having a jurisdictional peak consumer or peak carer body as the auspicing or 'hosting' organisation for the Peer Liaison Specialists could be problematic.

Conflict could occur if one of these organisations were willing to provide support, but they were either primarily focused on a consumer or a carer perspective only and the best person selected as a Peer Liaison Specialist for that particular jurisdiction did not have the same lived experience, ie a Peer Liaison Specialist with a carer lived experience being co-located within a jurisdictional peak consumer organisation, for example Mental Health Carers Tasmania (who have expressed a willingness to co-locate) to provide for a Peer Liaison Specialist who may have a consumer lived experience. The same

argument could also be applied to consumer peak organisations in various jurisdictions ie CoMHWA, Being or Victorian Mental Illness Awareness Council (VMIAC) although we received no responses to our approaches to Being or VMIAC and hence their views and willingness to co-locate a Peer Liaison Specialist is unclear.

Most CMHA community managed organisational members and other consumer or carer jurisdictional peaks, do not have continuity of funding over an extended period, with many relying on state or territory funding for their existence. Some are housed in small premises and this would preclude their capacity to offer to accommodate any additional staff even if they were willing to do so.

However, we have articulated peak community managed organisations, but an alternative could be mental health commissions, PHNs or other appropriate organisation.

A variety of insurance issues could make things complicated, as well as staff interactions, oversight, management and responsibility.

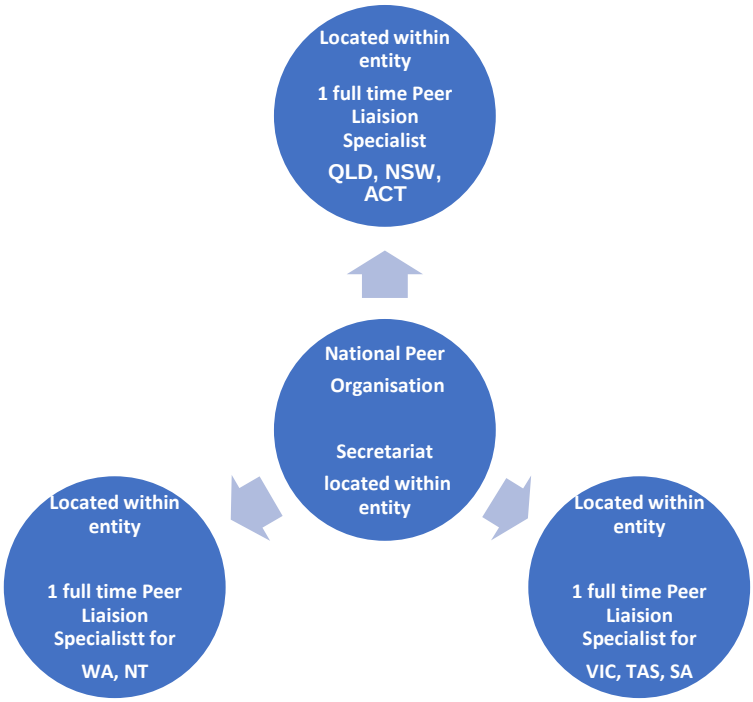
Model four or hybrid:

In the short term and in order to get a national organisation established as quickly as possible, a model for consideration may be an adaption of models two and three above. This would see a centrally located Secretariat within an entity such as a community managed organisation, a mental health commission or other appropriate entity such as a PHN.

For this to be successful, there must be a clear endorsement of the concept of a national peer workforce organisation and a willingness to provide resources such as office space, and the preparedness to auspice or provide in-kind support.

This will be a challenge, but the Project Team believes this could be achieved.

Concept Model Four:



Strengths

This model is seen as a 'fall back' model should Model 3 not be adopted. The only difference with this model is that it would be less costly and have less Peer Liaison Specialists employed.

The Secretariat would be housed within an existing entity and this could be anywhere in Australia, staffing would be as suggested below.

It would see the following:

WA, NT - 1 Full time Peer Liaison Specialist

QLD, NSW, ACT – 1 Full time Peer Liaison Specialist

VIC, TAS, SA - 1 Full time Peer Liaison Specialist

Weaknesses

Although a good option and a lesser cost, this model would place a large work load on the three Peer Liaison Specialists because they would be required to have in depth knowledge, partnerships, and networks across multiple jurisdictions. This may not be easily achievable or efficient.

Travel would also be a requirement and whilst the model would be less costly, significant costs would be incurred to cover a large amount of interstate travel.

Establishment

The key to the establishment of a national entity is flexibility. Many respondents have a real sense of ownership of any model and are keen to have one that is the most positive and feasible which can be established now with flexibility to change and expand as the organisation and the peer workforce grows.

The functions obtained through the consultations have been detailed in Section 5 so we don't intend to note these here. However, what is detailed are some key areas on which to make the decision as to which model is best suited for adoption now.

Options for growth - What can be implemented now, and how can this change over time as the organisation grows.

The role of the organisation would change over time as the peer workforce expands, peer member numbers grew, as contact with other stakeholders is established and the need for growth to ensure promotion of the peer workforce, offer education and training and provide other services critical to peer workers.

The role of individual and professional advocacy would be an initial role, but this would expand with growth of peer workforce numbers, membership and increased contact and engagement with health service providers in particular.

As peer work roles expand, so will the role of the organisation. Access to web-based services for members and organisations and services is an area that has an unlimited capacity to grow. With resources, educational materials, guidelines, and information on peer work, industrial information and the use for peer work members as a 'clearing house' for information.

News items from around the country relevant for each jurisdiction with contributions from the peer liaison specialists would be crucial to capture. From this information, an e-Newsletter for members can be developed and used as a current mechanism for updates and broad mental health information, with particular relevance and interest to the peer workforce.

Stakeholder interactions

The staff of the Secretariat and the peer liaison specialists could be located within any jurisdiction, as the purpose of the entity, the roles and functions, would be similar wherever staff are located. As we have referred to through this report, it is important that employed staff have the flexibility to move around in order to build relationships and make connections with a broad range of stakeholders. The utilisation of technology and web-based resources and information, although fundamental, the 'face' of the entity needs to be prominent in the early stages of establishment and development.

An example of this was the establishment and ongoing work of the National Mental Health Commission, and the way in which they have remained connected across the country. Meetings of the Commissioners and the NMHC forums across the country, including in regional and rural areas has shown the Commission's flexibility, innovation and the level of commitment to the work to be done.

Innovation

The peer liaison specialists have an important role, not only being peer workers and maintaining local contact and connection with the national entity, but also the contact point for health services, training providers, peak bodies and others.

They would be responsible for making connections within their own jurisdiction, representing peer workers locally, and ensuring that there is a better understanding of peer work roles. There is an opportunity through a professional peer workforce and a national representative body to work on improved communication and challenging the current siloed approach to care. The growth and inclusion of peer workers has the potential to contribute markedly to genuine mental health reform which does put the person at the centre of their care.

Coordinating regular visitation at PHN regional based offices in each jurisdiction could be achieved and the peer liaison specialists could work from the PHN office during their visit. This would allow for genuine building of collaborative relationship and engagement. This would be quite innovative and of mutual benefit to the peer organisation and the PHNs. Exchange of information, a growing understanding of the work and roles of each, local connections and assisting in local, state and national engagement and partnerships. This would not happen overnight, but a start would be to have the peer liaison specialist on a regular visiting schedule initially with a view to potentially sitting in the office for short periods.

Relationship building

Potential ways of working with other sectors i.e. governments, state and federal, PHN's, community managed organisations, peak consumer and carer organisations, training organisations, professional and industrial bodies will be key to success. Raising awareness and improving knowledge of the peer workforce would be one of the initial important roles of a national entity. Staff would also need to establish and build relationships with organisations, services that employ, support or provide networking and training opportunities for peer workers.

Connectedness

Key issues of importance for a national organisation would be the ability to connect with PHNs and consumer and carer/peer worker networks that are being established and other key stakeholders.

A national organisation must also have the ability to connect with public and private sector mental health services. This will be one of the challenges, but it is anticipated that with a national entity established, the peer workforce will have a unified voice, provide a greater awareness and understanding of peer work roles. The organisation can provide answers to questions, education for service providers with consistent messaging about peer work.

There appears to be inconsistency across PHNs with a limited number having commissioned services to employ peer workers. The Project Team see this as an area where a national entity could make significant progress working collaboratively with PHNs by providing resources, support, training and information which could contribute to the development and roles of peer workers across the 31 PHNs nationally.

Travel will be a key component of funding for the national entity to be the most effective, have the ability and resources for staff to travel, (particularly the peer liaison specialist) is an important function. This will allow them to remain informed by the peer workers they represent, stay abreast of mental health services and activities in their jurisdictions, and build and maintain communication links with a range of stakeholders across all mental health sectors. Regional areas have issues that are different to their metropolitan equivalents, and peer workers in rural settings would benefit from direct contact with the peer liaison specialist, this role was strongly recommended by peers working in regional areas who expressed their feelings of disconnectedness and isolation.

The capacity to meet face to face with mental health service providers is one mechanism for improving awareness and establishing links and building relationships.

The Project Team strongly believe a further key component will be the interaction with peer educators, peer managers, peer academics, peer researchers and other peers working in various roles. The extensive value they bring would inform and add to the work and direction of the peer workforce and the national organisation. These views, perspectives and insights will be crucial to capture going forward.

Recommendation

The Project Team recommends the following:

Adoption of Model 3

Model 3 could be established to provide the ability and flexibility to move to the establishment of jurisdictional branches (Model 1 – gold standard) as the organisation expands in the future and as more funding becomes available.

Section 8

Support for a national organisation

Part of this Project has been to seek financial or in-kind support for a national organisation for the peer workforce in both the short and longer term.

The Project Team explored this aspect with the four Mental Health Commissions when face to face meetings occurred during the consultations in the states of WA, QLD, NSW and SA where the Commissions are located.

As the Project is primarily a scoping study at this time, all four mental health commissions showed an interest in supporting any new national organisation in a variety of ways. However, a definitive response is not possible until each commission receives a formal funding proposal detailing the amount requested, and other aspects which would be required by them before they would be willing to provide any financial commitment.

A follow up email was sent to each of the four Commissions and posed these two questions:

1. If there was a member based national entity for the mental health peer workforce, what would it look like from your (the MH Commission) perspective?

2. If a national peer organisation was established, do you see a role for the Mental Health Commission, and if so, what might that look like?

State Based Mental Health Commissions

The State Based Mental Health Commissions (WA, QLD, NSW and SA) advised verbally that they were supportive of a national organisation and would provide a formal response following submission of a proposal for support.

Mental Health Directorates and organisations

Formal letters were sent to the following with most providing a response.

NSW - Mental Health Branch, Strategy and Resources Division

SA – SA Health, Mental Health Directorate

TAS - Department of Health and Human Services, Statewide Mental Health Services

VIC - Engagement and Integration, Mental Health Branch, Health and Wellbeing Division, Department of Health and Human Services, via teleconference 8 November, 2018

ACT - ACT Mental Health Directorate

WA –Mental Health Unit, WA Health

QLD –Mental Health Alcohol and Other Drugs Branch

NT –Mental Health Alcohol and Other Drugs Branch

Ramsay Health Care

Catholic Health Care Australia

Healthe Care Australia Pty Ltd

Don Dunstan Foundation

Beyondblue

In-kind support

In following up the peak CMHA member organisations seeking their thoughts on how they could support a national organisation, we have an indication from the following organisations. Consideration would be required as outlined previously in terms of insurances, staff management etc. together with a formal approach detailing requirements.

Mental Health Council of Tasmania

'MHCT would definitely want to be involved in some capacity, what that would look like would depend on what was required of us given who we represent, being the community managed mental health sector as opposed to professional associations. We would as always be wanting to consult with other jurisdictions where relevant to ensure we are being as useful as possible'

Mental Health Community Coalition ACT

'The Mental Health Community Coalition ACT would be willing to consider the co-location in their office of a Peer Liaison Specialist if a national peer work organisation is established. With the activity and commitment to the peer workforce in the CMO sector and their ongoing strategic work with ACT Health, it would seem an appropriate fit with the MHCCACT. This would of course be subject to an appropriate proposal or business case.'

Mental Health Coalition of SA

'MHCSA could see the state representative co-locating with us. This could be particularly useful if they are working essentially alone or in a small team. There are some good synergies.

SA doesn't have a Lived Experience Peak at the moment, however the MHCSA does have the Lived Experience Workforce Program (LEWP) which has been in operation for over 3 years. The project team has lived experience with the Senior Officer role designated as LE. We also have a Reference Group that has co-designed everything we do. MHCSA has 2 important threads in our work - lived experience and now human rights. We make sure we have significant numbers of people with lived experience at all forums and research projects. On that basis I'd like to suggest MHCSA could be a relevant organisation to operate from in SA.'

Mental Health Coordinating Council

'If a national peer work organisation were to be established, it would be important to ensure a state/territory presence. Subject to an appropriate business case and the support of our consumer and carer peak bodies, we would be happy to consider peer liaison specialists being co-located with the MHCC.'

NT Mental Health Coalition

'It would make sense to have this position sit within the community mental health sector'. Additional comments are:

- ‘I would also say as the peak body for the peer support workforce, advocacy and giving voice to this workforce is important.
- The NT MH Coalition could provide support for peer workers to undertake training by offering networking and mentoring opportunities and as a liaison point for any RTO that is delivering the national peer work qualification.
- Expect the RTO to ensure the principles of best practice are taught in each state & territory, and to meet the standards required by a peak body.
- Feel the process for the development of the Aboriginal & Torres Strait Islander Health Workforce is a rigorous process and provided an example of a good model process and subsequent necessary training and pay scales linked to training and qualifications’.

Additional responses were received from the carer peak body in Tasmania and WA.

Mental Health Carers Tasmania

‘With appropriate resources MHCTAS would be very happy to assist in any way we can. We would have office space to offer plus a high profile as the Peak Mental Health Carer body in Tasmania. We also have a partnership with an RTO that delivers Cert IV in Mental Health peer and carer work and the RTO is in the same building as our Office’.

HelpingMinds WA (Formerly Mental Health Carers Arafmi WA Inc)
‘Has indicate a willingness for HelpingMinds to consider co-location of the role of Peer Liaision Specialist given the importance of this role being locally situated’.

Recommendations

The Project Team recommends the following:

That the National Mental Health Commission progress or commission the:

Development of a business case or formal funding proposal which details the funding sought and other critical requirements. This would be provided to the entities which have indicated an interest in receiving a formal request for potential funding contributions.

Or

Develop a business case or formal funding proposal for the Mental Health Principle Committee:

1) Seeking funding via the established formula for states and territories funding requirements for a three-year funding commitment.

2) Provide additional funding beyond the population-based funding formula or an adjustment to the formula to the smaller states of WA, TAS and NT where additional work is required to establish and expand the peer workforce.

Once the funding has been secured, the National Mental Health Commission to progress or commission the:

3) Development of a formal proposal seeking in-kind support from the organisations who have indicated an interest.

4) Establishment of a Steering Committee of peer workers and other relevant experts including legal to oversee:

    - Legal documentation required including a Constitution to establish the Company Limited by Guarantee

    - Recruit the CEO, and Policy and Governance Officer to further the work required for the establishment of the organisation

    - Explore, approach and establish the Secretariat and Peer Liaison Specialists within appropriate entities

Section 9

Focus on the Employer

An important part of this Project was to liaise with the NSW Mental Health Commission regarding the work that has been undertaken focusing on the employer.

The contents of the resources were informed by research conducted by Craze Lateral Solutions and in consultation with peer workers. The Peer Work Hub is supported by the Mental Health Commission of NSW.

Three resources were developed however the Commission advised they are currently under revision as is the work and content of The Peer Work Hub:

Employers Guide to Implementing a Peer Workforce:

Employer's guide to implementing a peer workforce – A Case for your Organisation

http://peerworkhub.com.au/wp-content/uploads/2016/05/Business-case.pdf

Employer's guide to implementing a peer workforce – Planning Tool Kit
http://peerworkhub.com.au/wp-content/uploads/2016/05/Toolkit.pdf and a further resource titled:

Employer's guide to implementing a peer workforce - Language Guide
http://peerworkhub.com.au/wp-content/uploads/2016/11/MHC_223072_Language-Guide_Carer_v4.pdf

The Project Team distributed these resources via the TheMHS 2018 booth of the Network. The promotional resources were made available together with the flyer promoting the *'Employers Guide to Implementing a Peer Workforce'*, Peer Workforce Hub, NSW Mental Health Commission.

The flyer promoting the resources was also distributed to those who attended the consultations, and those on the Project interest register. The distribution and promotion of this resource through TheMHS 2018, the Network contacts, National Mental Health Consumer & Carer Forum, National Register, Mental Health Australia and their members satisfies the requirement of the Project.

The promotional flyer of the resources follows:

Employer's Guide to Implementing a Peer Workforce

Download these three resources to guide you

People with lived experience have unique expertise that can be transformative for people who access services, their families, carers and for mental health services and systems. To achieve a recovery-oriented system of mental health and social support, we need peer workers everywhere in that system. We need peer workers to provide peer support to consumers and carers. We need peer workers to participate in quality improvement, evaluation, and design of services. We need peer workers in policy and planning roles. We need peer workers in management positions and working as system leaders.

The Private Mental Health Consumer Carer Network (Australia) is pleased to promote these valuable resources that support organisations to establish quality Peer Work models. These employers guides are currently under review but can be downloaded from the Peer Work Hub www. peerworkhub.com.au

Employers Guide to Implementing a Peer Workforce:

A case for your organsiation
peerworkhub.com.au/wp-content/uploads/2016/05/Business-Case.pdf

Planning Toolkit
peerworkhub.com.au/wp-content/uploads/2016/05/Toolkit.pdf

Language Guides
peerworkhub.com.au/wp-content/uploads/2016/11/MHC_223072_Language-Guide_Carer_v4.pdf

The Private Mental Health Consumer Carer Network (Australia) is currently undertaking a project to investigate the feasibility of establishing a member based National peer worker organisation. To provide input and see updates, go to www.pmhccn.com.au/PeerProject

The content of the resources was informed by research conducted by Leanne Craze of Craze Lateral Solutions and in consultation with peer workers. The materials presented in this publication are distributed by the Mental Health Commission of NSW as an information source only. The information and data in this site is subject to change without notice.
ISBN: 978-0-9945046-5-4

Private Mental Health Consumer Carer Network (Australia) Limited
engage, empower, enable choice in private mental health

Section 10

Recommendations for future work for the National Mental Health Commission

The NMHC has representation on the Mental Health Information Strategy Standing Committee. Also, at the Project Reference Group meeting of the 19th April 2018, the NMHC representatives agreed to seek an update on Action 30 of the 5th National Mental Health and Suicide Prevention Plan.

Work is scheduled to begin in mid-2018 and will be ongoing:

Action description:

Governments will monitor the growth of the national peer workforce through the development of national mental health peer workforce data including data collection and public reporting.

Roles:

1) MHISSC will continue development of data sources to monitor the growth of the national peer workforce in public sector mental health services.
2) MHISSC will also identify opportunities for reporting of employment of peer workers in the non-government sector, including PHNs.

Data collection

1) Consistent definition

Apart from supporting and influencing the development of data sources the NMHC could provide funding to an organisation to undertake work or could do the work itself to determine and clarify a nationally consistent definition of a peer worker including their role.

2) Non-Government Organisation Establishment Data Set

The AIHW referred to the Non-Government Organisation Establishment Data Set Specification (NGOE DSS) which has been developed, but as at February 2016 there has not been agreement for this to be implemented nationally. According to AIHW the NGOE DSS is a lower stringency data set type compared with a National Minimum Data Set. The NGOE DSS does include data items relating to mental health peer workers, and so is a potential future data source (dependent on national implementation) for providing a more comprehensive view of the peer workforce.

The NMHC could advocate for the implementation of this data set nationally,

OR

Mental Health Non Government Organisation National Best Endeavour Data Set

The Western Australia Mental Health Commission has decided to implement the *National Best Endeavour Set* and Queensland has expressed interest in implementing it also and the Project Team understands this has taken place.

The NMHC could advocate for the implementation of this data set nationally especially given that two jurisdictions are collecting the data on the peer workforce for the community managed sector.

Guidelines for the Peer Workforce

The 5th National Mental Health and Suicide Prevention Plan requires the NMHC to develop Peer Workforce Development Guidelines. At the time of this Report a roundtable has been undertaken with key stakeholders by the NMHC on Friday 30th November 2018 at Parkroyal Hotel, Melbourne Airport.

The Network was invited to attend, we were represented, and the Project's Peer Specialist also attended.

Guidelines developed by other organisations.

A number of organisations have developed their own guidelines. One of these the Project Team wish to detail is from the Mental Health Coalition of SA which has spent a great deal of time developing Standards and Guidelines and these are available on their website. The process in the development of these resources, involved extensive consultations with peer workers, the Lived Experience Workforce Project committee, Aboriginal and Torres Strait Islander representatives and people from culturally and linguistically diverse backgrounds and LGBTQI.

http://www.mhcsa.org.au/lived-experience/lewp/

The website states in relation to the Standards and Guidelines:

NGO Mental Health Lived Experience Workforce Standards and Guidelines

The Standards and Guidelines have been co-designed by members of the Lived Experience Workforce (LEW) Reference Group: people who are in designated Lived Experience roles or Leaders of Lived Experience Workforce (LEW), within the NGO sector.

Designed as a self-assessment tool for organisations, the Standards and Guidelines offer best practice principles for embedding and growing the LEW. Organisations are able to assess where they stand in terms of recruitment, support (retention), leadership and growth and development. Conducting a gap analysis provides opportunity to develop clear, purposeful strategies for embedding the LEW within the organisation.

Implementing the Standards and Guidelines demonstrates commitment to support of the LEW and creates a unique opportunity for organisations to become a provider of choice.

Who better to support someone in their recovery, than someone who's been through it?

The Lived Experience Workforce Standards and Guidelines can be downloaded here:

Mainstream/LGBTIQ Standards and Guidelines

CALD Standards and Guidelines

Aboriginal Standards and Guidelines

Standards and Guidelines Action Plan

The Project Team believes these Standards and Guidelines are excellent and commend them to the National Mental Health Commission.

National Qualification

The uptake by Registered Training Organisations in offering the nationally recognised qualification **Certificate IV in Mental Health Peer Work CHC43515** has been slow broadly speaking with no organisation offering this in the Northern Territory.

The Project Team believes the NMHC has a role in advocating for a broader role-out through the training sector of this qualification. Further, we believe it is essential that the NMHC seeks to influence the introduction of this qualification into the Northern Territory. The NMHC could also have a role in building the capacity of the workforce for example, supporting or advocating for the uptake of introductory courses, traineeships, scholarships, etc.

Recommendations

The Project Team recommends the following:

The National Mental Health Commission advocates for or influences the uptake or introduction:

In relation to data collection:

1) Develop or engage an entity to determine a nationally consistent definition of a peer worker including their role.

2) Advocate for the implementation nationally through the AIHW & MHISSC of the Non-Government Organisation Establishment Data Set OR the Mental Health Non Government Organisation National Best Endeavour Data Set

In relation to Peer Workforce Guidelines:

3) Finalise the development of the Peer Workforce Development Guidelines with due consideration to those already undertaken by other organisations.

In relation to the national qualification and other training:

4) Advocate for the greater role out and uptake of the **Certificate IV in Mental Health Peer Work CHC43515** national qualification.

5) Seek to influence the introduction within the training sector of this qualification into the Northern Territory.

6) Advocate for the uptake of other professional development or as an introduction to peer work through things such as Intentional Peer Support (ISP), introductory courses, traineeships, internships or scholarships across jurisdictions.

Gaps, barriers and opportunities

The Grant Agreement required the Project Team to summarise any gaps, barriers and opportunities.

We have endeavoured to highlight these consistently throughout the various sections of this report and have therefore not felt that they need to be repeated in detail here. Suffice the noting below:

Gaps

Within this Report, the Project Team have identified numerous gaps. These are primarily around data collection on the peer workforce, their roles and a nationally consistent definition. At the moment most data is collected only for the specialised mental health services and does not extend nationally to the community managed sector. Additionally, the update of the peer workforce within the private sector is a significant gap. It is unclear as to why this is so.

A number of priorities for the peer workforce have been identified within the 5th National Mental Health and Suicide Prevention Plan with details articulated within the Implementation Plan with work for the National Mental Health Commission and the Mental Health Information Strategy Standing Committee.

We will not list these again here, having already been noted in detail elsewhere.

Barriers

The Project Team have articulated within Section five - national consultations, the view from some consumers that any national organisation for the peer workforce should be for consumer peer workers exclusively. We have noted the drive from some to argue for and promote this view. There has also been a view, though very limited, that even some other peer workers should be excluded, namely those working in the areas of alcohol and other drugs, the NDIS, volunteers, and carer peer workers. These views are not consistent with the feedback from the broader national consultations or online survey findings. These could potentially be the main barriers to the uptake of a national organisation for the peer workforce.

The results once obtained and analysed, from a survey distributed by two of the state peak consumer organisations on the 21 December 2018 may provide content which is not consistent with the findings of this Project and could raise dissent with the recommendations made in good faith by the Project Team based on all feedback from all consultations across Australia.

The Project Team has some concerns that with a sense of division of this nature, this could waylay or jeopardise the strong argument for the establishment of the national organisation.

Opportunities

The opportunities for the peer workforce are boundless and are restricted only by full acceptance of the role, resources and innovation.

Greater expansion of the peer workforce has been noted throughout the consultations with initiatives in Tasmania, NSW and South Australia especially.

Much has been achieved in the United States for example where innovative services have been created, amongst these:

1) Peer staffed crisis centres as an alternative to emergency department presentations
2) Co-operatives for and by peer workers
3) Peer workers working alongside mental health clinicians on mobile assertive teams attending call outs
4) Peer work has been recognised federally in America as an evidence-based mental health practice and profession for some time. The services of certified (accredited) Peer Specialists are Medicaid billable from http://peerworkhub.com.au/the-case-for-peer-work/peer-work-globally/

With the establishment of a national member based organisation for the peer workforce, Australia will lead internationally. This has not been established in the US for example, although discussions are also happening.

This would be a first. We called this Project the **'Community of Peers'** and we believe this is what is required to firmly embed the peer worker role in all facets of mental health in Australia.

Do we dare to dream?

Resources

Below is a list of Resources provided to the Project Team during the course of the Project.

A critical discussion of Peer Workers: implications for the mental health nursing workforce Journal of Psychiatric and Mental Health Nursing (2016)

Annual Report 2016 – 2017 CoMHWA

Annual Report Team Health (2016-2017)

Australian Association of Social Workers Limited, Governance Charter, June 2017

Australian Institute of Health and Welfare. Australian Government (2016) Mental Health Peer Workers

Barriers and enablers to lived experience workforce development Queensland Mental Health Commission (2017)

Best Models for Carer Workforce Development: Carer Peer Support Workers, Carer Consultants, Carer Advocates and Carer Advisors, Prepared for ARAFMI WA**,** November 2011

Best Practice Framework in Peer Support Chronic Illness Alliance (2015)

Better Choices, Better Lives, Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025, WA Mental Health Commission

Centre for mental health and Mental Health Network, NHS Confederation (2013)

Considerations when operating a peer support service, 2013 ARAFEMI Victoria

Developing a strategy for the Consumer Workforce in Victoria Consumer and Carer Workforce Development Team (2018)

Discussion Paper: To identify the role of Primary Health Networks in the development, commissioning and support of the peer workforce, PHN NSW and ACT 19 February 2018

Draft framework for the establishment of a peer workforce in public mental health services Tasmanian Government. Mental Health, Alcohol and drug directorate (2018

eMHPrac, E-Mental Health in Practice, A Practitioners Guide to Digital Mental Health Resources June 2018

Employers Guide to Implementing a Peer Workforce: Peer Hub, Mental Health Commission of NSW

A case for your organisation; peerworkhub.com.au/wp-content/uploads/2016/05/Business-Case.pdf
Planning Toolkit; peerworkhub.com.au/wp-content/uploads/2016/05/Toolkit.pdf
Language Guides; peerworkhub.com.au/wp-content/uploads/2016/11/MHC_223072_Language-Guide_Carer_v4.pdf

Establishing an effective peer workforce, A literature review, Tori Bell, Graham Panther & Sarah Pollock, Mind Australia May 2014

Growing Peer Support in Services and Communities, WA Peer Supporters' Network, CoMHWA

Incorporated association or company limited by guarantee, June 2013 NSW Not-for-profit Law Guide

Identifying barriers to change. The Lived experience worker as a valued member of the mental health team Dr. Louise Byrne, Helena Roennfeldt, Dr. Peri O'Shea (2017)

Interim report on Peer worker review Michele Banks. CHSA Workforce Strategy Committee (2018)

Lived Experience Workforce – South Australia History, Issues and Recommendations (2018)
Mental Health Peer Workforce Literature Scan 2014, Australian Government, Health Workforce Australia

Lived Experience Transformational LEADership Academy. A Curriculum for Facilitating a Virtual Academy Chyrell Bellamy & Maria E. Restrepo-Toro Yale Program for Recovery and Community Health, 2017

Mental Health, alcohol and other drugs-consumer engagement activities Primary Health Network Brisbane North (2018)

Mental Health Peer Workforce Study, 2014 Australian Government, Health Workforce Australia

Mental Health & Suicide Prevention Service Review Northern Territory Mental Health Coalition (2017)

Needs Assessment of the Mental Health Peer Support Workforce in the Northern Territory Northern Territory Mental Health Coalition (2018)

Peer Participation in Mental Health Services (PPIMS) Network – 2017 Snapshot, Brisbane North

Peer Participation Project, Report July 2016, Brisbane North Partners in Recovery

Peer Support Association, Strategic Plan and Development Strategy; Outcomes of the Strategic Development Day for Peer Supporters 29 November 2014 Hosted by CoMHWA and Carers WA

Peer Support Toolkit Department of Behavioral Health and Intellectual disAbility Services (2015). Available at: http://www.acharaconsulting.com/peer-support-toolkit/

Peer Support Workers: a practical guide to implementation. Available at: http://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/7---Peer-Support-Workers---a-practical-guide-to-implementation-web.pdf?dl=1

Peer Work in Australia, (Meagher, J, Naughtin, G., September, 2018)

Peer Work Champions' Community of Practice, CoMHWA News

'Peer workers, family, friends vital to mental health recovery'' 11 October, 2018 South Coast Register, PEER WORK in South Eastern NSW PHN, Tim Heffernan, November 2018

Peer Work Leadership Statement of Intent, A National Professional Association for Mental Health Peer Workers 2017

Peer workforce development guidelines 2013, Health Workforce Australia

Peer Workforce Forum, 29 March 2017 Write up of discussions and ideas for moving forward

Peer Work Strategic Framework Western Australian Association for mental health (2014). Available at: www.waamh.org.au

Peer workforce valuing lived experience framework Far North Queensland Mental Health Alliance (2016). Available at: www.peerworkforce.com.au

Peers Australia: A national association for the promotion of peer work.
Geoff Phillips, Charmaine Gallagher and Mark Streater,1 SA Themhs 2011

Professional/Reflective Practice Supervision for the Lived Experience Workforce in Queensland's Public Mental Health and Alcohol and Other Drugs Services Michelle Edwards (2018) *Resources to assist the sound development of mental health peer workforces across NSW* Leanne Craze (2015) Grow Well Resource Bank.

Queensland and lived experience workforce: Building Foundations Forum, May 2018 Brook RED and Brisbane North PHN
Service user, consumer and peer workforce - A guide for managers and employers (2014) Available at www.tepou.co.nz

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Appendix A

Compilation notes from workshops

1. Adelaide Consultation – Thursday 7 December 2017 - Community of Peers Project held at Walkerville Town Hall.

Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	**Attendees – 29 in total from a mixture of settings,** NGO's public MH, Office of Chief Psychiatrist and those who have had some years working in a peer worker role, now consultants or educators/trainers Also people enrolled in current TAFE Cert 1V in Mental Health Peer Work Participants generally understood the Governance models and the importance of set up
Staffing: • Executive director and staff - Will they be required to have a lived experience?	• General consensus that ED role and staff should have a lived experience • But importance placed on the importance of appropriate skill and the 'right' person • and people to fill the roles – experience important, but characteristics, personality a priority
Table 1: *Professional development, educational or training activities* – would do you want the body to offer training or PD opportunities? Differences – see attached sheet *Support Services:* ○ What might these look like for you	Rather than offer training or PD directly the national organisation could direct standards of care and accreditation for the LE workforce. • Best practice framework to support LE workforce • List training options available on a website: ○ State options ○ Regional ○ Specialisations Support services: • External supervision – set standards • Register of providers • Recruitment & selection standards • Evidence based/impact/outcomes (published) info
Table 2: *Advocacy: systemic rather than personal?* • do you see this as also promoting the profession of peer work? • Includes the development of policies and guidelines for peer work?	The lived experience to be embedded in systemic advocacy and policies Definitely – profession of peer work is the key – Having a skill set Systemic advocacy for the LE embedded in programs – federal & state policies • Personal advocacy has a place – nothing will change unless systemic advocacy is done correctly Systemic advocacy stays on message and is relentless ○ But individual concerns inform this ○ Identify trends ○ Individual Advocacy • To happen indirectly through education

Promotional activities of the organisation: What would these include: • Representation to Governments and NGO's Working with educational institutions	• Referral Work or equivalent to Public Service Associations/Unions • themes to be addressed systemically (mechanism) e.g. Data / research • Reference to reasons for advocacy – eg. having indemnity insurance Accept all feedback – formal/informal • If an individual issue – opening up to peer workers e.g. survey/workshop to gauge whether or not is a systemic issue **Promotional:** Definitely representing: • Volunteers • NGO • Government Yes, to work with educational institutions • More speeches • Provide education • Oversee education
Table 3: *National representation of peer workforce*: Would this include: • Setting standards for leadership of organisations employing peer workers • standards for payment of peer workers • standards for what peer work is and what it isn't • standards for supervision of peer workers	**Setting Standards** • Overarching standards for peer workforce across specific to state/national (guidelines) • as opposed to detailed …..variation in roles / organisations / services • National Guidelines, state branch interpret to suit local demographic/aware/situation etc. • Audited, accredited, embedded within organisations/services • Consider language (eg peer work, LE work, LE practitioner, LE consumer, LE carer etc.) • varies nationally: impact on Award/remuneration/utilisation of LE skillset etc. • Remuneration/Awards • Professional development – priority, resources (e.g. database, intranet, sharing) • includes management/leadership training • Supported mentoring time for LE staff, includes volunteers/trainees/students – including skills/strengths beyond LE skillset • Supervision • Peer work principles (& recovery, TIC, approaches as key) – values, qualifications, clearly defined roles/ J&P's - What is the standard: what constitutes LE? How is it effectively utilised? - Value of LE within mental health & beyond (other sectors): recognition formally • Career pathways, position/security • Current state of peer workforce in SA, projected growth & development • - regularly reviewed: numbers, roles, where/how work, register, movements • - advocacy: funding, minimum of peer workers in services/organisations, fit within NDIS *or* • NDIS to fit into peer work model *or* another model

	• Peer work – scope
	• Peer to peer
	• Scope of lived experience
	• Scope of practice
	• Appropriate to job role and who you will be supported
	• Guidelines & monitoring – bringing together nationally shared vision of LE roles
	  ○ Recommend structures
	  ○ Unifying (consistency) – bring together what is fragmented

Table 4:
Code of Conduct:
Does this include:
• establish, monitor and improve practice standards and ethics
• Advice on Quality and safety
 	
Membership:
Who will be eligible?
• paid peer workers
• volunteer peer staff
	• Accreditation for peer workers – keeping up the standard
	• Quality control – yes
	• Is this for paid or volunteer positions?
	• Does this have a membership fee?
	• Will it be tiered?
	
	Membership to be:
	  ○ Paid peer workers
	  ○ Volunteer staff
	  ○ Carers
	
	Government & NGO – i.e. TAFE
	Relevant to <u>Lived Experience</u>
	Organisations working with private mental health networks
	
	CODE OF ETHICS
	<u>National MH Peer Workforce Development Guidelines - Regular Review of Code</u>
	• Respect for different perspectives & diversity
	• Mutual support
	• Confidentiality/disclosure/privacy
	• Consumer-centred
	• Advocacy & empowerment
	• Recovery principles
	• Active development of LE workforce practice
	• Working in partnership
	• Co-design equality
	• Multidisciplinary collaboration
	• Authenticity / excellence – professional development & learning & reflective practice
	• Constituent (consumer & carer) representation

General comments - Leader of the organisation and staff	• Bring the right skill set • Lived experience preferable • Using the 'extraordinary' people • Consideration where people are at in their recovery journey • Lived experience at decision making level • Professional body – treating lived experience as a discipline • If two people have the skills – the person with lived experience should get it

	• If you have the skills, you have to 'get' lived experience and allow them to be supervised/mentored • Right individual who can get outcomes and have just the right skills and 'get' lived experience • It needs to be someone with lived experience who is supported to further develop their skills
Professional development, educational or training activities	Rather than directly offering training – monitoring role? • Standards of care – best practice framework • Accreditation of peer workers • Valuing principles of TIC, recovery • Work roles – growth, career development • Website listed all training options nationally (including state) • Others supports – external supervisions o Provide or set standards o Have register • Recruitment and selection standards • Knowledge of evidence based outcomes published • Qualification levels • Identifying people who want to move into leadership roles • Provide mentoring • Register people who are willing to mentor • Provide supervision
Advocacy: Systemic rather than individual *Promotional activities of the organisation*	• Systemic advocacy for lived experience skill set • Indemnity insurance for discussion • Top down/bottom up policy approach • Holder of evidence • National representation • Credential peer workers – bios of credited peer workers • Recognise prior learning and experience • Local branch liaises with Cert 4 RTO's? • Point of contact – with website o Can be used to find peer workers/participants for programs e.g. NDIS o Update information as a 'go to' – more information for the public • Connect with 5th plan promotion/activities • Recognise the profession through communication – videos/youtube • Values diversity • Education and promotion of the peer workforce • Including definition/roles/values/skills/ethics/supervision • Write & implement policy Representation to Government, NGO's, PHN's and volunteers To other services ie. referral mechanism/spot Maintaining integrity Work with educational institutions through: o Programs o Workshops o forums Peers to share experiences – issues to inform

	Promoting policy for lived experience workers Can be used to inform other services/if & when needed Maintaining integrity for who it represents giving it a status

National representation of peer workforce:	Set standards for:
	• Quality control – oversight for/responsibility for S & Q
	• payment levels – base level and experience
	• remuneration – multiple levels / volunteer /trainee
	  ○ base level / experience / & qualification
	  ○ volunteers not to be devalued (clear scope)
	• leadership
	• supervision
	• what peer work is and isn't
	• recruitment
	• National Standards for managing peer workers
	• Minimum standards for student training
	• Scope of the peer workforce
	• What is a peer? Lived experience to lived experience
	• Value volunteer peers
	National Guidelines
	Organisations considering guidelines as 'Gold Standard'
	• Interpretation
	• Local levels for payment etc.
	• Ratio – clients to peer workforce Eg. Flourish – "why not a peer worker"
	• Auditing capabilities
	• Accrediting organisations
	• Quality assurance
	• Language – unified, standardized

2. Melbourne Consultation – Thursday 15 February 2018 - Community of Peers Project held at VMIAC, Brunswick East, Melbourne

Separate brief consultation with Tandem, Abbotsford

Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	**<u>Attendees 33 – in total from a mixture of settings, majority consumers</u>** Explained – no additional comments
Staffing: • Executive director and staff - Will they be required to have a lived experience?	All have lived experience Strong discussion around having a separate lead organisation for consumer and carer peer workers Group would like to be consulted on the final report Vote taken: Question: <u>Those who want the organisations to be separate consumer and carer</u>

	Yes 29, No 1, Not sure 3 Employers need to have lived experience – Board member and consultants (at least 75%) e.g. GROW
Table 1: *Professional development, educational or training activities* Would you want the body to offer PD opportunities or training? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as a professional development activity	Offer professional development opportunities and training – large and small Mandatory supervision and training Peer internships. Create unity for same practice within peer work Make Cert IV accessible and assist with funding Opportunities train ASIST Make sure lived experience is valued before qualifications Trauma informed care training Professional development opportunities and training Education of peer workers role to mh services and community (all points on the Agenda to be included) For the body to offer PD opportunities and training as this provides credibility to positions of peer workers and employees/managers are more likely to look favourably on these positions. Is/should there be any requirement to undertake PD. Should 'Registration' be contingent upon this? Time should be provided for this, staff should be supported. What is this? PD going to look like and who makes this decision? <u>Professional Development idea:</u> Guidelines and opportunities created at a national level for career development that feed back to the smaller organisations (gain funding) • Mentoring and supervision mandatory in training, particularly first 3 months of employment to avoid feelings of isolation. Ongoing thereafter • Peer internships available • Foster carers and consumers in their career development aligned with their aspirations • Create unity to provide same practice within the peer discipline <u>Education & training activities</u> • on the job training for carers and consumers • make Cert lV in Peer Work accessible to those who may find it hard to afford • make education & training available to everyone <u>including regional area peer workers</u> • fund courses & training within employment possibilities • give a range of courses available & training days e.g. IPS, suicide assist, emotional CPR, de-escalation training etc. • make sure lived experience and work readiness are valued ahead of qualifications <u>MORE FUNDING IN PD & TRAINING</u>

Table 2: *Support Services:* What might these look like?	Liaise with unions and community of practice re issues and needs of the peer workforce e.g. reasonable adjustment Group supervision for isolated peer workers Support diversity Support CALD Peers Peak issues and needs Highlight fantastic outcomes **<u>ALL OF THIS FEEDBACK IS ONLY RELEVANT TO A CONSUMER ONLY ORGANISATION.</u>** • Define boundaries and overlaps with unions • Liaise with unions – a community of practice – a new workforce with issues and needs that unions don't always understand eg. reasonable adjustment, scope of practice (this is often misunderstood by clinicians) and services asked to practice with other disciplines that don't fit with our skills or ethics • Community of practice / or group supervision for isolated / rural workers • Support for diversity in peer work & related issues • Provide referrals to qualified supervisors and counsellors when required (& not provided by employers) • Research workforce experiences, key issues & needs, outcomes, discipline (body of knowledge) • Actions to hold employers accountable for supporting the workforce appropriately Fact sheets for members – o Support entitlements o Workforce issues and strategies eg. isolation – pressure to be unethical, discrimination, harassment, bullying <u>Professional Development</u> • Provide a position on supervision needs of workforce o for different roles o for different contexts/settings o individual & groups • Provide training & continuous education • Provide training standards & accreditation of training by others • Annual conference with well funded bursaries <u>Advocacy</u> Mostly systemic advocacy – • For workforce & clients of the workforce ** the ethics of consumer advocacy are critical & complex • Advocacy to clinical and other non consumer services that are employers – to educate on peer work ethics, principles, needs, etc. – understanding organisation readiness to employ consumer workforce
Table 3: *Promotional activities of the organisation*: Would these include? Represent and advocate for the interests of members as a group = promotional activities/advocacy	Fact sheets for members Common workforce issues and strategies National position on workforce needs Training standards Offer accreditation Conference with bursaries due to low salaries Provide individual support in the workplace Disseminate resources

How and what would the organisation promote: • Peer workforce • External – consumers, funding bodies community, government etc.	Policy and funding university and other bodies Build strengthen and grow the peer workforce Promote: ○ peer led services ○ examples of best practice ○ job opportunities/training ○ peer work as a career – create pathways ○ the model ○ peer educators developing professional development for others ○ pay parity ○ the importance of peer supervision, training, PD ○ importance of adequately funding these ○ peer educators co-developing PD for other professions Promote the value of peer work & peer workers to public: Govt: other professional bodies, Unis, academic institutions, funding bodies, policy makers ○ Build, develop, strengthen and grow as a discipline alongside others ○ Research, build evidence, collect stats & critique existing research ○ Collect, disseminate resources and a clearing house (CEPS) ○ Build a quality brand that demands respect ○ Build strategic relationships – influence policy – get funding Need for debriefing and support Recommend or refer services to go to for debriefing and support Organisations within work organisations to provide cultural change
Table 4: *Advocacy:* Should this be systemic rather than personal (for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services)	Advocacy: Will this be a union model? • A place for organisation to support workers experiencing conflict in work place? • Process and procedure to draw upon • Advocacy with legal power / legislation – not needing to handball **BOTH** - Systemic is important Also advocating for individuals Without personal advocacy you can't have systemic Ideas and change coming from individual experiences = systemic Advocate for the discipline: • More peer role • Lived experience in all services for equal rights • Systemic- using mental health ACT/legislation as part of system approach • and human rights General comments from Table 4 Lobbying Quality development Legislation Pay rates, Duties and expectations Standardisation and improvements Assist employers to draft enterprise bargaining agreements

	Personal Advocacy: Equal/appropriate pay rates: information – general resources Systemic Advocacy: General resources: policy development: lobbying
Table 5: *National representation of peer workforce*: Do you see this as promoting the profession of peer work? Would this include: • Setting standards for leadership of organisations employing peer workers • standards for payment of peer workers • standards for what peer work is and what it is not	Awards Position descriptions Flexibility to needs of workforce Legitimise the workforce Board members, employees all need to have lived experience Education of peer worker role to people working with lived experience workers Offer professional development opportunities and training Will create more peer positions and change the culture e.g.NDIS – Peer positions being made redundant Currently peer workforce lacks: Award, PD, career path, supervision, manager who allows flexibility and are tolerant to the fluctuating needs of the peer workers they employ A national body will *legitamise this occupation*
Table 6: *Code of conduct:* What needs to be included? Examples: Social Workers, RANZCP (ie establish, monitor and improve practice and ethical standards = code of conduct/ethics) Should this be linked to provide advice on or monitor Quality and safety?	Yes: thinking about how we practice – every situation is complex, unique and different. How does one make an ethical decision about what to say and do? Re: quality and safety - how is this to be monitored? The role is and cannot be clearly defined. So how can a code of conduct be applied to this? To capture wisdom of all aspects of lived experience work – drawn up by lived experience workforce Code of ethics and code of conduct would be different for consumers and carers No specific award Scope of practice Organisational requirements Legal support / professional indemnity how specific or general will a code of ethics or practice be? What informs our practice and what is our philosophy – things like recovery-oriented practice as an overarching philosophy Practice standards – what is ethical and what is not e.g. Peer workers will not engage in compulsory practice Supervision and safety – lived experience supervision Does this form part of organisation's responsibility Is this to be professional experience or a work ethic? External vs internal (context) someone who understands the work environment. Code of ethics – *We are not there to 'fix' people*

	"consumer workers will never promote or participate in compulsory treatment" – there are points like this that are central to our work and inviolable As well as what we don't do, we need our scope of practice to include the many highly skilled things we can and do undertake (eg. working with people to understand – living with hearing voices) Sherry Mead: Peer workers are human rights workers, not health workers – this need to be clear & supported
Table 7: *Career Pathways:* What types of opportunities would be available for peer workers? examples: peer advocate, peer leadership, peer training, peer management	Organisation- consist totally of consumers – National standards Accredited training packages for different roles of peer workers Advocate and lobby for new roles Lobbying government "why not a peer worker" Professional development update – registration/yearly updates Promotion for diversity, inclusion and wellbeing in the workplace Duty of care National standards Emerging roles for peer workers: Advisory roles Helpline Outreach Mentoring Teaching Training – Accredited packages Degree course base level Cert IV Mental Health Peer work i.e. education pathways Emergency services supervision Leadership Community Development School peer workers Leadership roles Consultants emerging – not just in mental health areas <u>different roles:</u> Advisory – employer: peers Advocacy: Outreach: Mentoring: Teaching: Training: Human Resources: Policy makers: • Emergency services • Supervision / peer worker • Leadership • Community development • School peer/welfare workers • Peer prevention line – SAP phone 24/7 • Authors of text books • Peers as debriefers
General comments	Facebook group – Peer workers network

	If organisation is both consumer & carer – advocacy would be difficult and probably unethical because of views on some issues are **so** different. • Codes of ethics must be different Lived Experience workforce • consumer workforce – need a professional body at this level • peer work (direct with peers) peer support – individual and group • consultants who work with consumers at service level (these roles are blurred issue) who do systemic advocacy • other consumer workers – volunteers, consumer academics & leaders, advocates, consumer educators & speakers There is enough complexity here for an organisation (without adding the different perspective of carers) carer workforce ?

3. Sydney Consultation – Monday 26th February 2018 - Community of Peers Project Held at Aerial UTS Function Centre, Ultimo.

First question: Do you want a national professional organisation?	**Attendees 20 – in total from a mixture of settings,** The general answer to the first question was a resounding yes. There was some discussion about the differences of consumer and carer peer workers, but this conversation did not identify insurmountable barriers to the establishment of an organisation or association that is for the mental health peer workforce • A carer peer worker felt that there were more similarities than differences • This was not the view of all
Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	Group wanted to identify who are managers and who are peer workers Vote: Who identifies as a lived experience worker – 8 Manager: -11 Those in lived experience role and manager: -3 Do you want a National Peer workforce overarching organisation? All Question asked if it would include all support workers. Explained the project refers to people who have a lived experience. Should it represent carers and consumers? Statement of intent- need to understand the different skill set and felt that the consumer movement needed its own professional association. Felt having consumer and carer arms may be possible but jobs are completely different. Change of language would assist in defining the roles.eg. Lived experience is people who have had mental illness or carer assistant. Many carers are employed as lived experience workers in NSW. Carer peer workers are often confused about their role. Identity of both groups has come from many years of struggle. If we have an overarching group, it would need to have separate arms. Leadership roles need to be in relation to the number of consumer/carer workers as the majority of peer workers are consumer roles.

	Having a strong voice is important and we would therefore need to be united. Should it have its own state branches? Yes What should structure look like? If there are state branches there needs to be consistency otherwise, they will differ and do their own thing. e.g. Diabetes Australia- state branches are different and have different policies etc.
Staffing: • Executive director and staff - Will they be required to have a lived experience?	Looking at other bodies such as AMA are the executive doctors? Ideal would be if they have lived experience and the leadership skills. Skillset for the purpose of the organisation is essential. IMHL were looking to establish a professional association that was consumer run and would be staffed by people with lived experience. People with skill set need to understand lived experience or we nurture people with lived experience to gain the skillset. People with lived experience should be at all levels not just because of their lived experience but because of the roles and other skills that they bring. Need to encourage people with lived experience to apply.
Table 1: *Professional development, educational or training activities* Would you want the body to offer PD opportunities or training? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as professional development activities	• Collecting information to see what is already available i.e. educational materials, programs etc. across all organisatons • Promotion of pre-existing programs – connect to other organisations • Possible issues of RTO and accreditation – process? • Direct people to different programs • Write programs • Not an RTO itself but a directory of what training is available • Could work as advisors for unions in relation to workforce peer specific issues • Political function of consumer workforce • Different perspectives ↘ Is the body a professional body concerned with standardisation which develops skills professionalisation Main centre for advocacy and change (Recognition and change vs training organisation) This may deter employers from sending peer workers for training??
Table 2: *Support Services:* What might these look like?	• Advising and leading peer leadership into human resources • Promote regular supervision and facilitate supervision • Advice for employers of "how to implement and support the peer workforce • Support phone line for peer workers • Networking and conferencing opportunities <u>Employment Issues</u> • Safety net? Advice and representation • Advisors to HSU for union issues without having to run investigations (PSA/HSU)

	• Advising and promoting lived experience in employment HR processes • Supervision – organising, facilitating • Employers can seek advice for peer workforce implementation, support etc. Helpline? Online forum? Networking and conferencing opportunities
Table 3: *Promotional activities of the organisation*: How and what would the organisation promote to: • the peer workforce or on behalf of the peer workforce • externally to: o consumers and carers o funding bodies o Government o Community	• Importance of peer worker role • Uniqueness of role (not complimentary) • Fidelity and strengths of the peer worker • Innovators for change and influence workforce decisions that include respect and belonging • Promoting the importance of our roles as peer workers • Promotes the uniqueness of peer worker in contrast to other workers • Fidelity of the peer worker/strengths of lived experience • Innovators for change and influences - promote workforce decisions that include the association with respect & belonging - Benchmarking with other services <u>Advocating</u> – (appreciate the tension & resistance as this will create change)
Table 4: *Advocacy:* Should this be systemic rather than personal (for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services)	Systemic advocacy and individual advocacy is crucial Increase in peer workforce and promotion of it Establishment of national peer work guidelines Appreciate the tension and resistance of bringing in a larger peer workforce Advocate for increased peer workforce, Housing, education etc Advocating for quality, diversity and inclusion 5th National Mental Health Plan - complete Peer Workforce guidelines nationally. Advocate for tools and resources for standards to be established and development of these Advocate for the establishment of a union or for strengthening the existing arm of a union Involves support and advocacy for all lived experience roles at all levels of services Advocate for policy in place to be implemented
Table 5: *National representation of peer workforce*: Do you see this as promoting the profession of peer work? Would this include: • Setting standards for leadership of organisations employing peer workers	• **Yes, to all examples on the agenda** • Advocacy • Professional standards • What defines the profession – ie. CPD = more or less than 30 hrs/year • Professional development (CPD – ongoing) members get a discount - if employer does not pay • Promoting the profession of peer work • Consistent name (for the Peer Worker)

• standards for payment of peer workers • standards for what peer work is and what it is not No. 5 cont**.**	• Research, data collection • Resources to inform projects • Educating employers (rights & responsibilities of peer workers) • "Hub of knowledge" – for new positions & PD's • Supervision, mentoring, coaching on relevant matters – Professional opinion • Lived experience in positions of authority • Representation in proportion of what would be ideal (carer & consumer) • Continuing professional development – affordable and number of hours • Clearing house (Holding data, position descriptions etc.) • Linking / advocacy to NDIS to ensure lived experience roles are recognised • Education – high schools and universities to promote roles and use of lived experience in work • National conference and links with international peer work community • Representing what the organisation anticipates would be ideal / appropriate workforce (balance) • Discussions with NDIS re importance of peer work and correct payment • Promote career path ways for younger people
Table 6: *Code of conduct:* What needs to be included? Examples: Social Workers, RANZCP (ie establish, monitor and improve practice and ethical standards = code of conduct/ethics) Should this be linked to provide advice on or monitor Quality and safety?	• Code of ethics • Code of conduct for Peer Workers and for organisation • Lead the development of National Standards of Peer Work through developing their own Code of Conduct – leading by example • Include ethical, social network footprint • Who are the staff representing (employer or personal experience? • Scope of practice (acting within skills and role) • Values of peer work • Responsibilities in the workplace (peer worker and employer) • Organisation can check that the employer is supporting role • Yes, should provide advice and monitoring to safety and quality • Legal advice (Human Rights, carer rights & recognition) • Professional Indemnity Insurance **YES** to items on the Agenda
Table 7: *Career Pathways: potential opportunities* What types of opportunities would be available for peer workers?	• Entry level → through to → Executive roles • 'Sticking/stopping point'– where do I go from here? • Community managed (NGO's) programs – benchmarking for number of peer workers • Practice lead / head of discipline → training to accompany this

examples: peer advocate, peer leadership, peer training, peer management	• Pathways to projects, leadership roles, committees • More paid hours – average in peer work in public health 3 days per week • Clear entry level from Peer Worker – to Senior Peer Worker – to Manager • Consumer researchers, educators – broaden the scope of the peer workforce • Advice and policy statement on grading and salary • Creating a National Award • Valuing of peer worker • Limited opportunities in most places • NGO – benchmarking number of peer workers limits positions Opportunities: • Practice lead • Head of discipline • Project management • Leadership roles, Committees • Lecturers, Researchers • More paid work – not just part time positions • Clear entry levels and pathways Peer worker- senior peer worker to manager What would we want from the organisation? • Advice and policy statements on conditions and salary • Promoting skill set with wages • Medicare provider
Other general comments	Union - Will employers see this as a union-type organisation? Extra comments from a participant: The consumer and carer peer workers have more in common with each other than differences, and it is worthwhile combining forces and sharing strengths / learning while the workforce is still in its infancy and with such low numbers. While the lived experience comes from a different perspective, the work is still about the lived experience. This is unique and different to other professions, and deserves a special focus to develop standards, support, recognition, professional development, resources and national representation etc around it. • We need to develop a national organisation that reflects how we would like the workforce to be and work towards the ideal. If Carer Peer Workers have very few paid positions available and limited job opportunities at the moment, it doesn't mean that we should keep it that way, and a 50:50 representation at a National level means we can keep working towards something better • Unequal representation between consumers and carers at the National organisation level runs the risk of not meeting carers needs once again, and further

	misrepresenting their needs for Carer Peer Work. Carers need to be fully present around the table in equal numbers to be able to advocate and support for Carer Peer Worker positions • While it seems like some health services have employed either consumers or carers to the same Peer Worker position, I think this has down-graded their value and services need to be clear about what they need from a position description. Peer Worker roles need to be clearly defined as either consumer or carer in focus. While they both require the lived experience, the experience is different, and I suspect the positions would be relating to different people, either consumers or carers, in the majority of their one:one support. • In NSW, the language around consumers and peer work seems to have evolved to the word 'consumer' sometimes meaning both consumers and carers and this has become confusing. For example, we have KPIs around tracking how many consumer peer workers we have, but there is no difference recorded whether these are consumers or carers

4. PERTH Consultation – Monday 26 March 2018 - Community of Peers Project Held at HelpingMinds, Perth

First question: Do you want a national professional organisation?	**<u>Attendees 21 – in total from a mixture of settings</u>** Yes. The answer to this question was generally in the affirmative. There was concern raised about existing infrastructure and Peer Networks in WA and the potential impact on these organisations as there has been a lot of development work done to date. Concerns raised about the possible inequities that exists between the Eastern states and WA where funding is usually allocated according to population. This creates less funding for Perth-based orgs and given the tyranny of distance in WA, makes for unreasonable and unbalanced resourcing. How would a national organisation work with the states? * Instead of separate branches, capacity build & support local peaks (peer support organisations) to take on this role. State representation is important. (There will be quicker runs on the board & less wheels reinvented)
Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	Participants asked a lot of questions with reference to the differences and the impact if it was a Company Limited by Guarantee. General consensus after discussing and explanation by Janne McMahon was that a Co. Ltd. by guarantee would be the most appropriate.

Staffing: • Executive director and staff - Will they be required to have a lived experience?	Views were divided on whether or not it was imperative that the head of the organisation would have a lived experience. Some felt that the skill set was the most important criteria, others felt strongly that majority of staff should come from those with a lived experience and recruitment should be targeted to preference for those with a LE to be employed. Participants felt that it is reasonable to seek staffing, including the CEO from people with a lived experience as many who have a consumer or carer experience have degrees, are qualified, well trained, are skilled professionals. It was stated that assuming those with a lived experience may not have the appropriate skills or qualifications/expertise remains a constant annoyance and frustration.
Table 1: *Professional development, educational or training activities* Would you want the body to offer PD opportunities or training? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as a professional development activity	P.D. opportunities, yes: • give credit points • added to Cert lV Peer work • online learning • Youtube videos with peers explaining unique experience and how to best support that experience • P.D. = accredited, linked to level and pay rises/pay rates Education / Training • Deliver intentional peer support • Training for peer workers on using their stories • Don't replicate other (local) organisations are offering in training • Accredit educational training standards • Further develop Cert lV in MH Peer Work • Deliver training for services, organisations • Targeted training / identify training to suit particular needs • Further higher education opportunities including Diploma of Peer Work, Post Grad. • Link to training provided by other organisations – and link to Cert lV • Training for external supervision • External supervision and group supervision – have standards for this • Peer oriented training – for peers, by peers • develop a model for learning management skills and leadership training • work with local agencies and groups to deliver the above – <u>not</u> compete with them • influencing & contributing to reviews of the Cert lV as they come up • developing new units in specific areas related to peer work (units of competency)

Table 2: *Support Services:*
What might these look like?
	Linked by educational providers – ongoing training to provide various services for peer workforce
	• training & P.D. for peer workers & their service
	• advice line
	• advocacy – systemic & individual
	• self advocacy skills of the role
	• online community
	  ○ Facebook
	  ○ chat rooms
	  ○ resources (knowledge hub)
	  • supervision (peer)
	  • social 'club' / program
	  • access to leaders
	  • mentoring
	• support for dealing with workplace concerns
	• online, phone, webinars
	• referral process on HR concerns/issues
	• advice on legal bodies to provide information/guidance re insurance, employment conditions, benefits
	• development of peer work consultancy service supporting local organisations (in a hub & spoke model)
	• learning from & partnering with local organisations
	• support organisation to build capacity to deliver good supervision & reflective practice
	• updating on issues affecting the peer workforce e.g. legislative changes
	• services to other bodies e.g. AMA, AASW, RACGP, ACMHN etc.)
	• general representation activities

Table 3: *Promotional activities of the organisation*: Would these include?	Working with organisations in relation to what information is needed re funding. • What is peer support? – provide educational sessions Promotional talks & education: • The value of peer workforce • Capabilities of peer workers • Inclusion of peer workers • How peer workers are different to clinicians • How many peer workers does Australia need? • Diversity of peer work roles • Good work practices Promotional talks to educational institutions Research & literature reviews To the community – raising awareness, activities at community events • Promote educational/qualifications • Educate the general population about peer work to encourage the public to ask for support from peer workers as an option in mental health care • Promote to vulnerable communities – FIFO, building sites, defence forces, emergency services, transport

	industry, CALD, Aboriginal & Torres Strait Islander, corporate business & hospitality and schools • Newsletters, information nights / breakfasts • Internal training & events • Education to clinicians • Promotion through social media • Promoting to individuals in Parliament / work towards having a representative in Parliament • Promote & monitor development of strong peer workforce structure in organisations • Actively promoting recovery-focussed practice • Promote family inclusive practice & how best to promote & support family peer workers • Need to differentiate between service provision & supporting peer workers • For consumers & carers • Conference/Forum • Coordinate workshops with activities & training • Provide brochures, flyers, information (including expectation & rights)
Table 4: *Advocacy:* Should this be systemic rather than personal (for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services)	BOTH – systemic and individual e.g. ANF does both Being mindful of state based & capacity building of local organisations / branches YES, to systemic at a national level • Partnership between unions and peer workforce association for individual advocacy • Further promoting and advocating for peer work to reduce 'stigma' (peer work not valued) • Being able to represent through organisations – e.g. speak to Parliament • Making mental health a normal part of conversation • Actively work to reduce stigma in society • Education to ED's & other mental health organisations • Using research & focus groups to challenge stigma & increase knowledge of peer work • Branches (jurisdictional) individual advocacy to inform National body to effectively advocate at a systemic level • Offer annual awards & annual conferences • Advocacy that targets stigma reduction in services • Use of media in advocacy (of peer workforce) ** Would an employer listen to an association that isn't a union?
Table 5: *National representation of peer workforce*: Do you see this as promoting the profession of peer work? Would this include:	• Should have standards of practice e.g. ethics • Examining Award standards for rates of pay, leave benefits – linked to qualifications • Potential for collective bargaining • JDF need to include skills, training, qualifications and clear roles & responsibilities

• Setting standards for leadership of organisations employing peer workers • standards for payment of peer workers • standards for what peer work is and what it is not	• Role descriptors instead of job characteristics • Job descriptions set across the board i.e. all jurisdictions – this will avoid regrading as a novelty and prevent organisations from setting their own standards, rates. • Works to highlight the importance of implementing peer work properly into organisations • Peer workers to be appropriately supported – currently it depends on which organisation you work for as to what type of experience you have as a peer worker • Support, education & training for services/organisations wanting to employ peer workers • Leadership may have to have lived experience • Ensure that peer workforce is included in ALL reforms (and especially workforce) • Ensure advocacy & representation in national policies, standards, strategies, guides & legislation
Table 6: *Code of conduct:* What needs to be included? Examples: Social Workers, RANZCP (ie establish, monitor and improve practice and ethical standards = code of conduct/ethics) Should this be linked to provide advice on or monitor Quality and safety?	Includes advocating respectfully • Code of conduct: expected behaviours • Code of ethics: values NEED BOTH • Standardised across the board • Establish best practice • Constantly reviewed • Reviewed by peers if practical (use of focus groups) • Based on evidence & research takes the best from all parts of the world • Gives safety to peer workers & known standards • Is it measurable? "Members should" ……..or organisations should" • Who develops these codes or ethics? • Trauma Informed responses • Conflict management • Non-violent communication approaches • National contribution to the Code of Conduct (for buy-in) requires broad consultation • Boundaries defined • Confidentiality respected and acknowledged – employers & employees • Employer responsibilities to peer workers • Safety 'contracts' i.e. for working with children Police clearance requirements • Includes boundaries for friendship/peers/colleagues • Clear role definitions Ethics and morals – this is what is wanted: boundaries & confidentiality etc. fall under code of ethics (may be recognised for the peer workforce through a national organisation)
Table 7: *Career Pathways:*	Executive Director of Jurisdictional Mental Health Body (e.g. Commission)

What types of opportunities would be available for peer workers? examples: peer advocate, peer leadership, peer training, peer management	• Across service, sector & system levels have career progression opportunities • Need jobs to be available initially • Is it only the qualification we need? • Need consistent naming and identification of the various roles of the peer workforce • Require protection for wages. 'Respectful' wages paid for our expertise • Be the hub in an organisation (not the spoke) • Develop ability to take peer qualifications and roles into other jobs (i.e. role of 'peer to peer' is an attribute of the worker) • Ability to act in other roles • Organisation wide mentoring role with other professions • Automatic role in design processes e.g. services, pathways, physical environs (all areas) • Creating a role for peer workers in non mental health space (e.g. HR roles, consumer participation role, consumer reviewer, consumer surveyor) • as part of Workforce development & progression – includes PD and training to acquire additional qualifications (enhancing a CV) • Opportunity to identify as a peer at every level of an organisation • Encouraging work places to sponsor peer workers to do higher education to upskill and get promotions in organisations • Tiered career pathway structure • Opportunities to move up and forward progression
	General comments: • A number of participants felt strongly that the wheel should not be reinvented. • Local organisations that may be consumer peaks or have established support networks/training for peer workers should be supported to capacity build. • Avoid alienating of local organisations/services.

5. Tasmanian Consultation –10 April 2018 - Community of Peers Project held at The Old Woolstore, Hobart

1st question: *Do you want a national professional organisation?* Do we need a Lead organisation?	**Attendees 17 – in total from a mixture of settings** • Yes, we want a member based organisation for peer workers or association • Organisation should only be for peer worker members • National organisation to represent peer workers • Organisation to support organisations supporting peer workers • Helping organisations to develop peer workforce • Organisations could contact the lead organisation for information and representation

	• Do not want organisations to be members of the organisations
Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	• Board of management under a structure • Capacity to work with existing State bodies (build from bottom up rather than top down)
Staffing: • Executive director and staff – Will they be required to have a lived experience?	• Board- people with lived experience that may have professional backgrounds • Staff on the ground should ideally have lived experience and the skills but skills are essential over lived experience • Recruitments needs to use people with lived experience
Table 1: *Professional development, educational or training activities* Would you want the body to offer PD opportunities or training? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as a professional development activity	• Training and professional development – needs to offer both • Professional development that may not be offered in the workplace: o External supervision o Diversity training etc. o Self-care training o Communications skills o Facilitation training o Professional identity and role • Providing employers with education and training around the peer work role • Training to support trauma informed work practice • Support and training to unions to understand what a peer worker is • Mapping exercises – know where peer workers are employed Difference? Professional Development to spotlight or provide master classes • Professional development to identify best practice • Diversity training (CALD) • Self care training • Communication skills • Understanding professional identity o Access to external supervision Training: o Facilitation training / governance o Access for people to attain a qualification in peer work & support for places o Providing employers with education and training to understand the role of peer workers o Employers to be trained on how best to work with people with lived experience o On Trauma Informed Practices o Support / training for unions to understand what a peer worker is o This is also required for other organisations

	• Training opportunities for addressing job applications/position criteria for peer work roles A mapping exercise to determine who is where around the state ie. Peer workers What the organisation CAN'T do: ○ Provide individual advocacy – should promote self advocacy, quite a different role to information sharing. ○ It requires clear definition of boundaries around the advocacy it provides ○ Provide counselling to people
Table 2: *Support Services:* What might these look like?	• Links to Accredited qualifications • Professional supervision • Information regarding critical incident debriefing • Support the development and sustainability of jurisdictional (state/territory) peer worker bodies • Resource bank including templates for Job descriptions etc. • Debriefing • Advocacy – workforce and worker advocacy • Professional development – identifying best practice What will the support services look like: • Online forums • Phone line for advice • Chat room • Annual peer work conference • Website well maintained – offering a range of resources (a clearing house for info) • Newsletter • Frequently Asked Questions (FAQ) sheets/brochures
Table 3: **part A:** *Promotional activities of the organisation*: **part B:** *Advocacy:* Should this be systemic rather than personal (for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services) Would these include?	• External and internal education • Want organisation to provide a clear message on reasons for/benefits of evidence base for having a peer workforce • Organisation to articulate & promote the benefits of becoming a member–both personal & professional • Advocacy for members where appropriate • Framework for standards and practice guidelines leading to accreditation ultimately in the future • Framework for organisational accreditation in the future Part B Advocacy • Promotes peer workforce with the intention of reducing stigma this (advocacy) should be both individual and systemic for its members • Advocacy – both individual and systemic • Use of common language – non jargon • Be open
Table 4: *National representation of peer workforce*:	• Advocate to promote the peer work profession, and for employing peer workers

Do you see this as promoting the profession of peer work? Would this include: • Setting standards for leadership of organisations employing peer workers • standards for payment of peer workers • standards for what peer work is and what it is not	• Setting standards and guidelines for leadership • Support in how to manage when role is tokenistic (put in role purely from lived experience but not being listened to) • Standard rates for pay • Standards for what peer work is and what is not-clarification around the role • Standards around terminology of the role • Set it apart from other disciplines • Provide clarity. Peer work is not about friendships, community support, being a support worker.
Table 5: *<u>Code of conduct</u>:* What needs to be included? Examples: Social Workers, RANZCP (ie establish, monitor and improve practice and ethical standards = code of conduct/ethics) Should this be linked to provide advice on or monitor Quality and safety?	• Code of ethics for those who employ peer workers and a separate Code of Ethics for peer workers - both would interrelate but would be separate • Ethical guidelines around what the role entails • Duty of risk verses duty of care – respecting and valuing descriptions (this being in a code of conduct) • Respect and understanding from co-workers around peer worker knowledge and skills and capabilities • Peer workers as leaders in teams • Code of ethics for employers for them to understand that wellness plans are optional and that peer workers are quite resilient and not always going to fall over if they are in a good work place <u>Peer Worker Code of Ethics</u> • Behaviour; expectations; boundaries • Skill boundaries: dignity of risk/duty of care • Respect/understanding for co-worker skills • Leaders in creating a healthy workplace culture <u>Employer Code of Ethics</u> • To be fair and respect the privacy of people's personal affairs • Recognition of professional skills in peer workers • Respect for the knowledge and unique expertise of peer workers
Table 6: *<u>Career Pathways</u>:* What types of opportunities would be available for peer workers? Examples: peer advocate, peer leadership, peer training, peer management	• Clearly defined e.g. Centrelink, Housing, Aged Care, Employment agencies, AOD, Co-morbidity- specialist peer work roles • Lived experience academic positions- providing education and research • Public speakers • Speaking about peer work roles • Roles that lead into peer work • Training for peer work supervisors • Mental health crisis response team • Inpatient peer worker roles • Emergency departments • Career pathways within the National organisation/entity itself

	- providing work related development opportunities e.g. could also provide linkages to states • Federal minister for Peer Workers (or a peer worker based in the office of the Fed. Minister for Health (MH) to advise the Minister on all matters of mental health reform • Official visitors (revisited) to suit qualified peer workers

6. CANBERRA Consultation –23 April 2018 - Community of Peers Project

Held at Mental Health Community Coalition ACT, Griffin Centre,Canberra

1st question: *Do you want a national professional organisation?* Do we need a Lead organisation?	**Attendees 11** • Participants had a discussion about the peer workforce as a 'profession' • Is it currently regarded as a profession?
Governance: • Difference between association and company limited by guarantee. • Constitution – development of a document	• Entity independence is vital • Preference for individual state/territory representation at a governance level
Staffing: • Executive director and staff - Will they be required to have a lived experience?	• CEO staffing preference is for people with a lived experience • Positions for people with a health background who could collaborate with other ○ Professional organisations • Mentoring for staff with a lived experience in the organisation in HR policy
Table 1: *Professional development, educational or training activities* Would you want the body to offer PD opportunities or training? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as a professional development activity	We want the entity to offer all: professional development, education and training, both necessary • Coordinates training – yes • Responsible for – no • Oversee? – yes • Accreditation – yes for Cert IV in MH Peer Work • Confidence building • Equip peer workers to oversee training – educate community and health professionals • Group facilitation model for training by the organisation Social modelling – learn from each other • Ongoing learning and development, continuous, life-long learning • Follow national model • Based on reflective practice • Developing and maintaining training standards
Table 2: *Support Services:* What might these look like?	• provide mediation services, supports and opportunities • advocate and provide information on consistent peer workforce employment issues

	• provide education and advice on reasonable adjustments in the workplace • website – clearing house for information • provide FAQ's – research on peer work • phone / information support • to promote and explain to services providers and the community about the value and need for peer workers • provide advice and help to peer workers who are having workplace issues • mentoring supports and opportunities • provide case studies to demonstrate what is working well in jurisdictions: what the peer workforce looks like in different jurisdictions,what works: what doesn't work and why • provide advice on remuneration, advocacy and career pathway issues • advise on appropriate supervision - and guidance on provision of independent external supervision • networking opportunities • convene forums • issue support groups • provide opportunities for peer worker feedback
Table 3: **part A:** *Promotional activities of the organisation*: **part B:** *Advocacy:* Should this be systemic rather than personal (for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services) Would these include?	Part A – promotional activities • organisation to provide validity and strength to the peer worker authentic voice • promote through employer organisations the opportunity to work with mental health clients and share experiences • support and advocate for peer workforce and promote benefits of employing peer workers • If an entity for peer workers is established more employees may identify as peer workers Part B Advocacy Both systemic and individual • Submissions to governments, service providers and budget submissions • Setting of and advocating for workplace standards • Provide and advocate for professional development • Should advocacy focus on external issues? i.e. mental health system and inadequacy of facilities o e.g. Proposed closure of Brian Hennessy (Canb. Facility) o Should not neglect major concerns in mental health o To link with other organisations who have similar issues - resulting in greater impact
Table 4: *National representation of peer workforce*: Do you see this as promoting the profession of peer work?	• Setting standards o professional standards o Codes of conduct for meetings as well as operational

Would this include: • Setting standards for leadership of organisations employing peer workers • standards for payment of peer workers • standards for what peer work is and what it is not	• does and don'ts; boundaries; leads by example; talk the talk; walk the walk • promoting as a profession (body and workforce) • separate from health – o answerable to the Human Rights Commissioner / Health Services Commissioner in each state and territory e.g. Mind & Body New Zealand (Jim Burnett) • lived experience leading by example, for debriefing and problem solving v's/group and individual debriefing • standards of payment of peer workers should be aligned to a Federal Award – i.e. moderators in conflict resolution • to understand the role of lived experience o not just a friendship club / boundaries
Table 5: *Code of conduct:* What needs to be included? Examples: Social Workers, RANZCP (ie establish, monitor and improve practice and ethical standards = code of conduct/ethics) Should this be linked to provide advice on or monitor Quality and safety?	Peer Worker Code of Ethics (values) • need reflective practices • lived experience should be recognised • linked to safety and quality • people come from their individual (work) environment which has a code of ethics - does this fit for the roles of peer workers? o or does the peer work organisation require a separate code of ethics? o If it is a professional body they can establish a code of ethics specifically for peer workers, in the same way as the AMA has it's code of ethics Which code of ethics applies? The employers, or the Code of Ethics developed for peer workforce?
Table 6: *Career Pathways:* What types of opportunities would be available for peer workers? examples: peer advocate, peer leadership, peer training, peer management	Training – by peer workers for peer workers Potential opportunities: o medical teams o community o MH consumers e.g. how to talk to ctors/counsellors Qualification base – agreed competencies e.g. Cert lV Training & Assessment Manager of peer workers – leadership – is formal training necessary? o What is the formal training o HR? o Management? Not too proscriptive – not too specific o eg. support coordinators /coaches (eg. Next Step) • Mentors • Professional Development providers • Develop study or support groups to generate discussion • Develop possible career pathway opportunities / structures o Do they exist? o What do the pathways look like?

	○ Is there a framework? • Organisational commitment to offering opportunities • Step out (of a role) totally but take 'peer worker' status with you
General Comments:	One of the participants: • asked if we would accept written comments. • Stated that PMHCCN need to make sure every effort is made to contact peer workers – advised about planned survey after the consultations

7. Brisbane Consultation –30.4.18 2018 - Community of Peers Project Held at Wesley House Brisbane

Do we need a Lead organisation?	**<u>Attendees 14 – in total from a mixture of settings</u>** • Need something to assist others to connect (We have an unemployed workers union) • There are some small networks but we need to have a larger organisation that can lead training etc. • Something like ASW or AMA • Lead organisation should be for Carer and Consumer peer workers
Governance: • Should it (the association/organisation) have its own state branches or • Should the entity work with currently established jurisdictional organisations supporting the peer workforce?	• It could have sub-branches in states or those that already exist • Independent roles that are paid by the entity and co-located • May not have funding to set up a representative in each state
Staffing: • Executive director and staff • Should they have a lived experience or be a peer worker?	• Advisory board • Co- hosted in the Mental Health Commission • Staff should have a lived experience. All positions should be open to people with lived experience and change job descriptions accordingly • People who can walk the walk and talk the talk • CEO should have a lived experience • Build capacity of people with lived experience • CEO needs to be a role model for people living with mental illness

Table 1: *Professional development, educational or training activities* Would you want the entity to offer training or PD opportunities? What's the difference? 1. Professional Development – promote and facilitate members' professional development and life-long learning 2. Educational or training activities: develop, review and accredit the education standards for peer work or do you see this as a professional development activity	• Limited take up on Cert IV – RTO for Cert IV • Liaise with MHCC to train trainers so that they can educate- currently training not doesn't work well • Develop guidelines/templates for supervision • Training for peers to be supervisors • Courses for consumers and carers to effectively deal with stigma and discrimination • In house training and education and PD • Transparent merit base levels for peer workers • Internships
Table 2: *Support Services:* What might these look like? What are the types of supports or services the entity could offer? What types of services or supports would you like to have access to?	• Mentoring counselling and advocacy • Peer worker union type support (reasonable adjustment, casual to permanent, work outside of frame of practice • Having an employee assistance program • On line peer support program • Hold resources re research • Directing body for training providers- setting standards • Auditing training • Consistency in roles • Advocates for lived experience workers • Promoting lived experience & consumer/carer participation • Support in workplace readiness to take on peer workers
Table 3: *Promotional activities of the organisation*: How and what would the entity promote: • To the peer workforce, or on behalf of the peer • Externally to: o Consumers and carers o Funding bodies o Government o Community **Part B** *<u>Advocacy:</u>* Should this be systemic or individual advocacy or both? (for personal choice, inclusion, opportunities and the development of stigma free workplaces and services)	• Individual and systemic advocacy to reduce stigma and discrimination • Promoting asset value of having people with lived experience and benefits • Contact point for organisations • Central advisory body • Clearing house of information – self- care etc. • Education and development • Dispelling myths associated with lived experience • Showcasing lived experience work and sharing success stories • Professional development opportunities • Individual and systemic advocacy • Having someone on your side when you need support and receive follow through • Quality control checks and balances • Ability to understand intersectionality for peer workers and approach the situation

	• Systemic advocacy for organisations to support peer workers (insurance etc.) • Promoting what peer work is to uni students etc.
Table 4: *National representation of peer workforce*: Do you see this as promoting the profession of peer work? Would this include: • standards for what peer work is and what it is not • Setting standards for leadership of • organisations employing peer workers • Standards for payment of peer workers	• Highlight differences between peer workers and people with lived experience • Diversity of peer workforce • Standards and guiding principles • Code of ethics • Promote what peer is and what it is not • Competencies/ capability frameworks • Leadership • Equitable pay • Clarity around pay levels • Voluntary role to workers • Education and training • Recognised qualifications • National register of qualified peer workers • Next steps from Cert IV Peer work- develop educational structure • Professionalise the workforce? • Tailoring roles better and build flexibility in existing roles for lived experience workers • Promote and engage and facilitate lived experience
Table 5: <u>Code of Ethics</u> Examples: Social workers, RANZCP(Psychiatrists) What needs to be included? i.e. establish, monitor and improve practice and ethical standards • To be done through ethical guidelines • Should this be linked to providing advice on or monitoring safety and quality?	• Ethical compass – when dilemmas arise look at what we are trying to achieve. Core of what we are trying to do • Good set of ethics will help outline everything that follows – job description etc. • Standards • Advocate for need for standards • Core principles and beliefs that make up the code of ethics – e.g. Equity, transparency, mutuality and reciprocity, hope, fidelity
Table 6: *Career Pathways:* What types of opportunities would be available for peer workers?	• Lived experience educators/trainers • Higher level of experience • Specialist skills e.g. BPD, Centrelink, Homelessness, Justice, CALD, Addictions, Inpatient, Youth, Community • Opportunities/pathways will vary in different sectors and settings • Need to identify the landscape • Peer advocates, one to one support coaches, peer facilitators, supervisors • Capability frameworks – map skills, education, needs, min skill set qualification • Workforce framework • Peer Internships and training to support this.

8. Darwin Consultation –10.5.18 - Community of Peers Project Held at YWCA Barbara James House Darwin

Do we need a Lead organisation?	**Attendees 18 – in total from: NT Mental Health Coalition, Team Health, NT Health Dept., PHN's, headspace, Carers NT, Anglicare** 3 peer workers present • Yes we want an organisation (they would ideally like a trained peer workforce!) • No current training available – pathways, no workforce structure • Would give organisations a sense of qualification if they are registered with the organisation • Would assist organisations to understand what they need to have in place to employ and support peer workers. • Need someone to do a gap analysis around what is needed in the Northern Territory • Need for training of all staff re peer work
Governance: • Should it (the association/organisation) have its own state branches or • Should the entity work with currently established jurisdictional organisations supporting the peer workforce?	• Would want a staff member employed by the entity to sit in Darwin and be able to travel to regional areas
Staffing: • Executive director and staff • Should they have a lived experience or be a peer worker? •	• Staff should have a lived experience –would create a career pathway
Table 2: *Support Services:* What might these look like? What are the types of supports or services the entity could offer? What types of services or supports would you like to have access to?	• Local network of peer mentors or workers to get together to debrief and train using case studies • Mentoring • Training through use of technology • Annual conference or workshop • Cultural diversity – understanding the local context • National qualification • Support a recovery college as a lead in to Cert IV MH Peer work (us to follow up) • Organisation training in incorporating lived experienced staff for all staff in the organisation

Table 3: *Promotional activities of the organisation*:
How and what would the entity promote:
• To the peer workforce, or on behalf of the peer
• Externally to:
  ○ Consumers and carers
  ○ Funding bodies
  ○ Government
  ○ Community
Part B *Advocacy:*
Should this be systemic or individual advocacy or both?
(for personal choice, inclusion, opportunities and the development of stigma free workplaces and services)
	• Educating organisations and providing guidelines re peer workforce- being part of the team. Reduce stigma, per workers feeling accepted and heard in their role
	• Articulate what the role and value of the skills & knowledge peer workers bring
	• Encourage standards and training of the peer workforce
	• Diversity and small communities – opportunities for external supervision
	• Address stereotypes that exist about peer workers, work with mental health staff to build understanding of peer workers who have been past service users, challenge perceptions
	• Build knowledge and confidence of peer workers to challenge and ask questions
	• Ensure external supervision, both formal & informal. A peak body to provide links & advocate for appropriate supervision
	• Provide clarity around level of responsibility in roles of peer workers
	• For NT: consider issues of lack of transparency of workers, connectedness to community and the need for policies to support this, including confidentiality for peer workers

Table 4: *National representation of peer workforce*: Do you see this as promoting the profession of peer work? Would this include: • standards for what peer work is and what it is not • Setting standards for leadership of • organisations employing peer workers • Standards for payment of peer workers	• Advocating for National training available in the NT • Provide an awareness of peer worker value add • Awareness of the value of lived experience for consumers and carers • Breaking down stigma • Why it is important for organisations to have peer works and lived experience voice • Advocacy for fair work place issues for peer workforce • Advocacy for mandating guidelines around employing peer workers • National mandate of equal pay etc. for peer workers. Raise the profile of the peer workforce • Mandate (national) percentage of workforce to peer workers • Advocate for and promote the role of peer workers to raise profile
Table 5: Code of Ethics Examples: Social workers, RANZCP(Psychiatrists) What needs to be included? i.e. establish, monitor and improve practice and ethical standards • To be done through ethical guidelines • Should this be linked to providing advice on or	• Value of importance of the peer workforce in the NT • Rep from peak body in the NT (they need to access broader body of remote voices) • Formalise development and training of peer work in NT • Payments that equal merit of roles on a professional level • Differences between NT and other jurisdictions requiring concentrated effort to develop and grow a peer workforce in the NT

monitoring safety and quality?	• Would like to see a dedicated role in the organisation to represent NT and gather evidence/information of what is happening in the NT (in mental health)
Table 6: *Career Pathways:* What types of opportunities would be available for peer workers?	• Perhaps the term "practice standards" • Normal community standards plus 3 key things related to peer – conflict of interest in community - Intent of sharing lived experience - Maintaining own recovery • Guidelines around structured pathways • National standardised pathways across state boundaries • Bridging courses prior to Cert IV MH Peer work • RPL structures for people with degrees • Cross engagement for peer workers across other organisations (employment panels, meetings etc.) • Peak body representation consulting with people with lived experience • More Peer work positions available • Where does peer work fit within the National workforce standards • Structured pathways that lead to positions of influence in organisations • Provide a pre/intro to peer work opportunities allowing people to work out whether the peer role suits them and if they're suited to the role • Comprehensive RPL structures – for support work ○ AOD ○ Disability ○ Psych degrees ○ social work ○ youth ○ Disability ○ Psych degrees

Appendix B

Peer Work Leadership Statement of Intent

A National Professional Association for Mental Health Peer Workers

Peer work leaders from Queensland, Victoria and NSW and colleagues from the USA participated in an International Initiative for Mental Health Leadership match in Brisbane on 27 & 28 February 2017.

The Australian peer work leaders resolved to issue a **'Statement of Intent'** that would communicate our intention to form a national professional association for the Australian mental health consumer peer workforce. We feel that such statement is necessary to provide the focus for national consultations to occur that will lead to the development of a peer-run organisation that can support and sustain the development of the peer workforce across all sectors.

The 'Statement of Intent' is supported by the international peer work leaders who attended the match – Gary J Parker, Executive Director Kansas Consumer Advisory Council for Adult Mental Health and Sherry Tucker, Executive Director Georgia Mental Health Consumer Network. Both Kansas and Georgia offer certified peer specialist training, certification and support.

Rationale

A national peer work organisation is essential for our growing workforce and it would aim to support and develop our profession in similar ways to other professional bodies such as the Australian Psychological Society, the Australian Association of Social Work, Occupational Therapy Australia and the Australian College of Nursing.

Peer workers must lead the development of models of peer practice, so that our work retains its authenticity, mutuality and reciprocity in a diverse and expanding range of services and employment.

Professional certification of the peer workforce in both Kansas and Georgia allows peer specialists to claim Medicaid reimbursements for peer support services. In a similar way a national professional association of peer workers may allow the workforce to actively participate in the commissioning of mental health funding through Primary Health Networks (PHNs).

History

- The **4th National Mental Health Plan (2009**) included a number of strategies which supported the Peer Workforce including the establishing a certified peer specialist workforce. Following the release of the 4th National mental Health Plan there was a Peer Work Forum held in 2011 led by Community Mental Health Australia, National Mental Health Consumer and Carer Forum and the Community Services and Health Industry Skills Council. The idea of a peer workforce forum began as a discussion between the NSW Consumer Advisory Group (CAG) and the Mental Health Coordinating Council.

- In response to the 4th National Plan, the **National Mental Health Consumer and Carer Forum (NMHCCF)** released a position statement with the action,
  *"**Develop supported networks and strengthen leadership of the mental health consumer and carer identified workforce.***
  Under the National Mental Health Consumer and Carer Identified Workforce Strategy, a formal national network of consumer and carer identified workers should be established to provide a support mechanism for local support networks and a forum for sector development."
  (Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery – A position statement of the National Mental Health Consumer and Carer Forum, 2010)
- The **National Peer Workforce Forum** held in Sydney in February 2011 identified that the establishment of a peer worker professional association *as 'the next possible step for Peer Workforce Development.'*

  (Final Report on the National Mental Health Peer Workforce Forum, May 2011, p.12)

- **Peers Australia**. In August 2011, at the TheMHS Conference workshop, Peers Australia: A National Association for the Promotion of Peer Work' held a workshop:
  "Peers Australia is a peer lead initiative to ascertain and, if relevant, develop a professional association to promote peer work in mental health service provision and recovery, and to support peer work through the establishment of national practice standards and professional networks. Peers Australia has developed eight objectives associated with the purposes of the organisation: advocacy, research, training, quality, standards, promotion, support and professional development."

  (Peers Australia: A National Association for the promotion of Peer Work. TheMHS Conference 2011)

- Recommendation from **Health Workforce Australia's Mental Health Peer Workforce Study (2014)**:
  "Establish National Mental Health Peer Workforce Development Guidelines for use in a range of settings inclusive of:
  - Agreed definitions.
  - Key roles and functions.
  - Guiding principles and a code of ethics.
  - National capabilities for peer workers and supervisors (including diversity).
  - Principles for employment and reasonable adjustment.
  - Training and support.
  - Practical resources.
  - Supervision, coaching, and mentoring.
  - Dissemination/implementation approach."

  (Health Workforce Australia [2014]: Mental Health Peer Workforce Study, p22)

- **National Mental Health Commission**

  "**Mental Health Peer Work Development and Promotion**

  The continued development and promotion of the mental health peer workforce remains a priority for the Commission and the Australian Government. Mental Health Peer Work has been an area of focus for the National Mental Health Commission since our establishment in 2012. The development and promotion of the mental health peer

workforce has been recommended as part of our 2013 National Report Card and the 2014 Contributing Lives, Thriving Communities report.
The Summary of Actions within the Australian Government Response to Recommendations to the Review of Mental Health Programmes and Services states:

"The Commonwealth…recognises the value of a mental health peer workforce, and will explore the inclusion of peer workers and other low intensity service providers as part of the development and trial of a stepped care approach. The National Mental Health Commission has also progressed important work in this area and will be looked to in building upon existing work and further promoting the mental health peer workforce as an important component of quality, recovery-focused mental health services.""

(from Website)

- **NSW Mental Health Commission**

"Developing the peer workforce
Peer worker roles are integral to the concept of lived experience at all levels – including peer support to consumers and carers, peer mentoring, peer leadership, policy development and research. People with lived experience of mental illness should be part of all workforces that deliver services to client groups with a significant number of people who experience mental illness.

Further action is required to build a supportive infrastructure to ensure the peer workforce is embedded in the culture of service delivery to people who experience mental illness. Services and agencies need to consider how to attract a mix of peer leaders and new staff, create support structures, develop career pathways and support training and development specific to this workforce. This would include access to training such as the Certificate IV in Mental Health Peer Work within the first year of paid employment for all peer workers with government and community-managed organisations. Peer workers should also have access to formal supervision or mentoring by a person with lived experience.

Creating training, development and supervisory structures for an emerging workforce can challenge services in relation to the initial investment. This should be seen as an opportunity for sharing resources across the sector, not a deterrent.

Actions

8.2.1 NSW Health will implement the Framework for the NSW Public Mental Health Consumer Workforce

8.2.2 In developing the NSW Mental Health Workforce Plan, as described in Investing in our workforce, p. 97, NSW Health, in consultation with the NSW Mental Health Commission, will incorporate the needs of the peer workforce informed by the lived experience of people with mental illness. This would include:

- education, training and accreditation of peer workers
- the full spectrum of roles that peer workers may fill (such as educators, support workers, advocates and managers)

- recognition and integration of peer workers as team members in the delivery of mental health services
- the governance structures that will be required to support peer workers in the workplace, including pathways for career progression.

8.2.3 Family and Community Services will develop peer worker roles in its front-line services. This could be through a partnership with one or more community-managed organisations which have a developed peer workforce.

8.2.4 Benchmarks must also be set to stipulate peer worker numbers across the public mental health system, the community-managed sector and the broader government service sector, including housing, disability and justice."

(NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW. pp101-102)

Mission

The professional association for peer worker will set the standards for certification, education, training and practice in peer work.

It will promote and regulate the peer work profession in Australia and represent peer workers by ensuring strong and sustainable development of the profession, the maintenance of accountability and the meeting of benchmarked standards.

It will enable peer workers to work collaboratively to lead the transformation of mental health and human services into recovery-oriented and trauma informed places that promote the strengths, hopes and dreams of each individual.

It will seek to develop collaborative and equal, partnerships with other professionals who work in mental health and human services.

The professional association will seek to always empower consumers of mental health services to participate in the development, governance and operation of mental health and human services. We will help promote hope and recovery that is led by each consumer, individually.

Objectives

- Promote the profession of peer work
- Establish, monitor and improve practice and ethical standards
- Contribute to the development of peer work knowledge and research
- Develop, review and accredit the education standards for peer work
- Advocate for personal choice, social inclusion, opportunity and the development of stigma free communities, workplaces and services.
- Drive the transformation of mental health and human services to be truly recovery-oriented and trauma informed
- Promote and facilitate members' professional development and life-long learning
- Represent and advocate for the interests of members as a group

Adapted from the Australian Social Work Association's Objectives)

Funding

The establishment of the professional association for peer workers will require funding support from government, and this should be from state and federal sources. Peer workers

are employed in state funded public hospitals and national and state funded community and peer run organisations. Peer workers are also employed in private mental health settings.

As the workforce and memberships grows subscriptions will make up an increasing proportion of the associations funding.

First steps

1. Promotion of the 'Statement of Intent' through the IIMHL website and IIMHL Updates.
2. Identification of key stakeholders in each state and territory.
3. Formation of a steering group to progress consultations and planning for the association.
4. Securing funding to hold a 2nd National Peer Workforce Forum.
5. At the forum, Peer work leaders from each state and territory will meet to establish the professional association, its charter and its governance.

Call for support

The Peer Work leadership match asks for the support of IIMHL delegates, Mental Health Commissions, governments and services for the establishment of a national professional association for peer workers.

IIMHL Match participants:

The Lived-experience Workforce: A Look at Diversity and Breadth of Roles that Lived-experience Workers are Making Their Own

- Eschleigh Balzamo - General Manager, BrookRed
- Jenna Roberts - Consumer Participation Officer, St Vincent's Hospital
- Sage Green - Acting CEO, Being
- Tim Heffernan – Mental Health Peer Coordinator, South Eastern NSW PHN (former Chair, New South Wales Public Mental Health Consumer Worker Committee)
- Sherry Tucker - Executive Director, Georgia Mental Health Consumer Network
- Gary Parker - Executive Director, Kansas Consumer Advisory Council for Adult Mental Health

Contact Tim Heffernan – theffernan@coordinare.org.au