

**National Mental Health Commission**  
**Peer Workforce Development Guidelines Leaders Roundtable**

**30 November 2018**

**Park Royal Hotel, Melbourne**

**Summary of discussions and feedback**

*The below is a summary of discussions that took place at the Peer Workforce Development Guidelines Leaders Roundtable on 30 November 2018. This document outlines the varied perspectives and views expressed by participants on the day and does not necessarily represent the Commission's views.*

**Existing frameworks**

Participants identified a number of frameworks to explore including:

- Far North QLD Peer Workforce Framework
- WA Peer Workforce Supporters Network
- WA AMH – Peer Workforce Strategic Framework 2014
- QLD Health Lived Experience Engagement Project (for representatives and peer workers) – 2019
- National Eating Disorder Collaboration – Peer Workers in Eating Disorder sector – draft – early 2019
- Consumer Perspectives Supervision Framework – VMIAC and Melbourne University – soon to be released
- NSWHealth – “Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities” – Action 10 – incorporates peer workers in mental health workforce plan
- PHN National Mental Health Lived Experience Engagement Network (MHLEEN) – stocktake report on lived experience engagement activities across PHNs
- ACT Peer Recovery Guidelines – now doing translational project which is broader – Michelle Banfield
- SA - NGO Mental Health Lived Experience Workforce Standards and Guidelines (Lived Experience Workforce Project – MHCSA) - for organisations employing the LE workforce
- TAS – Peer Workforce framework 2017

**Vision - Why a National Framework? What do you want to achieve?**

- Change the NDIS
- Integrate peer work into PHNs, NDIS and all mental health services
- Inform work of PHNs and get consistency across Australia
- Have an implementation strategy that is consistent across the country
- Need to consider implementation levers and strategy. We don't want the guidelines to sit on the shelf and collect dust.
- Guidelines need to be relevant for Aboriginal communities
- Guide everyone through an overarching approach and be inclusive

- Capture best practice and apply it nationally
- Provide support and authority for peer workers as an essential mental health workforce
- Capture differences between sectors. E.g. public sector vs CMO
- Provide a driver for action e.g. through KPIs or by requiring accountability from individual organisations
- Provide an onus for collaboration and help to achieve equity
- “Our vulnerability seen as our strength”
- Peer workers should not be solely responsible for anti-stigma interventions
- Values differences between consumer and carer workforces
- Different research base for family/carers workforce
- Support for peer workers. E.g. Peer supervision and mentoring
- Peer work is not just frontline work. What about research and academia, policy positions etc.?
- Peer-led research is vital to ensure peer voices are at the forefront
- Ensure there is evaluation built in as well as monitoring
- Recognise there are different environments for peer workers
- Stimulate benchmarking which helps to set minimum expectations
- As a means of collating diverse information e.g. research and evidence base and providing an overview
- Opportunity to recognise the need for local implementation but the opportunity to adapt it to best fit local circumstances and needs
- To overcome the current lack of authority that peer workers have and to drive best practice applied flexibly to meet diverse needs
- Keeping consumers and carers at the centre of practice and why we are here
- To prevent the colonisation or the alienation of peer workers
- To secure recovery focussed services for people in services
- Aim high
- Articulate the pride and intentions of peer workers
- Aim to secure funding and build into accreditation requirements
- How do we qualify and quantify the work that peer workers do?
- Tools to capture the work we do.

#### **Additional priorities/themes**

- Core standards and ethics
- Values and principles
- Build capacity for peer workers to get training
- Language – difference between lived experience and peer workforce; ‘mental health’ peer workforce will narrow the frame; consider lived experience of, for e.g. stolen generation, being incarcerated, etc.
- Consider frontline and other roles
- Carer workers – needs are different to consumer workers
- Community education and awareness
- Culture – resist being co-opted by government
- Leadership and authority
- Flexibility and nuance of peer work
- Evidence base and evaluation

- Wellbeing and support for peer workers
- Research
- Co-design and co-production
- Lateral and horizontal violence
- Coaching and mentoring
- Culture and stigma within mental health services
- Invest in the NGO/CMO sector
- Inclusion and relationships
- Targets for peer-led researchers – dedicated funding for positions
- Specialisation for peer workers – physical health coaching, art therapy etc.
- Identifying barriers for employment – literacy and numeracy, transport, licensing, criminal record, gaps in employment, wellness at work, insufficient sick leave and carer leave
- Cert IV in MH Peer Work needs to be reviewed. More electives for the Cert IV? High quality trainers who are peer workers. Peer Educators to be trained up to teach Cert IV.
- Recognise Cert IV as minimum plus additional training like Intentional Peer Support
- Promoting peers as trainers. RTOs require Peer Trainers for courses
- Wide range of skills - law components, advocacy, writing, policy writing, research
- Dedicated research fellow positions to evaluate peer programs and do peer-led research. – PhD project level
- Guidelines need to have power and authority, and provide an overarching framework whilst accommodating flexibility and opportunities for local variation

## **Themes**

### **Theme 1: Terminology and language**

- Must provide clarity
- A challenge is to define in a way that also respects cultural nuances and jurisdictional differences
- Distinction between paid peer workers and volunteers must be addressed (some disagreement in relation to this issue)
- Do we need to consider specialisation for peer workers? E.g. Mental health, AOD, suicide prevention, forensic, etc.
- Also note the difference between different support settings e.g. telephone vs. face-to-face vs. online
- Would be good to get national agreement on language and terminology
- Reflect the work that has already been done

### **Roadblocks**

- Need to have a common ground amongst peer workers but also don't want to paint ourselves into a corner that is too restrictive.
- Victoria has an Enterprise Bargaining Agreement for peer workers that defines the role poorly (along with carer consultants also)

### **Way forward**

- Establish a cross-jurisdictional reference group that can undertake a stocktake and map what currently exists
- Include a cross-cultural perspective
- Consider an EOI process for any reference groups/ steering committees
- Engage with key stakeholders e.g. NMHCCF but don't just use the same old faces – find some new people to include; include consumer peaks
- Engage with volunteers and paid workers to ensure that this issue is appropriately reflected and discussed
- Consider the issues that link to the terminology e.g. roles, pay scales, peer worker award (note mixed views about whether there should be a peer worker award), union representation, national association for peer workers
- Consider potential role for a national Peer Work Organisation
- Constantly challenge “Why not a Peer Worker?” – ask the question about every role being considered in an organisation

### **Theme 2: Key roles and functions/ethics/ values/ competencies**

- Participants had varying perspectives on whether a common vision or mission was required and what this might include
- It is about what we are wanting to achieve that is a commonality
- There needs to be a common vision and mission across all roles e.g. research / peer worker/ policy roles
- Fits within the broader context of the consumer and carer movements
- Address the lack of clarity that currently exists around the role of peer workers

- Make sure everyone understands the purpose and the structure and supports necessary to achieve the purpose
- Peer supervision feeds into career progression, workplace safety etc. How can you understand the peer worker role without supervision?
- Set out the evidence base – both that which has come from research but also that which derives from experience that has arisen from a social movement and has a human rights basis
- Some concern expressed about setting minimum training requirements for peer workers because there are many challenges to achieving this (e.g. not easy to get into, not easy to fit into working life, expensive, difficult to get the required practical placements) and it should not be a reason to exclude people
- Acknowledge there is a need for professionalism but not sure that a minimum requirement is the way to achieve this
- Should be able to commence work and then transition over time to achieving the minimum requirement
- Also recognise the value of training on the job
- Delineation of terminology important e.g. peer worker vs lived experience
- Does the term lived experience dilute the role? Does it mean that people without the relevant skills/experience might end up in the role?
- Targeting lived experience. Example provided: someone with no service use experience probably not well suited to be on committee about service redesign
- Need to make sure that position descriptions and duty statements are very specific about what is required
- Work environments (including recruitment processes) need to be more receptive to people with lived experience in general. Allows processes to be in place for everyone. People and culture.
- Consider how to work with HR and adjust their expectations (note example from Ireland) -> This can help to make the workplace more inclusive for everyone and help to 'normalise' the challenges that everyone might face
- How do you embed human rights, keep integrity of social movement as you move towards professionalisation?
- Clinical roles should not be supervising peer workers. Clinical job descriptions should not be applied to peer workers.
- Reasonable adjustments, limitations put on peer workers. People forced to sign agreements around boundaries, forced to be clinical boundary keepers instead of peer boundary keepers. Forced to do Prevention and Management of Violence and Aggression (PMVA) training when it goes against peer ethos.

#### Way forward

- Keep the integrity of the social movement
- Support clinical professionals to cast off their previous conceptions and look anew
- Get HR to look at job descriptions, how reasonable adjustments are defined, how boundary issues are defined – not the same as for clinical professions
- Ensure there is training for peer workers but not necessarily the same as what clinical professionals receive e.g. how to “take down” a consumer is antagonistic to the peer ethos
- Note that clinicians approach is not deliberately provocative or antagonistic to peer workers – it is just not considered

- Be prepared to acknowledge what needs to be different

### **Theme 3: Organisational readiness/culture/community awareness**

- Peer work should be core business
- Need to change attitudes – at all levels, including Executive Management
- Collaboration and (mutual) respect: where peers understand role of colleagues, as well as non-peer staff knowing peer workers roles. Decreases defensiveness and allows staff to be brought along with peer workers.
- Address social determinants: this is social justice work, sits within societal, social/relational (not just medical, individual) recovery; recovery orientation, trauma informed care and relationships
- Need to educate funders about peer work and impact of funding changes
- Need to draw on organisational knowledge already in existence
- Tools to build up culture of acceptance in organisations
- Need to get buy in from organisations
- Safety for all workforces, not just peer workforces
- Start with exposure and move to understanding and then create value and then achieve active commitment
- Aim for an organisation where everyone understands where peer workers fit and there is mutual respect and a comprehensive approach
- Culture – 2 levels of need:
  - Organisational level – Culture of organisation itself and whether it's a good fit for peers.
  - Whether peer workers can be safe, authentic and not co-opted
- Cultural diversity i.e. for Aboriginal and Torres Strait Islanders and others
- People of diverse cultural backgrounds – language, definitions and concepts of the mental health sector may be at odds with culturally appropriate language and ways of working. Can't be a national way of communicating – needs to be a regional conversation.
- Need to see a change to concept of recovery – personal recovery not just medical or co-opted recovery.
- Focus on Social justice - within the broader societal frame
- Government funded systems may need to approach culture change differently as structures are more set and difficult to change
- HR need to be brought along in the process too of organisational buy in.

### Roadblocks

- Organisations must be willing to make and embrace change (within teams and structures/systems)
- Need influencers who can facilitate and champion change
- Recognise it is difficult to achieve organisational change
- Peer workers should be enabled to be change agents
- Organisation must embrace change

### Way forward

- Learning Collaborative model (e.g. as implemented at Yale University)

- 4 members of organisation attend course for 12 months. Led by peer leaders. Direct information delivery, opportunities for organisations to talk about challenges. Peer networks/organisation networks created to seek advice from one another. 1-to-1 assistance from peer operators who run learning collaborative. Participants identify area of needed change and are assisted to work on that over 12 months.

#### **Theme 4: Training and Research**

- Only currently have a Cert IV – nothing below it and nothing above it
- Need to develop alternate qualifications
- Need to consider what peer workers want and need and also what employers want and need
- Also need to think about what training should be included for the mainstream mental health professionals. E.g. how to work with peer workers, induction, management of peer workers, etc.
- Need to develop leadership training for peer workers
- Note Mental Health Coordinating Council (MHCC) guidance for employers has a module on the management of workers with lived experience
- Start with a Cert II as a pathway into learning for those who wish to work in a peer worker role but don't have a strong educational history to be able to complete a Cert IV
- Scholarships can help peer workers get started or progress e.g. WA Mental Health Commission offered scholarships for graduate certificates, diplomas and masters level qualification
- Clear benefit in having inter-professional learning – helps to bring about culture change
- Current Cert IV is now 5 years old and needs to be reviewed – consider whether organisations have had benefit from the qualifications; what are the perceived deficits by organisations and peer workers
- Must include human rights, CALD, LGBTIQ+ and Aboriginal and Torres Strait Islander components within training
- Also include the quality and pride in being a peer worker
- Need to consider how to promote enough peer workers to be qualified to train and assess for peer worker training qualifications
- Role for peer Research Fellows
- Vic – recently awarded a PhD scholarship for evaluation of their Hospital to Home workforce – could have a scholarship in each state and territory to evaluate implementation of the Guidelines
- On the job paid training through traineeships should also be considered – should be supported by another peer in the workplace and must have an appropriate induction that is lived experience specific
- Can then progress through a graduated training program e.g. IPS, then Cert IV etc. (using an RTO to do this 'on the job')

#### Roadblocks

- Cost of a Cert IV: ~ \$5200 – a financial impediment
- Other impediments include practical issues like literacy levels, transport, time required away from work

- Any training requirement once working as a peer worker means time away from service delivery – many reluctant to place their needs before the people for whom they are supporting
- Funding is also an issue for employers
- Need funding models that include provision for training along with the funding for positions – particularly difficult in NDIS funding model that is individualised.

#### Way Forward

- Look to make best use of existing resources within organisations e.g. mentoring or bolstering existing training
- Acknowledge the similarities between peer workers and mainstream mental health workers and the differences
- Consider alternate ways to employ peer workers. E.g. traineeships
- Ensure that the evidence base for peer work is strongly set out
- Remuneration is an issue – need to think about alternate funding models
- Reference to the doughnut economy (presentation from NEAMI – attached) – can we live within the doughnut? [More information can be found here: [https://www.ted.com/talks/kate\\_raworth\\_a\\_healthy\\_economy\\_should\\_be\\_designed\\_to\\_thrive\\_not\\_grow?language=en](https://www.ted.com/talks/kate_raworth_a_healthy_economy_should_be_designed_to_thrive_not_grow?language=en)]
- Important that people who do the training for peer workers have training expertise, not just expertise in peer work; otherwise they rely on the usual training packages which may be co-delivered but are not embedded in lived experience; lived experience needs to be at the core of any training
- Peaks bodies may assist in developing the capacity required
- Recovery College model where peer workers become peer educators
- The Guidelines should state that Peer Training needs to be peer-led, peer developed and peer delivered.

#### **Theme 5: Peer Supervision / Support / Mentoring**

- Issue of colonisation of peer workers
- Need to consider a range of different supports – supervision, coaching and mentoring
- There isn't a strong evidence base in terms of what is best for peer workers
- Need a clearer definition of the different types of support
- Need to understand the research that does exist and what is best practice for supporting peer workers – this may not be a single approach but may be a combination of approaches
- Probably need to accept that we need a suite of options to support peer workers
- Need peer mentors who have been peer workers for a long time
- Need to consider mutuality and reciprocity in supervision. If you don't have the same experiences is mentoring etc. appropriate? Coaches don't need to have the same experiences and skills so may not be peer workers?
- Also need to consider peer workers in rural and remote settings
- Use technology to facilitate peer supervision e.g. use of Zoom teleconferencing
- Consider communities of practice
- Could develop a regional or national group of experts to act as mentors



- Link requirement for supervision to systemic drivers e.g. KPIs, accreditation, so organisations have expectations to provide support

#### Roadblocks and way forward

- Risk that organisations see peer supervision through the traditional 'clinical' lens when it should be tailored to the individual peer worker needs and recognise how the peer workforce is different
- Need to facilitate ways that the peer workforce can educate the rest of the workforce about their role and how it is different to a traditional clinical role; have peer workers recognised as experts in their own journey and the workplace
- Peer supervisors must understand the cultural context of working e.g. the Indigenous culture if working with Aboriginal consumer workers
- Peer workforce needs to be well defined to get the right support
- Requires proper resourcing to enable the appropriate level of supervision, coaching and mentoring to occur

#### **Dot exercise priorities**

This exercise asked participants to choose their overall top priorities from the discussions throughout the day by placing sticky dots next to their chosen priorities (each participant had 3 dots). The below priorities are the top-rated results.

- Put together a cross-jurisdictional reference group (by EOI) to develop a common language/terminology. Group must be aware of dominant culture and find ways to ensure terminology is inclusive
- Peer Work embedded as core business. Exposure → understanding → value → active commitment
- Identify tools for building workplace culture
- Development of other training/education/qualification packages including higher education
- Promote, train and recruit peers as trainers (there is a lack of peers training peers)
- Research on best practice support for peers
- Find, establish and create connections to local or regional peer mentors/leaders
- Common mission and vision for peer workers. E.g. human rights, social movement

#### **Other points raised**

- Reflection back to 1992 when the first group of consumers met at Rozelle Hospital to devise a structure that could employ consumers to support people in the service
- First peer workers employed in January 1993
- Based their salary on existing awards with a view to developing their own award
- Wanted to have an independent body to recruit and employ peer workers, using consumer and carer peak bodies
- Also planned to have a peak body to educate and support peer workers
- Now 25 years on – not much progress has been made!

- Today is “quite a memorable occasion and shows how far we’ve come and how far we haven’t come”.

### **Comments on developing the Peer Workforce Development Guidelines**

- Question underpinning assumptions
- Consultation is problematic if done in the traditional way
- Need to resist the language of oppression!
- Power is a fundamental issue
- Process is important in the development of this work
- Agree there must be some sharing of power but don’t want to be part of an Advisory Group that can have their advice disregarded
- Would prefer to have the work led by an Expert Steering Committee of Peer workers
- Can implement a range of engagement processes within the project – peer-led, co-design, consultation
- Focus on what we want to achieve and why
- Need time to explore what the problem is; haven’t come to shared understanding of the issue
- Think about connecting to organisations with success in effecting change
- Learn from other workforces about how they progressed development
- Important to work with clinicians and organisations, to avoid ‘us vs them’ perception
- Need to ensure we have a shared understanding of what the problem is that we are trying to solve e.g. for consumers, for carers
- Need time to build relationships, get the right people on board, get the appropriate guidance and think about the pitfalls
- Others felt we are still asking for the same things as 25 years ago and we need to get on with it
- How do we bring traditional mental health professionals along with us?
- Start with lived experience and filter with consultation
- ‘Connect the cacophony’: there are many frameworks and guidelines, but they are not connected. People are vulnerable, people will leave if we don’t get some bigger structure that says here it is, this is how we work.
- Ensure there is an Aboriginal or Torres Strait Islander representative on the Advisory Group
- Include existing evidence and ways of working from successful organisations that engage peer workers (draw on existing works, not starting de novo)
- Qualitative or quantitative research can inform the development
- Consider sending surveys out through existing organisations and networks
- Spectrum of options: runs from consultation with peer workers to co-production to peer worker led models
- Request it be at the higher level if possible
- Must ensure that there are young people included
- Consider whether a clearinghouse should be developed – or use an existing model like the Peer Work Hub
- Address systemic barriers
- Guidelines must have an implementation plan
- Need to meet organisations halfway

- Must engage with other mental health professionals, states and territories, peak bodies, private sector and NGOs
- Did other professions look to others for their own best practice guidelines?
- Peer-led
- What are the guidelines trying to do? Are they best practice guidelines or development guidelines?
- Address systemic barriers
- Overall, must be inclusive in its aim and approach – not just creating a separate silo-ed approach for peer workers