ACT Mental Health Consumer Network Inc.
The Griffin Centre, Level 2, Room 11
20 Genge Street, Canberra City, 2601
P.O.BOX 469, Civic Square, ACT, 2608
Phone: 02 6230 5796 Fax: 02 6230 5790
Email: policy@actmhcn.org.au
Website: www.actmhcn.org.au

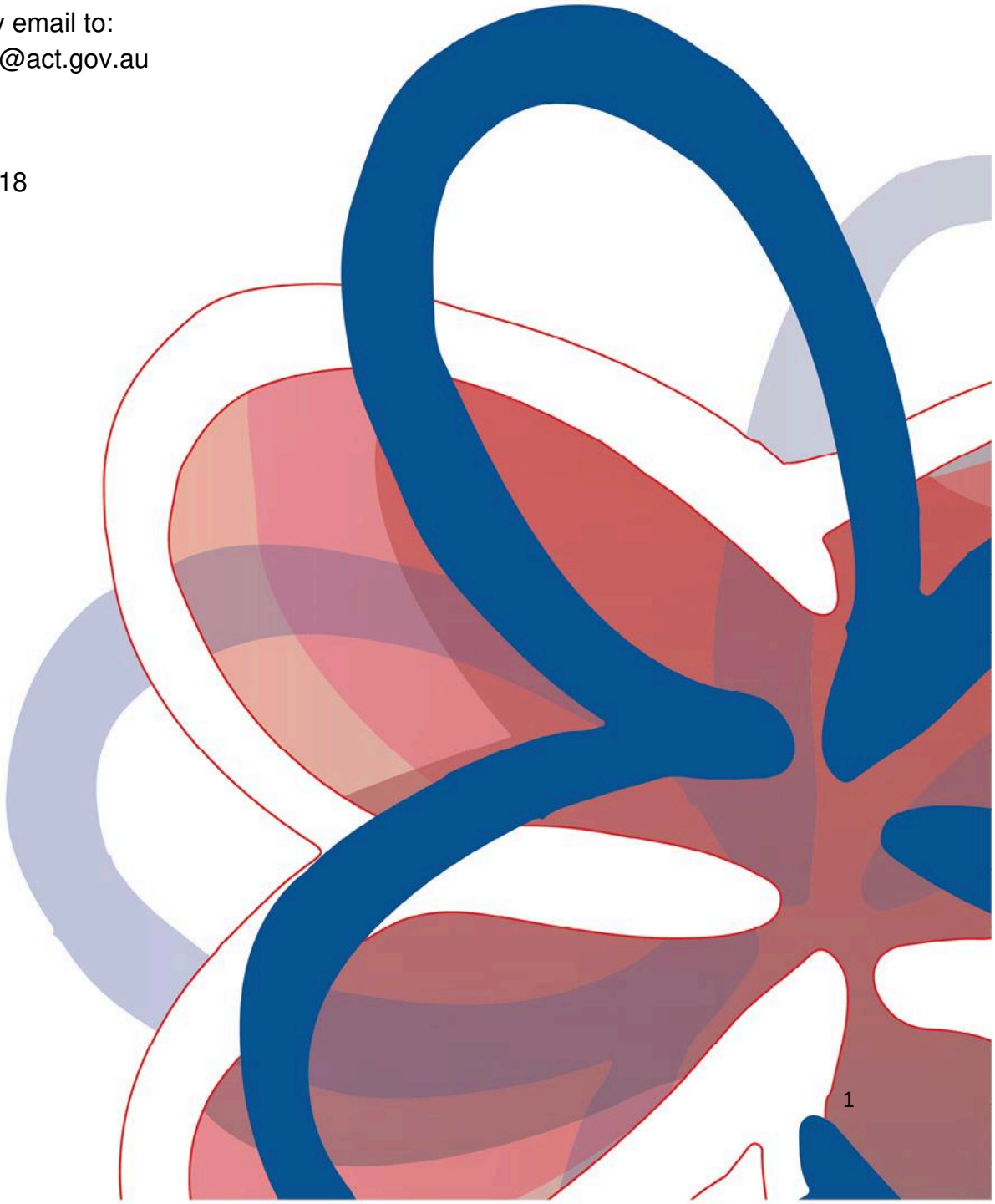
Submission:

Draft Peer Recovery Workers:

Guidelines and Practice Standards

Submitted by email to:
connie.galati@act.gov.au

22 March 2018



SUBMISSION: PEER RECOVERY WORKERS: GUIDELINES AND PRACTICE STANDARDS

This submission has been prepared by the ACT Mental Health Consumer Network in response to the draft Peer Recovery Workers: Guidelines and Practice Standards.

About the ACT Mental Health Consumer Network

The ACT Mental Health Consumer Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is a member based organisation committed to social justice and the inclusion of people with lived experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

The Network sought input from our members who generously contributed feedback as to how peer recovery workers in the ACT Health, Mental Health, Justice Health and Alcohol and Drugs Services, context should operate and what their role/s should entail.

Overall Comments

There is contained excitement regarding the proposed inclusion of weer recovery workers in the Act Health MHJHADS context. One of the most important aspects identified by consumers as an essential component of the introduction of peer recovery workers is a solid structure of continuing, adequate internal and external supported professional supervision. We do not believe this is adequately covered in the current version of the draft document. Not only would this provide the peer workers with a safe, reliable structure to work in, it would also assist with the successful introduction and continuation of peer workers as part of the broader team, reducing the development and continuation of stigma in the workplace.

The guidelines have underlying assumptions that peer work can be accommodated relatively readily with the existing organisational culture and practice with a nod to the possibility of peer workers undertaking tasks otherwise undertaken by a general member of staff such as identifying issues and completing paper work trails.

Unfortunately, the tone of some of the language in the document could be construed as patronising or stigmatising for peer workers working in this context. Several such examples of this issue appear throughout the document and further revision to remove this disjointedness is required to illustrate that peer recovery workers are part of the larger multidisciplinary team, which in turn will reduce stigma. Examples include but are not limited to:

- at 2.4: where benefits of a peer recovery worker include the breaking down of *perceived* stigma and reducing self-stigma. Consumers raised the language at this point, stating that the word *perceived* needs to be removed;
- at 2.6: where it states that peer recovery workers can *plan, lead or co-facilitate peer led groups **to** people, such as ending self-stigma.* In line with nothing for us without us, such peer led groups should run **for** people, not to them; and
- at 3.3: peer recovery workers appear to be outside of 'staff' rather than within, by explicitly referring to 'some Peer Recovery Workers and other staff', rather than simply referring to 'some staff'.
- At 3.3.2 (p. 20): we recommend the following wording adjustment – 'Peer Recovery Workers ~~need to be mindful that once they have shared part of their personal story they cannot take it back. They~~ need to consider their person.

Overall, the peer recovery worker Guidelines and Practice Standards are unclear about the role and scope of peer recovery workers. Further, there is little information that provides guidance for consumers in existing peer roles within MHJHADS, making it difficult for peer recovery workers to adjust to their roles in the workplace. This has potential to cause difficulties for both peer workers and other staff, which is a quick path to failure. We note that the document acknowledges that the introduction of peer recovery workers will require cultural and organisational change, and states that leaders within MHJHADS will support peer workers in advancing issues where cultural change is needed.

It is acknowledged that peer workers contribute to the multi-disciplinary team, collaborating with administrative and clinical staff. However, to ensure true collaboration with clinicians we stress the importance of including clinicians in the development of these guidelines and hope this has occurred and will continue through to finalisation of the document.

Minor editing recommendations

The following are minor edits noted in the Draft Peer Recovery Workers: Guidelines and Practice Standards:

- p. 11: Peer Recovery Workers positions are clinically-related roles. The words, “In this context” should begin this paragraph;
- p. 44: The inclusion of Qualifications and Experience on this page, along with a separate selection criteria is confusing. Plus, the selection criteria do not include lived experience, or other essential/desirable things noted here. Needs to be simplified or include instructions for applicants about how to apply (including which bits they are meant to be responding to)
- p. 44: We do not know what a ‘passenger’s driver’s license’ is and suggest this statement be revised.

2.5 Role of the Peer Recovery Worker

There are some contradictions in defining the role of peer recovery workers in the document. For example, one member noted:

> *…on page 9 in the dot points there is the suggestion that peer workers might co-facilitate therapeutic groups. This is at odds with the statement on page 11 that their role does not include the provision of therapy. I recognise that this is only a subtle difference between the two, but in a very fuzzy and new environment, think this sort of contradiction doesn’t help.*

There are concerns about the ability of peer workers to effectively advocate for individual needs. We note that the document stipulates that peer recovery workers will be able to advocate on behalf of an individual or assist them to self-advocate (at 3.3.7), however the process appears unnecessarily rigid. While we understand a need to record such instances, we query why an appropriately trained peer recovery worker would need to work in communication with senior staff and/or the treating team in order to undertake simple advocacy support that may not related to treatment. In addition, consumers strongly recommend that systemic cultural reform is needed to ensure peer recovery workers are supported to raise concerns when they don’t think the system is working effectively or appropriately.

The peer recovery workers are going to be paid at a low level, putting them at the very bottom of the hierarchy in any multidisciplinary team that they work with. In addition, the peer recovery worker will be paid under the allied health stream, not their own stream, which could result in difficulties in relation to career advancement as peer recovery workers do not have to have any formal health training. We are concerned that the notable lower pay scale of peer recovery workers, and their limited access to career progression, may result in them being an undervalued

addition of “what we have to have” rather than valued member of the multidisciplinary team.

3. Professional Standards

The current phrasing of the education requirement (3.1 Qualifications, point 2) is unnecessarily narrow and is likely to cause recruitment difficulties. Specifically, the inclusion of the word ‘health’ before the words ‘related field’ will narrow the field of applicants in a way that we do not believe is intended or appropriate. That is, the Certificate IV in Mental Health Peer Work and its equivalent sibling qualifications: the Certificates IV in Mental Health, Alcohol and Other Drugs, Disability, Youth, Community Work and Aged Care, are all community sector qualifications, not health, but are clearly related to the role given they share the same core competencies. We recommend that the word ‘health’ be removed from the education requirement field noting that, while certainly being related, health is not the only related field.

We also recommend that, as part of this same point, words to the effect of ‘and/or experience in a relevant role (paid or unpaid)’ be added to the requirement. We further recommend that suitable candidates who have relevant experience but do not hold a current qualification be supported to achieve one through their employment. This is an important change, recognising that many potential candidates may have been prevented from attaining a relevant qualification due to the substantial costs involved.

On a related note, while the ACT has not had the Certificate IV in Mental Health Peer Work operating for some time, the Canberra Institute of Technology has recently advertised that they will start to deliver this qualification in mid-2018. We welcome this addition to the CIT course list and hope that ACT Health will seek to support consumers to complete this important qualification.

Working With Vulnerable People Registration

We agree that Working With Vulnerable People (WWVP) registration is an important protection for vulnerable people in the ACT and we note that currently the document stipulates it will be a requirement for candidates to hold current registration. We recommend including words to the effect of ‘or documented evidence that registration has been applied for’ at 3.1 point 3 in recognition that highly suitable candidates could be disadvantaged by the time it takes for registration to be finalised by the ACT Government.

Further, the Network is aware of many cases where difficulties have arisen for people with lived experience in obtaining a WWVP registration. It is very important to recognise that some consumers with extremely valuable experience who have been through the justice system may continue to struggle to attain WWVP registration, and recommend that accommodations be made to support suitable candidates to obtain conditional registration where those conditions do not prevent them from undertaking their role. By building in a supportive system where suitable candidates can feel safe to disclose conditions that may arise on their WWVP registration once obtained, it will be possible to ensure that only suitable candidates are accepted whilst awaiting finalisation of the ACT Government process.

3.2 Core competencies

In general, consumers like the idea of having clear competencies, but had some concerns with the way they are currently stipulated. There was general agreement that the competencies outlined in the left hand columns ('all peer recovery workers') were relevant as they are measurable through actions, whereas those from the right hand column ('senior peer recovery workers') were rote/textbook answers. A great deal of detailed information currently included in the core competencies has the potential to deter highly suitable applicants from applying. We do not believe this level of detail is necessary for solidifying the varied aspects of the role and recommend that it be simplified for the sake of clarity.

The core competencies identified in the document are stated to be universal across all peer worker roles (p. 12) despite the diversity of such roles. This statement appears inaccurate, given the core competencies that follow are then repeatedly and explicitly stated as referring to the proposed peer recovery workers.

There is also no explanation of the difference between the peer recovery worker and 'senior' peer recovery worker roles in the competency table. Is it an illustration of career progression, with the 'senior' peer recovery worker on a higher salary? This terminology is not used elsewhere throughout the paper and requires explanation.

Further, in the core competencies there is an assumption that peer workers will know who provides which services and in what form. Consumers are concerned that this requirement is a huge hurdle, and reduces the ability of other staff to see where the new role fits. One person, notably a senior employee for a research agency**,** stated:

I struggle to keep track of all the various services and types of professionals available within them, but a clinical colleague tells me I'm a good reflective listener and an effective storyteller. Would I be unable to apply for a peer worker role in ACT Health because I can't follow who is where and what they do? Isn't it the job of the guidelines to show (preferably visually) this information?

Finally, consumers asserted that peer recovery workers will need to be supported to identify any reasonable adjustments that would assist them in their work. There is currently no mention of reasonable adjustment in the document, and we recommend that this is rectified to acknowledge that adjustments to support individual needs due to an employee's disability will be made available.

3.4 Clinical Records

Consumers are concerned as to why peer recovery workers will be required to have their professional supervisor continue to check that their clinical record entries are within acceptable standards within ACT Health. We query whether this is a standard requirement for all staff or if it is distinct for the proposed peer recovery workers. If the latter, it is difficult to understand why this is required despite a peer recovery worker's skills, qualifications and training to first be recruited into the position then having effectively passed the orientation period.

3.5 Continuing Professional Development (CPD)

It was noted that the proposed peer recovery worker roles were based at a very low level which has the potential to cement stigma that may arise about the roles. While there does seem to good coverage of the range of general professional development available, the document doesn't provide any information regarding career development pathways. The table on page 12 makes mention of peer recovery workers and senior peer recovery workers but this is not further defined anywhere in the paper.

In addition, the actual training and development needs of an individual are not currently taken into consideration. Quoting a consumer response:

…the actual needs of each individual [need to be] identified [so] it does not turn out to be just a checklist and 'bums on seats' exercise.

Where the document outlines the CPD requirements for peer recovery workers (p. 24) it states that clinical and clinically related staff, including peer recovery workers are required to engage in CPD. We query whether this is this a requirement for all staff, or only clinically related and clinical staff If it is required for all staff, it is unclear whether the number of hours been adjusted in recognition of the number of hours a person will be working or if this is the requirement for staff on full time hours. There is currently no stipulation anywhere in the document of whether these roles are fulltime, part time or flexible in nature. We would support a range of these roles as provision of only full time roles would rule out some very good candidates.

Consumers also raised concerns that the section on resources available to support the structured peer programs, at 3.5.3, is under developed. We note that there is a wide range of programs available with varying degrees of evidence about effectiveness. As new roles within the system, this is one area where starting with an evidence-based structure is very important as it provides some protection for peer workers, the consumers and peer work as a profession.

3.6 Professional Supervision

Consumers identified the provision of continuing, adequate internal and external supported professional supervision as an essential component of peer recovery worker management. The document in its current form does not adequately state how supervision will operate or who will be providing it, especially in regard to ongoing support.

We question who the peer recovery workers' supervisor/s will be, and whether or not funds will be made available for continuing, external support. We note that the document currently identifies that peer workers will be generally supervised by existing clinical staff employed by ACT Health. The wording of the document states that, in addition to internal supervision, peer recovery workers will be able to access supervision from a health professional. However it is unclear who will pay for this service if accessed which has the potential to cause concern given this option is likely to be quite costly. The capacity to undertake supervision of this nature is very important for peer recovery workers as they may need support and advice about how they relate and work with individual consumers.

Further, consumers were disappointed that there was no mention of capacity for supervision by an external peer paid for by ACT Health, such as through the Network or other suitable organisation. In addition, we recommend adding specific mentions

of how the Network can work with peer recovery workers to support them in their roles, for example with regard to the work that we do in relation to self-advocacy, consumer representative and co-facilitation training programs, and systemic advocacy.

In addition, the wording for the professional supervision of peer recovery workers is condescending at best. All professional supervision should be positive and enabling, offering opportunities for employees and a skilled supervisor to reflect on work practices. We query why supervision for peer recovery workers is so different to supervision for all other employees, where it is stated that ‘the three common issues [of] role clarification, boundary issues and self-care’ will be addressed.