Peer Workforce Development

Keynote Presentation

by Sandy Watson



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TITLE: Peer Workforce Development

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SLIDE: PEER WORKFORCE DEVELOPMENT

Background

Hi, I am Sandy Watson and I am a consultant with inside out & associates, and it is a pleasure to be here today. Inside out & associates is a not for profit partnership between myself, a consumer, Kath Thorburn and Michelle Everett, and we operate in NSW. We have different expertise that the three of us bring to bear on our projects. I bring a lived experience perspective to the partnership, as well as my experience of working in a range of consumer designated roles over many years, starting with the inception of the consumer consultants at Rozelle Hospital in Sydney in 1993. It is now the 20th anniversary of this significant consumer workforce event. I have worked as a consumer consultant, a consumer advocate, a consumer participation coordinator, a consumer educator, consumer academic and consumer representative.

In 1993 I was naive about consumer work, recovery wasn't talked about at all until many years later, and there was nothing to go on to provide me with the guidance I needed as to what my practice as a consumer consultant ought to look like. So I began to work on defining the principles and ethics of my own practice, stumbling in the hardest classroom of all, identifying my mistakes,

reflecting upon and understanding what I was doing wrong. Interestingly, 20 years on, some consumer or peer workers are in the same predicament, not knowing what they should be doing and having little access to experienced peer mentoring or supervision or any guidance as to how to work in an authentic way.

As an aside, in the early days of consumer work, nearly everyone complained about the word 'consumer'. When I use the term consumer I take the consumer/survivor movement sense of the term, to mean a person who exercises freedom of choice over their mental health and wellbeing. It is about freedom of choice, not about being a user of a health service. But if you really don't like the word consumer I am happy to identify as an 'eclectic chooser'.

Where I am coming from in my presentation today

My work these days is largely as a consumer educator and or consultant to organisations. In terms of numbers, I teach a lot more mental health workers and managers than I do consumers. Primarily I teach in three subject areas: recovery, mental health peer work, and consumer advocacy.

As a consumer educator, I have delivered specific training about mental health peer work in several States in Australia over the last 2 years, and my presentation at this conference is grounded in my observations of the issues as they appear to me from within a classroom context. This paper consists of a personal bird's eye view of peer workforce development issues; my observations today also derive from my reading of the literature on peer work, as well as my conversations with a lot of peer workers, non-peer workers and managers about the issues they are addressing in the context of their respective roles.

The reason why I have chosen this approach to my keynote address is that I am observing some disturbing trends across Australia. The workforce development challenges I encounter aren't occurring in little pockets as aberrations that I can attribute to one confused service here or there.

It doesn't much matter where I deliver peer work training, or to which mental health sector - be that public or community managed - I see the same worrying phenomena, and so I want to focus on what I perceive are deepening problems that must be addressed if we want to have any hope of arriving at a standard of best practice across Australian services that employ peer workers.

In what other industry would people apply for a job having no idea what the job is that they are applying for, and employers recruit people to these jobs, also having no idea what they are recruiting for? And six months further down the track neither the employee nor the employer are any the wiser about what the work actually is, and how it is practised.

What I argue in this paper.

SLIDE: FOUR KEY THEMES

I argue that the mental health peer workforce has reached a new level of maturity, and now consists of two distinct but related disciplines. The discipline of consumer engagement and leadership; and the discipline of recovery peer work. It is time to recognise these as different disciplines and to recruit, train and support people in such a way as to treat these as different types of work.

I will discuss four central problems that impact on both of these disciplines: firstly the failure to recognise that mental health peer and consumer workers

are *not* mental health workers; secondly the problem of hybridisation of consumer and peer work roles; thirdly, the 'Eve from Adam's Rib Syndrome', which is the tendency of managers and the non-peer workforce to create consumer and peer workers in their own image; and finally, the new form of discrimination being experienced by consumer and peer workers, and this is what I call 'discrimination by sameness', somewhat caused by a lack of understanding about positive discrimination provisions under the Disability Discrimination Act 1992.

I will allude to other issues throughout these key discussion points. And perhaps you will be disappointed with me for not giving you some glowing story about peer work best practice. I know there is great work going on, there are fabulous people doing very important work consumer and peer work, and services providing quality support. There is a great deal of commitment and definitely a growing interest in peer work, as evidenced by this conference and by the existence of the Centre of Excellence in Peer Support. But at the end of the day, I just can't be silent about what I see as disturbing trends when peer and consumer workers are integrated into existing service settings. We can't look away because the integrity of our work, the valuing of our knowledge base, and its future viability relies on our ability to get this right. And we can't do this if we ignore things when they are going so badly wrong.

Consumer worker or peer worker?

Firstly, there is confusion about what the differences might be between consumer work and peer work. I am regularly asked, are they the same thing? Can we just use these terms interchangeably to cover the same types of roles? I am struck by how much confusion there is out there in the sector on these questions, and if we want to develop the consumer and peer workforce, we need to be a lot clearer in our answers.

One way of answering this is to take a step back and look at this from a historical perspective. Simply put, we are witnessing two distinct historical phases of consumer and peer work and this is creating confusion.

The First National Mental Health Plan covering the early 1990s represented a watershed moment in Australian national policy in relation to the recognition of consumer participation in service development, delivery and evaluation, recognising participation as being a right. Following from this, soon after there were many consumer & carer roles that emerged, with a wide variety of consumer job titles, Consumer Representatives, Consumer Consultants, Consumer Support Workers, Consumer Advocates, Carer Representatives, Consumer and Carer Participation Coordinators and so on.

With the emergence of what is often called the Recovery Movement, there developed a gradual shift away from an emphasis on consumer participation/engagement roles towards roles where consumers are providing peer support services to facilitate service user self-directed recovery. Job titles show this transition, with titles such as Peer Specialists, Peer Support Workers, Peer Recovery Workers, Peer Mentors and so on. We now have a plethora of job titles in this country, and that is a big problem, but what is far more

problematic is that critical distinctions between consumer engagement work and peer recovery work are not being acknowledged or addressed.

SLIDE: CONSUMER CARTOON #1



I am witnessing consumers drifting into peer recovery work who have been doing consumer engagement work, some for many years, but with little knowledge about recovery beyond their own journey of recovery; little knowledge of the values of peer work if they even know there are values of peer work; little exposure to the very extensive body of literature on recovery and recovery oriented practices.

There are peer workers who think that their role is to tell people to take medication because that is what helped the peer worker in their recovery; they think then that they need to convince service users to do the same. A peer worker staples a large recovery document to the service's Wellness Plan, and on page two service users are already being advised by the peer worker to take their medication. Or the consumer representative who tells me his role is to help people get insight into their condition and to convince them to take their medication so that they can recover.

I argue that we ought to use the term 'consumer' for job titles to describe consumer engagement & leadership work, and use the term 'peer' to describe job titles that entail recovery peer work. We then need to ensure people are recruited to either consumer engagement or recovery peer work with the relevant training required for them to function within these more delineated disciplines. Whilst it isn't a perfect solution by any means, it would demarcate these different types of work and make it easier for employers to stop the practice of bundling consumer engagement and peer recovery work into the same – sometimes - very excessive job descriptions, that ultimately leave consumer or peer workers at a loss as to what they are supposed to be doing.

And consumer or peer workers would be better positioned to apply for work more suited to them if the recruitment process was much clearer and if

everyone, including employers actually understood what the work entails and what is different between consumer engagement work and recovery peer work. Interviews would be better designed to elicit the level to which applicants actually understood what it is they are applying for.

The theoretical underpinnings between consumer engagement and peer led recovery disciplines are different in fundamental ways: the mechanisms are different, the practices are different, the evidence base is different, the skills & techniques are significantly different, and the manner in which lived experience knowledge is used is different, especially in relation to the use of personal disclosures. I will address the disclosure question later.

In the same way as the mental health workforce represents a range of different professions, including psychology, occupational therapy, and psychiatric nursing, the consumer engagement & recovery peer workforce represents two disciplines (I deliberately avoid calling these professions because they are not, and there are good reasons not to position consumer and peer work as 'professions' or as 'professionals').

The discipline of recovery peer work entails facilitating self-directed recovery. It is not about providing care; rather it is about facilitating a service user's ability to self-care. Peer work isn't a new model of care, any more than recovery oriented practice is. Recovery peer support has both an individual focus in support of a person's self-directed journey of recovery, and a systems level focus where recovery peer workers ought to be providing leadership to services regarding recovery-oriented practices. A recovery peer workforce must be providing this level of leadership and peer workers need to build up their knowledge base about recovery, recovery oriented practice, and international best practices.

A peer recovery worker is using their own lived experience of recovery deliberately, intentionally, as a core aspect of their practice, as well as relying more on their knowledge of the diverse pathways other people use in their recovery journeys; on the range of ways people make sense of their mental distress in the first place, and their knowledge of the impacts on identity, social and emotional wellbeing of receiving a psychiatric diagnosis or service.

A consumer advocate on the other hand isn't really making their own disclosures in an advocacy situation, the focus is altogether different. Consumer advocacy is not about telling your own story. Consumer advocates must be thoroughly grounded in rights and policy frameworks, they need to be able to interpret what they see happening in services through a rights framework and act accordingly. But I have met consumer advocates who are totally ignorant about international law and of the most powerful tools for our advocacy: the Convention on the Rights of People with Disabilities (2006), and the real sleeping giant in relation to any use of coercion in psychiatry, the Convention against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment (1984).

We now stand at a historical crossroads between these two disciplines: the discipline of consumer engagement and the discipline of peer recovery work, and the sign at the crossroad says, 'confused' and this points in all directions. If we blur these disciplines as much as we have already, we risk the quality, viability and integrity of both.

This leads into the second problem I wish to discuss, the problem of hybridisation.

The problem of hybridisation.

I want to address something I am identifying wherever I am teaching about peer work, no matter what State and no matter what service type, and that is the problem of hybridisation, and there is a double-decker hybridisation bus descending upon us. That is, the hybridisation between consumer engagement work and recovery peer work; and on the other hand, the hybridisation of consumer engagement work and or peer recovery work with non-peer, community and or clinical mental health work. There are community managed settings within Australia, as I speak, where people recruited into consumer and or peer work roles are doing exactly the same work as the mental health workforce is doing: they are indistinguishable in every respect, except for the job title.

More disturbingly still, this phenomena has occurred in one Australian State after people had completed the Certificate 1V in Mental Health Peer Work in 2012, indeed I was informed by 3 of these peer workers that they were advised at completion of their course, after they had qualified, that they could now do peer work in *any* role. I have encountered so much resistance in workshops I conduct, to the critical point that you recruit specifically for mental health peer work, in designated mental health peer work positions, and then support and facilitate authentic peer work from the point of recruitment onwards.

I commonly encounter situations where consumers have been recruited into peer recovery roles, and been in the job for several months without any grasp that their work is not business as usual community mental health work or public mental health work, and they can become quite distressed, and angry with me, when they attend my training to discover that their work is *not* mental health work and that they are *not* community mental health workers.

In one course I ran for peer workers who had already been recruited to provide recovery peer supports in designated peer worker roles, a peer worker walked out of my course after it was clarified and explained that peer work was not mental health work. Believing he was now 'a mental health worker' because he worked in a mental health service, he became angry that this was not the case, and was silently uncomfortable for the rest of the course after I coaxed him back in. He viewed peer work in the following terms... telling everyone that... "I gave up a lot to get this job, if this is what it is I don't want to do this lowly work".

Indeed, the recruitment process for recovery peer work often completely fails to convey what peer work actually involves such as the use of purposeful disclosures, and some consumers go into the role thinking they are now mental health workers but just with a peer work job title. Further to this trend, I have noticed some peer workers deliberately gravitating to non-peer work practices because that is what they value and this is what is valued and often encouraged in their workplace by non-peer workers.

Some quick examples: a peer worker *triaging* consumers on the telephone line in a community managed service including calling the police on service users; peer workers conducting assessments and documenting these in the exact same way a community mental health worker in the service would conduct and document these assessments; accessing clinical files without the knowledge or the consent of any person for whom the clinical file pertains; sitting on treating teams and seeing themselves as part of the treating team; taking available community mental health worker shifts in the same service they are recruited in as peer workers because there isn't enough peer worker hours and they want more work; sitting in on clinical changeover whilst clinicians discuss patients; peer workers talking about their caseloads and describing service users as their

'clients'. Often this occurs with some vague sense of discomfort that something isn't right, but no valid analysis follows. Employers and employees alike can't seem to think the problems through and work it out when things have gone off the rails, and for this reason, many of these issues persist for years, and become entrenched.

SLIDE: A HYBRIDISED PEER WORKER

Values of peer work

SLIDE: MARY OHAGAN

Any person being recruited in Australia to a designated recovery peer work position should be recruited in light of the values of peer work. This is a new workforce and it is imperative that these values are used, rather than just the stock and standard values of the service, or of the other workforces. I just give you two examples, I don't have time to cover what these values mean in any detail, but organisations need to be explicit as to the values they recruit the peer workforce to, as is the case with the Scottish Recovery Network, then at least people know where they stand, and it is clear that it is a different workforce and consumers know when they apply for a job, what the values are going to be for their practice. The values of peer work are fundamentally different to that of the mental health workforce, especially around the concepts of equality, mutuality and reciprocity.

SLIDE: SCOTTISH RECOVERY NETWORK

I think the values of consumer engagement and leadership work are different again in some respects, as they would have a much stronger emphasis on rights and community development, where the two examples of the values of peer support work don't mention rights at all. Again if we hybridise, we lose critical

points along the way, and there is nothing more critical to consumer engagement & leadership work in this country than Australia's failure to adhere to international law surrounding the rights of people with psychosocial disabilities.

Lived experience knowledge base

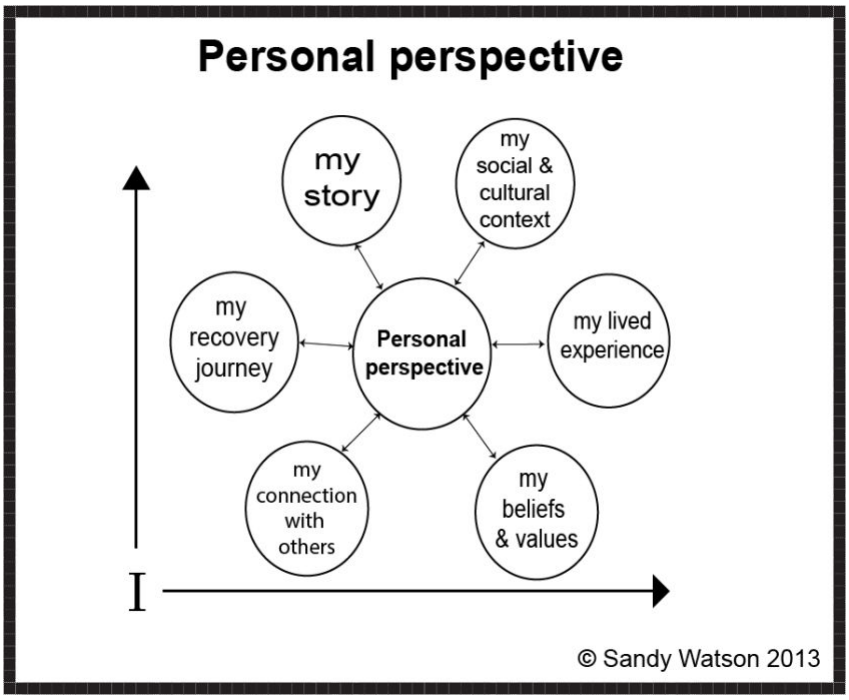
Just to clarify that 'lived experience' is not the same as 'life experience', and these are commonly confused. All workers bring life experience to their work in mental health, but in recovery peer work, it is lived experience of mental distress and of recovery that we draw upon as a core resource in our work, and this distinguishes peer work significantly from mental health professional practice for which there is a strong taboo about making such disclosures. Lived experience is a paid for knowledge base, the idea being that a peer worker through their lived experience of mental distress and of recovery, as well as their knowledge of recovery research and literature, demonstrates that recovery is possible.

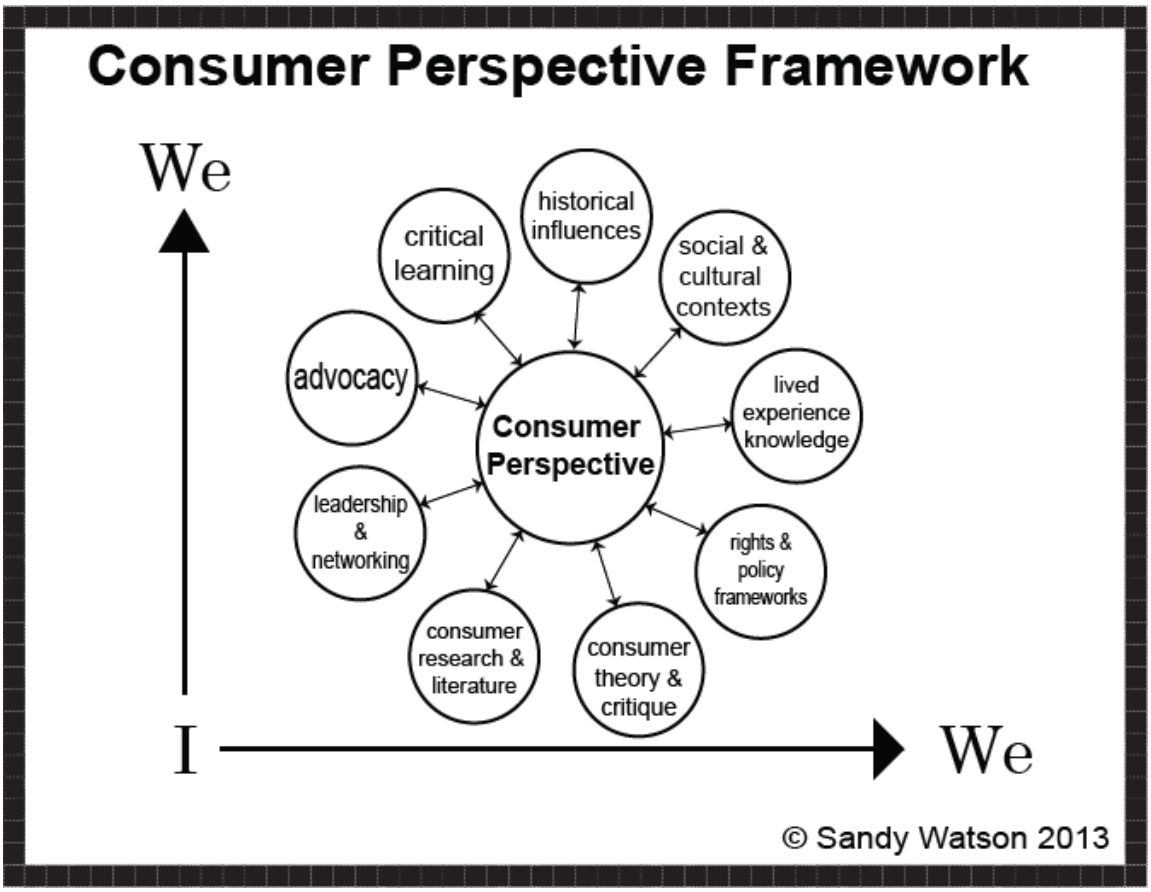
Consumer workers and peer recovery workers share the concept of 'consumer perspective', another element of the lived experience knowledge base. Consumer perspective encapsulates a range of domains as the following slides illustrate.

SLIDE: PERSONAL PERSPECTIVE + CONSUMER PERSPECTIVE FRAMEWORK

The consumer worker and the recovery peer worker move on from their own lived experience and demonstrate an ability to incorporate into their worldview, other consumer perspectives.

When services employ us they are paying for a lived experience knowledge base, and this goes way beyond the level of personal perspective alone.


Personal perspective
my story
my social & cultural context
my recovery journey
Personal perspective
my lived experience
my connection with others
my beliefs & values
I
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Consumer Perspective Framework
We
historical influences
critical learning
social & cultural contexts
advocacy
Consumer Perspective
lived experience knowledge
leadership & networking
rights & policy frameworks
consumer research & literature
consumer theory & critique
I
We
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Eve from Adam's Rib Syndrome

One hybridisation problem in the double-decker bus has at its roots a simple error in logic, and the logical error is to describe consumer and or peer workers as being a 'part of the mental health workforce'. Such statements are common, and position peer work as being 'relative to', or 'part of' the mental health workforce, when it is everything but. But this idea of consumer and peer workers as adjunct to the mental health workforce isn't new, indeed it has its origins in the early 1990s American research on peer work, when adjunct roles were created for the purposes of randomised controlled trials, roles such as 'Consumer Case Manager'. Following on from this historical error in logic is a pattern of behaviour that creates consumer and peer workers in the mental health workforce's own image, what I call 'Eve from Adam's Rib Syndrome'. When peer and consumer workers are largely doing the same or very similar roles, or are behaving the same as community or public mental health workers, then you know this syndrome is flourishing.

The simple fact of working in a mental health service does not mean a peer worker is by default, a mental health worker. I work at Parliament occasionally and I don't think of myself as a Parliamentarian; indeed if I represented myself as a parliamentarian I could be arrested and charged with fraud. So let's get the logic sorted out.

We firstly need to delink the fact of *where* consumer and peer workers are working from *what* consumer and peer workers ought to be delivering. To think of consumer and peer workers as 'part of the mental health workforce'...'part of the team'...'part of the same team'...' part of the treating team'...is to assume,

in an uncritical way, that they are mental health workers by default because of the fact that they work in a mental health service. This is deeply problematic because it fails to recognise that the mental health peer workforce is intrinsically embedded in the lived experience of recovery, and is the first post-institutional workforce in mental health services history.

For consumer and peer work to be positioned as part of the mental health workforce is directly antithetical to the work itself: its social and political histories, its critical analysis, literature, research, values and practices. It is the differences that need to be upheld for consumer and peer work to maintain its integrity as a workforce in integrated mental health service settings.

Furthermore, this assumption that peer workers are part of the mental health workforce sets a precedent for positioning recovery peer workers especially as providers of '*mental health care*'. I often hear peer work referred to *as a new model of care*. Again this assumes that peer workers are providers of 'care' because they work in a mental health service, the consequence of which is to position peer work somewhere at the back-end of psychosocial rehabilitation, assertive community treatment and person-centred models of care. Recovery peer work is not about providing care, we are not health care providers: we are facilitating the process of self directed care, which is altogether a different thing; it is the difference between the North and the South Pole.

There are health services in Australia where there is severe hybridisation going on in the public sector with the blurring of consumer work and/or recovery peer work with mental health professional work. And when you think that there is a high likelihood that consumer and peer workers have their own histories of trauma *prior* to starting in their roles then we must be concerned about this problem because there are serious consequences that go beyond any discussion

about the ethics of peer worker practice. This leads me into the next problem I want to discuss.

Discrimination by Sameness

Take the example of the peer worker who was forced to do the same mandatory training as the mental health clinical workforce was required to do. Peer workers were required to train for 5 days in take down procedures, yes, being on the mat doing aggression management training for four of those days practising the techniques for how to take patients down so they can be restrained, sedated and or placed in seclusion rooms. One peer worker had been subjected to these practices as a patient, years prior, and found it deeply disturbing. We can feel horrified about this, but at the root of the problem is the very common error in logic, and that is that peer workers are part of the mental health workforce, which leads to the even more faulty logic and that is that peer workers must be treated the *same as* the mental health workforce and therefore must do the *same* mandatory training.

I have trained approximately 100 managers about peer work in the last 18 months, in 3 Australian States and I can tell you that they haven't grasped the difference between negative discrimination (when you treat a person unfairly on the basis of disability) and positive discrimination, (when you treat someone favourably on the basis of disability - which is legal). They think that they have to treat peer workers and consumer workers the same as the rest of the workforce, because not to do so would constitute discrimination and would be unlawful. But this is incorrect, and the Disability Discrimination Act 1992 is designed specifically to encourage positive discrimination in our favour.

Employers have to distinguish between treating people *unfairly* on the basis of disability, and treating people *favourably* in the workplace on the basis of disability because the same term 'discrimination' applies in both instances; one being potentially unlawful and the other not.

Consumer and peer workers are often just as distrusting of the idea of positive discrimination as their employer is. They will argue that they don't want to be treated differently, which is ridiculous since they were employed on the basis of difference in the first place, since this Act allows for people to be employed on the basis of a disability. It is under those legal provisions in Commonwealth law that they got their job in the first place. The difference doesn't stop post the appointment stage.

Employers recruit people with lived experience of mental illness, and this is a requirement of the position for which they are recruiting. They understand positive discrimination at this point, the fact they can legally discriminate in our favour in order to advertise for the position, but no sooner are we employed than they are quickly erasing any difference and slipping into telling us we are the same, we are part of the *same* team – you are either in or you're out, I treat everyone the *same* here, I treat all of my staff the *same*, there are no special measures for you...I have heard all of these statements.

It is bizarre considering that we were appointed on the basis of *difference*, and positive discrimination is legal. My point is that positive discrimination in our favour doesn't stop once the advertisement is in the paper or online, it runs throughout the entire course of a consumer or peer worker's employment. We have the legal right to be treated differently in the workplace, through positive discrimination measures and that is by way of the provisions in the Act for reasonable adjustments, adjustments that workers who don't have a disability

don't have a legal right to obtain in the same way as we do. But there is intense resistance against this in Australia, despite the fact this Act has been around for more than 20 years, employers continue to misunderstand its implications, or they don't care. Ignorance isn't an excuse in law.

I argue therefore that we now have a new form of discrimination, and that is 'discrimination by sameness', where the fact of our difference as the basis for our employment, and legally protected through positive discrimination measures, is then as quickly erased as if somehow it spontaneously combusts at the door when we get the job. We step through the door of mental health services and our difference is cleansed with the disinfectant of sameness. But you can't have it both ways, employers and peer workers alike can't have it both ways, and this problem alone stands to bring integrated approaches to peer work to their knees in Australia.

There is a major effort required to educate employers, and consumers about the Disability Discrimination Act 1992 and its implications in relation to positive discrimination rights in the workplace. And we need to muscle up and use this Act a lot more to force the issue so that consumer and peer workers get the adjustments they have a legal right to.

Discrimination by sameness can function to disguise disability discrimination by effectively depriving consumer and peer workers of their legal rights to access positive adjustments in the workplace to accommodate their disability, so they can perform the inherent requirements of their job. For any peer or consumer worker to argue that they want to be treated *the same as* any other worker sets a poor precedent given they were appointed on the basis of disability, & undermines the most significant and powerful legal protections that we have in this country.

Personal disclosure in recovery peer work

SLIDE: PURPOSEFUL STORYTELLING

It is helpful to think about the concept of Purposeful Storytelling, to address the many concerns raised about the use of personal disclosure in recovery peer work. The concept of Purposeful Storytelling derives from the report of Altenberger and Mackay in Scotland , and I quote...

> **We suggest that the journey of storytelling is a process that starts with creating a story from raw lived experiences and that over time the personal story is developed, amended and edited using a range of resources. The telling of the personal story can be presented in different formats and for different purposes but essentially the person needs the skills and personality to tell that story in a way that meets the objective of a particular event or media production and the needs of the audience. The story becomes the medium for delivering core messages, such as anti-stigma, recovery, I am the message, and self-awareness. Following the telling of the story there needs to be space for debriefing, review and re-editing of the story.** [i]

I use purposeful storytelling all the time in the recovery education that I do. The process is to reflect on my experience of recovery, and then to draw out from my raw experiences aspects that shed light on core recovery processes, such as hope, personal meaning making, identity, empowerment, discovery, self-direction, non-linearity, autonomy and self agency and so on. I am not telling other people how to do their recovery, far from it, just demonstrating that it is

possible, and shedding light on the process to help others understand these concepts and their relevance to recovery. It is important to recognise how nuanced peer work is and to provide the supports needed to mentor peer workers through their decision making processes about making safe & purposeful disclosures; how they use these disclosures in their work, and to be clear about what not to disclose.

For example, I have a hope story that I developed and this one story can be used in multiple contexts, it can work for a 5 minute interaction or for an hour, I can concertina the one story for multiple purposes, shedding light on how I first got hope that recovery was possible, on connectedness in recovery, and so on. And I am very clear about what I don't disclose in my work. It keeps me safe in terms of personal disclosure, and it is purposeful. I always tell my story but I have never told my story.

Indeed, a core implication of mental health peer work values is that we don't re-enact old roles through being positioned as experts in other peoples' lives.

SLIDE: META

In a quote from META, 'A peer worker is an expert at not being an expert and that takes a lot of expertise'.

The mental health peer workforce operates on the basis of core values of equality and mutuality in all that it does in relation to service users, and these critical points of difference lie at the heart of its authenticity and integrity as a workforce. Peer work isn't a para-professional workforce but the practice of peer work is highly skilled. Consumer engagement work and peer recovery work are disciplines, not professions; they involve a high degree of expertise but when we position ourselves as professionals we are claiming power and status over and

above service users. Indeed, the academic literature suggests it is precisely because we aren't professionals that we are rated as accessible and effective by service users.

Workforce development

I recently taught a workshop on peer work to @ 30 managers and senior practice leaders from a public mental health service, a service that has had consumer workers since the mid 1990s, and only one of these 30 had any prior exposure to training about peer work, and that one person had attended a peer work workshop at a conference. Managers were really enthusiastic to find out about peer work. And yet for years they have been managing consumer workers, and wanting to bring more on board on the back of the recovery policy agenda, without understanding even the most rudimentary values and principles that characterise the work.

If we want to develop the consumer engagement & recovery peer workforce, then a major effort is required to educate managers and senior practice leaders, and non-peer workers so that they have some knowledge of what this workforce represents.

Worth mentioning, the discipline of health consumer engagement presently has two generic vocational qualifications in Australia: the Course in Consumer Leadership, and the Vocational Graduate Certificate in Consumer Engagement, well worth doing.

Recovery peer workers need to be able to move beyond their own journey of recovery. Evidence demonstrates that there are many pathways to recovery, so they require a broader knowledge of recovery and different bodies of research, as well as of international recovery oriented practices, in order that they can

both work with individuals as mentors but also provide leadership to services about recovery oriented practices and peer led initiatives.

The new Certificate 1V in Mental Health Peer Work will go some way to addressing some workforce development issues but it won't resolve the problem of hybridisation nor the issue of the widespread ignorance in Australia about what peer work is and what it is not, nor will it address the many questions that arise regarding how to integrate peer work into existing mental health systems whilst maintaining its integrity, authenticity and independence.

In summary, successful development of the recovery peer and consumer engagement workforce is contingent upon the recognition that peer and consumer workers are a substantively *different* workforce to the 'mental health workforce' and that peer recovery work and consumer engagement & leadership work are two different but related disciplines, with their own sets of values. There are critical points of difference that need to be understood and upheld, and the rationale for these points of difference more widely appreciated and accepted if we are to develop the peer and consumer workforce to operate in an authentic way, whenever they are integrated within mental health services.

I thank you for your time today and wish you all the best for the Melbourne Cup. Thank you.

[i] Altenberger & Mackay, R, 2008. *What matters with personal narratives? Report on how personal narratives are used in the promotion of recovery and social inclusion by mental health service users in Scotland, Robert Gordon University, Scotland.*