dapaanz

fostering excellence in addiction practice

Scoping AOD peer workforce career progression pathway

A report for the dapaanz board
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the addiction practitioners' association aotearoa new zealand dapaanz.org.nz

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Introduction

Dapaanz, with support from Matua Raki, commissioned a project to scope options for supporting a peer workforce career progression pathway. The Project Proposal: Scoping to establish *how dapaanz could support the peer workforce career progression pathway* (dapaanz, 2017) states that such a pathway has the potential to:

- Enable greater accountability
- Provide clear benchmarks of skills and experience
- Support training providers to develop relevant training options
- Support employers to feel more confident about creating and recruiting to positions for peers
- Create an acknowledged and valued career development pathway for the peer workforce.

To carry out this work dapaanz engaged an Advisory Group comprising representatives of the AOD peer and consumer workforce and contracted Paula Parsonage, HSD, to work with the Advisory Group to complete the project requirements. The project was carried out in the period from September to November 2017.

Project processes included:

- A scan of selected international literature relevant to peer workforce career pathways
- Review of the dapaanz Code of Ethics to determine its relevance to peer support work
- Stakeholder workshops: held in Auckland, Christchurch and Dunedin
- Key informant interviews of people from the AOD sector in a range of roles
- Development of a report and recommendations for consideration by dapaanz Executive.

This report sets out findings related to each of the processes above, options for dapaanz consideration to support development of a career progression pathway for the AOD peer workforce and recommendations from the Advisory Group.

Terms used in this report

For clarity, key terms used in report are defined below:

Career pathway refers to structured, connected and recognised steps and processes that enable entry and advancement within the peer workforce.

AOD Peer worker/workforce includes those roles that require the worker to identify as having lived experience of addiction and recovery, and work in the 'front line', offering support to people experiencing addiction-related issues. Such roles are variously described within organisations, with titles including for example, peer support worker, peer advocate, peer support specialist, peer mentor and other variations. This excludes consumer advisor and similar roles which work at systems and strategic levels, rather than directly with individuals. This is inclusive of those identifying as having lived experience of addiction and mental health (ie, co-existing problems or CEP).

Themes from literature

Process

A search was conducted using key terms such as peer support career progression, peer support credentialing, peer support qualifications, addiction peer support, alcohol and drug peer support, peer workforce and peer recovery coach. Additional reports and articles were provided by members of the Advisory Group. A snowballing method was used to identify further relevant literature from the reference lists of the publications found. The focus was on identifying guidance to support peer workforce career progression.[1]

[1] Evidence for the efficacy of addiction peer work was not a focus of this project. For information on this see, for example, literature reviews by Bassuk et al, 2016; Reif et al, 2014 and Tracy & Wallace, 2016. These reviews highlight that those receiving peer-based support experience benefits in a range of recovery outcomes.

The literature found was a mix of theses, published studies in peer-reviewed journals and 'grey literature' including guidelines and policy statements. Much of the literature is about the mental health peer workforce however this has been included as the learning is relevant to the AOD peer workforce.

Key themes are summarised below.

Seeking legitimacy alongside other roles

The quest for peer roles to be viewed as credible and legitimate while remaining authentically 'peer' is a dominant theme (Rebeiro Gruhl, 2016; Scott, 2015; Substance Abuse and Mental Health Services Administration (SAMHSA) & Center for Substance Abuse Treatment, 2012; Scott et al., 2011; Mead & MacNeil 2006). Most health professions achieve legitimacy via formal means including:

- Recognised educational qualifications gained from accredited institutions.
- Certification processes administered by formal professional bodies, often mandated by law.
- Professional standards established by widely accepted authorities.

In contrast legitimacy in the peer workforce is achieved via "*an identity-based claim to legitimacy through lived experience* (Scott, 2015: 40)." There can be negative attitudes and stigma from those who do not value experiential knowledge and expertise (Scott, 2015, Health Workforce Australia, 2014).

A key risk in the pursuit of formal legitimisation and professionalism of peer work is loss of authenticity and there is concern about 'over professionalisation.' The authenticity of peer work is viewed as being at the core of what peer work brings to the service spectrum and therefore of utmost importance (Rebeiro Gruhl, 2016; Gillard et al., 2015 cited in Vandewalle et al, 2016; Scott, 2015; Scott et al., 2011; Mead & MacNeil 2006). However, the opposite argument is also made, ie, that without formal legitimacy peer work is at risk of being diluted and distorted and will not be promoted and supported via government and other funding and development channels (Tandem & Carer Consultants, 2015; Repper, 2013). For example:

When people are employed in large, bureaucratic organisations, there are perhaps even greater dangers of the role being blurred and people being exploited as 'cheap labour'. The trappings of formality – job descriptions, managers, individual review – thus provide safeguards as well as risks (Repper, 2013: 12).

Three discourses on the legitimacy of the peer workforce in mental health are outlined in New Zealand study of the peer workforce (Scott, 2015). Briefly these are:

- Health professionalism discourse where the competence and credibility of health workers is assured via educational qualifications. Life experience is of lesser or no value. Practical experience is valued but only secondary to qualifications, which enable a worker to practice safely.
- Grass roots discourse which values job-based training, hands-on experience, life experience and 'common sense'. Qualifications hold little or no value.
- Transformational peer support discourse where formal qualifications are not necessarily valued but peer support training is highly valued and seen as transformative.

Scott (2015) argues that a growing number of mental health peer workers align with the transformational discourse.

Others also argue that peer work should be supported by formal systems of high-quality, ongoing training and education, proper remuneration, appropriate supervision and a clear career trajectory for example:

Policy levers available to governments and organisations to shape the mental health workforce include education, occupational regulation, and healthcare funding. Using these policy levers can play a part in promoting uptake of the workforce and this can assist in addressing the substantial variation in wage levels, depending on service, sector of employment and jurisdiction (Tandem & Carer Consultants, 2015: 6).

Applying a development lens

Another way of looking at the issue is to consider how the peer workforce could or should be developed. Much of the literature supports the need for development to promote growth of peer services (Australian Peer Work Leaders, 2017; Vandewalle et al, 2016; Scott, 2015; Tandem and Carer Consultants, 2015; Health Workforce Australia, 2014; Western Australian Association for Mental Health, 2014). For example:

There is also a caution that without formalisation, peer work will remain on the periphery of the 'mainstream' and remain inadequately supported via training opportunities and adequate financial remuneration (Vandewalle et al, 2016).

Suggestions for developing the peer workforce include evidence-based training (such as that supported in the Transformational peer support discourse described by Scott, 2015 and outlined above), ongoing professional development, a clear scope of practice, professional supervision, remuneration systems and establishment of professional bodies (Health Workforce Australia, 2014; Mental Health Commission, 2012; Matua Raki, 2010, Scott, 2015; Western Australian Association for Mental Health, 2014).

Peer values are paramount

Ensuring that mechanisms for developing and governing the peer workforce remain faithful to peer values is one way to ensure that the dominant health professional paradigm does not undermine peer work (Australian Peer Work Leaders, 2017; Vandewalle et al, 2016; Scott, 2015; Sunderland et al, 2015, Walker and Bryant, 2013 in Vandewalle et al, 2016;).

In New Zealand there is a broadly agreed statement of peer values set out in *Competencies for the mental health and addiction service user, consumer and peer workforce* (Te Pou, Northern Regional Alliance and Midland HealthShare Limited, 2014).

A recent statement of intent from a group of Australian peer leaders to develop a national association for mental health peer workers provides an example of professional development underpinned by peer values and led by peers. The group is seeking to set up "*a peer-run organisation that can support and sustain the development of the peer workforce across all sectors* (Australian Peer Work Leaders 2017:1)*."* The professional association will set the standards for certification, education, training and practice in peer work.

Ethics and boundaries

The complexity of ethical and boundary issues in peer work are frequently discussed in the literature (Reamer, 2015; SAMHSA, 2013; Scott et al, 2011; White, 2007). The need for peer workers to maintain clear boundaries and the challenges in this are regularly cited (Reamer, 2015 White, 2007). Making the transition from client to colleague is noted as a boundary issue requiring skilled navigation, as is the drive that peers may have to 'go the extra mile' in their work. The requirement to manage the transition in the peer relationship when the 'peer client' is no longer a 'peer client' is also noted (Reamer, 2015).

Key ethical issues for the peer workforce highlighted in literature (Reamer, 2015; SAMHSA, 2013; Scott et al, 2011; White, 2007) include:

- Dual relationships: dual relationships are generally prohibited in professional ethical codes however they are commonplace for peer workers who are usually embedded in peer communities involving multiple and overlapping relationships, something which makes them particularly effective in their work.
- Self-disclosure: sharing life experiences is part of peer work and it can be challenging to navigate the potentially ambiguous territory between friendship and professional relationship.
- Sharing information with colleagues: managing agency and collegial expectations of sharing information can be particularly challenging in peer work.
- Physical contact: typically prohibited in professional relationships contact such as sharing

a hug can be normative in peer communities.

- 'Recovery time': there are various views and no clear consensus on when a person is ready, in the context of their own journey to wellbeing, to take on the challenges of peer work. Some organisations require a fixed length of abstinence from substances.

The importance of ensuring that ethical frameworks for peer work are firmly underpinned by peer values and are designed for peer work is emphasised (SAMHSA, 2013; White, 2007).

Peer workforce in New Zealand

AOD Peer roles in New Zealand have emerged in the absence of a consistent strategy (Matua Raki & National Committee for Addiction Treatment, 2017). Evaluations of services have highlighted a number of benefits of AOD peer support (King & Panther, 2014). There is growing recognition at a policy level of the value of the peer voice in shaping and providing services (Ministry of Health, 2017; National Committee for Addiction Treatment and Matua Raki & National Committee for Addiction Treatment, 2017). The *Mental Health and Addiction Workforce Development Action Plan 2017 – 2021* (Ministry of Health, 2017) clearly signals an intention to grow and develop the peer workforce and names the following priorities for action:

Action 4.3: *Increase recruitment and retention of the peer and consumer workforce by strengthening the infrastructure, providing effective leadership, management and supervision, and strengthening networks at regional and national levels.* (p37)

Action 4.4: *Increase training and career opportunities for the peer and consumer workforce, including by offering leadership programmes and meeting the requirement of the peer competency framework.* (p38)

The plan advocates resourcing the development of the peer workforce *meet the requirements of the peer competency framework and support local and national networks.* (p36).

Literature highlights the interconnectedness of key elements to support the growth of the AOD peer workforce including, well defined roles which are understood and valued by all stakeholders, training and policy matched to role requirements and availability of positions for trained peer workers (King & Panther, 2014; Matua Raki & National Committee for Addiction Treatment, 2017).

The need for and importance of developing service user leadership at all levels of the mental health and addiction sector has been highlighted. This is viewed as a key element of a career progression pathway for the peer workforce and a way in which peer work will increasingly be seen as a viable career option (Matua Raki, 2010; King & Panther, 2014; Matua Raki & National Committee for Addiction Treatment, 2017).

International approaches

AOD peer support in countries other than New Zealand is professionalised to varying degrees.

The International Association of Peer Supporters (iNAPS) whose mission is *to grow the profession, by promoting the inclusion of peer supporters throughout mental and behavioral health systems worldwide*[2] published national practice guidelines for peer support in 2012. This includes a values statement and ethical guidelines.

The United States is the most professionalised, with most states having a training and certification process in place. These requirements have been evolving for the last 10 years. The peer workforce is well established in the United States in both government and NGO services with the Center for Medicare and Medicaid Services, recognising peer support providers as a distinct provider type for the delivery of support services, and recognising peer support as an evidence-based model of care. A National Association of Peer Specialists was formed in 2004 (Health Workforce Australia, 2014).

In Australia the peer workforce is inclusive of "consumers and carers" and the literature appears to be mainly about people with lived experience of mental health issues and is not always specific as to whether addiction peer work is included. There appears to be no agreed entry level qualification for peer support workers and training occurs in various ways ie, through in-

service training or via registered training organisations. A level IV Certificate in Mental Health Peer Work is required by some organisations as an entry level qualification. There is a Western Australian *Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors* (Western Australian Association for Mental Health, 2014) which aims to inform and support organisations to employ peer workers and providing guidelines to support consistency.

As noted above, there has been a signal from mental health peer leaders to develop a national association to promote, regulate and represent the peer workforce (Australian Peer Work Leaders, 2017). A web search indicated that there are some state level peer support associations in Australia include The Western Australia Peer Support Practitioners Group (WAPSPG), Partners for Change - a Sydney Mental Health Consumer Worker Network and Grampians Mental Health Peer Workers' Network, Victoria, Association of Mental Health Peer Specialists (Victoria).[3] These associations appear to be in the early stages of development and offer support, networking, information sharing and facilitating training and mentoring opportunities. The Sydney group also signals an intention to improve career pathways.

Peer support is emerging in the United Kingdom and is currently promoted in policy documents.[4] In Scotland, mental health organisations are working with the peak body for training and qualification's, Scottish Qualifications Authority (SQA) to develop an accredited award and learning materials to further support the training of peer support workers. In addition to training, a values framework has been developed to help increase understanding of the peer worker role, ensure that it maintains the peer support ethos and guidelines to support the implementation of peer work (Health Workforce Australia, 2014).

[2] https://inaops.org/mission/

[3] See http://www.peersupportvic.org/index.php/2014-12-15-22-41-58/peer-worker-networks

[4] Peer support is emerging in the United Kingdom and is currently promoted in policy documents.[4] In Scotland, mental health organisations are working with the peak body for training and qualification's, Scottish Qualifications Authority (SQA) to develop an accredited award and learning materials to further support the training of peer support workers. In addition to training, a values framework has been developed to help increase understanding of the peer worker role, ensure that it maintains the peer support ethos and guidelines to support the implementation of peer work (Health Workforce Australia, 2014).

Review of dapaanz Code of Ethics

The dapaanz Code of Ethics was reviewed to determine its potential relevance as a guiding ethical code for peer work. The Advisory Group undertook a comprehensive review involving an initial face to face discussion, an interim write-up of key issues for consideration and a final face-to-face discussion.

After careful consideration, the Advisory Group reached a consensus view that the dapaanz Code of Ethics is not a document that can adequately provide ethical guidance to support the work undertaken by the peer workforce. The Code of Ethics has been developed to support AOD clinical practice and therefore:

1. The language/ terminology is not the language of peer work.
2. The nature of the relationship between the professional and the client which is implicit in the Code of Ethics does not reflect the peer relationship. Critically the absence of mutuality as a core principle is problematic.
3. The dapaanz Code of Ethics does not provide the necessary guidance on some ethical issues which are frequently encountered within peer work, such as management of dual relationships.

In terms of mitigation of the issues identified, while the language could be addressed via minor revision of the Code of Ethics, it may not be possible to reflect the level of mutuality in the professional/client relationship in such a way that would meet the requirements of both the peer and the clinical groups within the addiction workforce. Further, some additions would be required to address point 3 above.

A purposefully developed peer work ethical framework would be a preferred option. This view is consistent with international commentary on this matter, see for example *Establishing Ethical Practices for Peer Recovery Support Services Within the ATR Model* (SAMHSA, 2013) and *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services* (White, 2007).

Key themes in workshop and interview feedback

Workshop and interview participants and processes

Fifty-five people participated in workshops and interviews. Participants were a mix of people in recovery, AOD peer workers, peer leaders, consumer liaison workers, consumer advisors, AOD clinicians, supervisors, managers and leaders, workforce development representatives, tertiary education providers, a funding and planning representative, mental health peer workforce managers and leaders, mental health peer workers and a peer worker and manager from a family violence service. Workshops were notified via an invitation which was published in the dapaanz e-bulletin and circulated via email to relevant individuals, groups and networks. Interview participants were identified by the Advisory group and via the workshops.

Support for growth of the AOD peer workforce

Feedback from the workshops reflected a strong vision for growth of the peer workforce and suggested that AOD peer support should be easily accessible in all health contexts, primary, secondary and tertiary. It was suggested that access to AOD peer support should not be determined by where a person accesses clinical services. It was noted that there is a vast untapped resource that could be offered alongside clinical services and has the potential to ease the pressure on the latter.

Support for the AOD peer workforce was echoed in interview feedback, with participants emphasising the value of lived experience, the ability of peer workers to engage peers in a recovery pathway and recognition that clinical engagement is time-limited while peer work has the potential to greatly extend the level of support available to people experiencing AOD related issues. For example:

….always seen the value of including the 'lived experience' perspective in the workforce. People connect with those who have walked the same road – they connect with the authenticity of that.
Non-peer participant

Peer support roles are excellent in some levels, we need them, they get alongside people and

bring them in to treatment. They engage people. That works really well.
Non-peer participant

Peer support is needed. The clinical service is time-limited, short term – entry and exit. Peer support is a way to stretch that support to cover more time, provide support in the community. Ongoing. You need both.
Non-peer participant

Concern that peer work is viewed as a cheap option

In the context of supporting growth of the AOD peer workforce, workshop and interview participants expressed caution that peer support should not be viewed as a cheap alternative to treatment. This concern appears to be shared by peer workers and non-peer workers alike. Many participants stressed the importance of raising the status of peer workers and remunerating peer roles more equitably with the clinical workforce both in the interests of fairness and to dispel the notion that peers represent a cheap workforce option. Poor remuneration was noted as a key reason why people leave the peer workforce.

Some expressed concern that development of peer support could be perceived to be at the expense of developing clinical roles and that this has the potential to create tensions in the workforce. For example, it was reported that managers can be in a position of having to reduce clinician numbers so that they can develop peer roles. As services are already stretched, it was suggested that there is potential for resentment if clinical positions are reduced which is not a good situation for the peer workers coming in.

This concern was also evident in interview feedback, for example:

There is some fear that the peer support roles will take over clinical roles – is it a cost saving thing?
Non-peer participant

Its important that the clinical team members understand peer support work and that having a peer support worker involved does not mean that the clinical worker's job is easier. It is not a cheap option.
Non-peer participant

Lack of credibility, and role clarity are barriers to development and equity

Workshop and interview participants consistently voiced the need for peer work to be seen as a credible profession with peer expertise being equally valued with clinical expertise. The issue of credibility is bound up with peer work being valued as a profession and a career option, professional status, pay equity and investment in peer roles. Lack of role clarity and lack of understanding of peer work, lack of opportunity for career advancement and the absence of a clear career pathway were frequently raised as associated barriers. It was noted that for many peer workers the only real advancement option in the AOD sector is to move into clinical work. For example:

My opportunities lie outside of the peer workforce. There is nowhere to go. I'm lucky in that my manager created a senior position as a way to help retain me in the organisation.
Peer participant

Development of recognised career pathways is viewed by many as a way of supporting credibility for the AOD peer workforce in the healthcare landscape. Peer workers want to be respected, trusted and valued, with peer expertise sitting alongside other expertise and recognized as a specialty. "No cowboys" was a phrase which came up often when peer workers were speaking about credibility and expressing the importance of delivering AOD peer support in a skilful way.

Linked to this, both peer and non-peer participants spoke about the overall lack of understanding of peer work within the AOD sector and raised issues of fear, reluctance and resistance to employing people with lived experience, without formal qualifications and without a broader endorsement or accountability of a professional body. Stigmatising beliefs about addiction and about the value of lived experience were noted. Both peers and non- peers commented that

lived experience alone is not enough preparation for a peer role and that peers need adequate training and support to fulfil their roles. For example:

…[at first] I wondered how to manage peer support workers; how to make sure of safety…..What I've learned about peer support workers is that they have had to do an awful lot to get to where they are. They are very good at owning their own processes and at critical reflection – it's ongoing for them; part of what they do in their lives.
Non-peer participant

There can be a marked difference in the way people treat you once they know you have lived experience.
Peer participant

It was suggested that the process of development of a more formal career pathway would assist with role clarity and shared understanding of AOD peer work, for the benefit of all. Additionally, it would highlight and support career advancement options. Poor remuneration and a void of options for advancement were cited as key reasons that peer workers are difficult to retain in the workforce.

Strong support for professional registration option

Support for development of an AOD peer worker registration option to support a career pathway was a dominant theme from the workshops. It was suggested that a registration option would support role clarity and promote development of defined training and supervision requirements for the peer workforce which in turn would provide a mechanism for increasing understanding or peer work, promoting ethical standards and providing accountability. There was strong support for dapaanz to take a governance and advocacy role in developing a registration pathway.

Support for development of a professional registration option was echoed in feedback from interview participants. Examples of comments include:

A registration option: It would be huge for peer support. Professional standards and career pathways would be great. Your're dealing up close with people. You need to be on the A team – no cowboys – not doing stuff that is not professional.
Peer participant

It could provide legitimacy, could create more jobs for peers, employers might be more willing to employ peers.
Peer participant

Everyone should be registered. It keeps our industry free from being unhealthy.
Peer participant

I think it would be great for dapaanz to have a role – someone needs to look after the peer support workers. There needs to be some structure – supervision, role scope, code of ethics, complaints procedure.
Non-peer participant

It would be a very positive move for the workforce. If you look at where AOD has come from it makes sense [for dapaanz to do this]. I see a lot of people out there who would be good at this work; they need a pathway; they need training; they need to know this is an option; it's a way for them to give back, help other people.
Non-peer participant

Some participants suggested that dapaanz could take a guardianship or leadership role as an interim option with the potential of nurturing development of a peer support workers association that would be inclusive of all peer workers across sectors. For example:

Not sure that dapaanz holding the registration option is ideal. Dapaanz could start it off… really focus on empowering the peer workforce and hand it over.
Peer participant

Considerations in developing an AOD registration option

Some commented that there could be downsides in having a registration option for only AOD peer workers and raised questions about 'splitting' the AOD peers from colleagues who identify as having lived experience of mental health problems. Many also noted that the distinctions between lived experience of AOD and mental health can be somewhat artificial as many people have experience in both areas. For example:

Not sure that dapaanz should hold the registration pathway. It should be for both AOD and mental health – together – or broader. A large proportion of peers have "coexisting experience."
Peer participant

We need registration for peer work not just AOD peer work.
Non-peer participant

Dapaanz is for practitioners and AOD – those are very defining of dapaanz.
[Paid] Peer support work has really had its genesis in mental health – so not sure of the implications of that for dapaanz.
Non-peer participant

A further consideration raised by many participants was the cost of registration in the context of the low wages paid to AOD peer workers. Many noted that cost would be a barrier to peer workers taking up registration options and that ideally organisations would support the peer workforce by meeting these costs. As one example:

There would be costs, the wages are not good – so that could be an issue.
Peer participant

Minority do not support development of a registration option

A small number of workshop participants who sit outside or who are on the periphery of the AOD sector were not supportive of developing a registration option. This group highlighted tension between 'peer' and professionalisation, questioning the value of introducing requirements for "*bits of paper*" (formal credentialing of peer workers). Some in this group also affirmed dapaanz for stepping into a void and taking initiative in supporting the peer workforce.

Training

Almost all participants commented on the need for accessible and appropriate training for the AOD peer workforce. Many stated a that an NZQA accredited AOD peer support work training programme is needed to provide an entry-level qualification. Such training
needs to be affordable and accessible to those wishing to develop a career in peer work. Many also commented on the lack of suitable on-going training and development options. For example:

Training definitely needs attention. There is less available. No one is picking up the National Certificate [in peer support]. DHBs are requiring that peer support workers do the MH&A level four certificate. I think we should head for the hills! Funders and planners are not understanding what peer support is about.
Peer participant

The training issue could be challenging – just because someone does WRAP [Wellness Recovery Action Plan] and PET [Peer employment training] does not mean that they are suited to a peer support role, even though those training programmes can be transformative.
Non-peer participant

There is no specific peer training available for AOD – it's all mental health. It is frustrating. There needs to be investment in training for addiction peer work…a qualification for AOD peers would be awesome.
Peer participant

There needs to be more training for peer support workers. There needs to be something in between PET and Mind and Body [peer support work training]. They're quite far apart. Maybe something in the middle would be good.
Peer participant

Peer support training is only a step. We should be aiming higher…we're on the front line…we're not behind people. We need to be competent to make decisions, to understand and explain things in terms [peers] understand.
Peer participant

From the feedback provided it was difficult to get a definitive picture of the training that is currently available and/or planned, especially at a national level.

Despite the reported absence of suitable AOD-relevant training, Needle Exchange Services Trust (NEST)[5] which oversees the largest group of peer workers in the country (85 nationally) has seen an opportunity to take up and tailor an existing option. It was reported in interview feedback that the organisation is undertaking a significant workforce development initiative to support employees to complete a generic NZQA accredited level IV certificate in peer support (in a partnership arrangement with Careerforce), with content tailored to the work undertaken in needle exchange services and tailored to the needs of the service delivery context. Clearly this requires significant organisational commitment.

Supervision

Feedback from both interviews and workshops indicated that various supervision arrangements are in place for peer workers depending on where they are employed. Mostly peer workers are supervised by non-peers, either clinicians or line-managers. Peer workers mainly indicated that they are well supported in supervision. The development of peer supervisors was seen by some as an important part of developing a peer work career progression pathway.[6] For example:

Some clinical supervisors can be effective – they have to take their clinical hat off and they need to be
informed by peer principles, values, competencies.
Peer participant

Other feedback

Dapaanz executive members and the project advisory group were invited to provide feedback on a draft of this report. The following items were raised in this feedback.

Joining an Australasian Association

It was suggested that a further option for the AOD peer workforce would be to investigate joining a peer body in another country. The parallel was drawn with New Zealand addiction nurses who become members of Drug and Alcohol Nurses Australasia[7] and doctors who become members of the Australasian Chapter of Addiction Medicine[8]. For both nurses and doctors becoming a member of these bodies is voluntary and additional to New Zealand professional registration requirements. Additionally, both are Australasian organisations.

[5] Recovery College (an education-based approach to supporting recovery) is growing in the UK and Australia. The approach is based on co-design and delivery ie, people with lived experience and those without, learn from each other and together; peer support is derived from interaction and connection with fellow students and peer trainers (AOD Provider Collaborative, 2017).

[6] Organisational details are reported here at the request of the NEST to ensure that dapaanz is informed of this initiative.

[7] Drug and Alcohol Nurses of Australasia is the peak nursing organisation in Australasia providing leadership to nurses and midwives with a professional interest in Alcohol, Tobacco and Other Drug (ATOD) issues.

[8] A Chapter of the Royal Australasian College of Physicians (RACP) Adult Internal Medicine Division.

To explore a comparable option for the peer workforce a web search was conducted. This indicated that there are some state level peer support associations in Australia including the Western Australia Peer Support Practitioners Group (WAPSPG), Partners for Change - a Sydney Mental Health Consumer Worker Network and Grampians Mental Health Peer Workers' Network, Victoria, Association of Mental Health Peer Specialists (Victoria).[9] These associations appear to be in the early stages of development and offer support, networking, information sharing, training and mentoring opportunities. The Sydney group also signals an intention to improve career pathways. None of these associations appear to offer any regulatory or credentialing function. As discussed earlier in this report, there has been a signal from Australian mental health peer leaders to develop a national association and this body intends to take a regulatory function (along with a representative function) (Australian Peer Work Leaders, 2017).

Whether these associations would be open to New Zealand members and what value membership might hold for New Zealand peer workers would need to be further explored with New Zealand peer workers and with these Australian groups. Suitability for the AOD workforce could be canvassed (it is unclear whether all the groups are inclusive of AOD peer workers). Additionally, it would be important to explore cultural considerations to determine whether there is an acceptable level of alignment, particularly for Māori peer workers.
Application in the New Zealand health landscape would be a further consideration.

Bi-Cultural considerations

A further item raised was whether consideration could be given to a more bicultural approach to the development of career pathways for the peer workforce. It was suggested that a simple step in supporting this could be to introduce a Māori word for 'peer' such as 'hoa aropā' or peer support, 'tautoko-ā-aropa'.[10] This is an option which dapaanz could consider in any ongoing discussions with the peer workforce particularly if there is a decision to further the recommendations set out below.

[9] See http://www.peersupportvic.org/index.php/2014-12-15-22-41-58/peer-worker-networks

[10] Opai K. 2017. *Te Reo Hāpai.* Auckland: Te Pou o te Whakaaro Nui.

Discussion

In view of the project findings there is strong support for the growth and development of the AOD peer workforce and there is agreement that currently career pathways are not well established *to support these objectives in New Zealand.*

The literature highlights some risk in moving towards formal systems typically associated with defined career pathways ie, the loss of authenticity in peer work, without which peer work ceases to be peer work. However, it is also evident that there is a risk that without formal systems, peer work can mutate into something that is defined by others. A further risk is that it fails to be recognised as a valued option alongside AOD treatment.

Internationally there appears to be a trend toward development of standards, guidelines, competence and a more 'organised' workforce and indeed the US has a fully professionalised AOD peer support work pathway operating in most states. It is also the country where peer work seems most well developed and recognised. A key signal from the literature is that development, standardisation and any other moves towards professionalisation should be firmly underpinned by peer values and preferably peer led.
Conclusions from a review of the dapaanz Code of Ethics are consistent with this view ie, the peer workforce needs a purpose build ethical framework.

Feedback from workshops and interviews indicates that overall there is strong support for development of a professional AOD peer worker registration option and this is seen as a key element of a career pathway. The absence of an appropriate AOD-specific NZQA accredited qualification may pose some difficulty, however as highlighted in work of NEST described above there may be an acceptable option available. An AOD peer work ethical framework would be needed to support a registration pathway and dapaanz would need to consider developing this either as a step towards developing a registration pathway and/or as a means of providing a meaningful dapaanz membership option to those in the AOD peer workforce. The process of development would need to be peer led. Dapaanz could also consider seconding peer worker representation onto the dapaanz Executive to support this work.

Concerns regarding 'splitting' the AOD and mental health peer workforce have been voiced and will need consideration by dapaanz in determining how to support the AOD peer workforce. However, the specific negative impacts of this were not articulated.
A further point for consideration is that there may be opposing or alternative views that have not been captured via project processes, for example, the AOD clinician workforce was sparsely represented in the feedback processes.

Conclusion and Recommendations

In view of the findings outlined above the Advisory Group sees two key options that dapaanz could consider supporting the development of a career progression pathway for the AOD peer workforce:

Option 1.
Development of an AOD peer worker registration pathway. An example of the key components of such a pathway are provided in Appendix 1. This is the preferred option and would necessitate development of a dapaanz AOD peer work ethical framework.

Option 2.
Development of a dapaanz AOD peer work ethical framework to provide the AOD peer workforce with a meaningful dapaanz membership option.

Recommendations

The Advisory group makes the following recommendations:

1. That dapaanz progresses Option 1 outlined above.

2. That if the decision is not to develop Option 1, then Option 2 is developed.

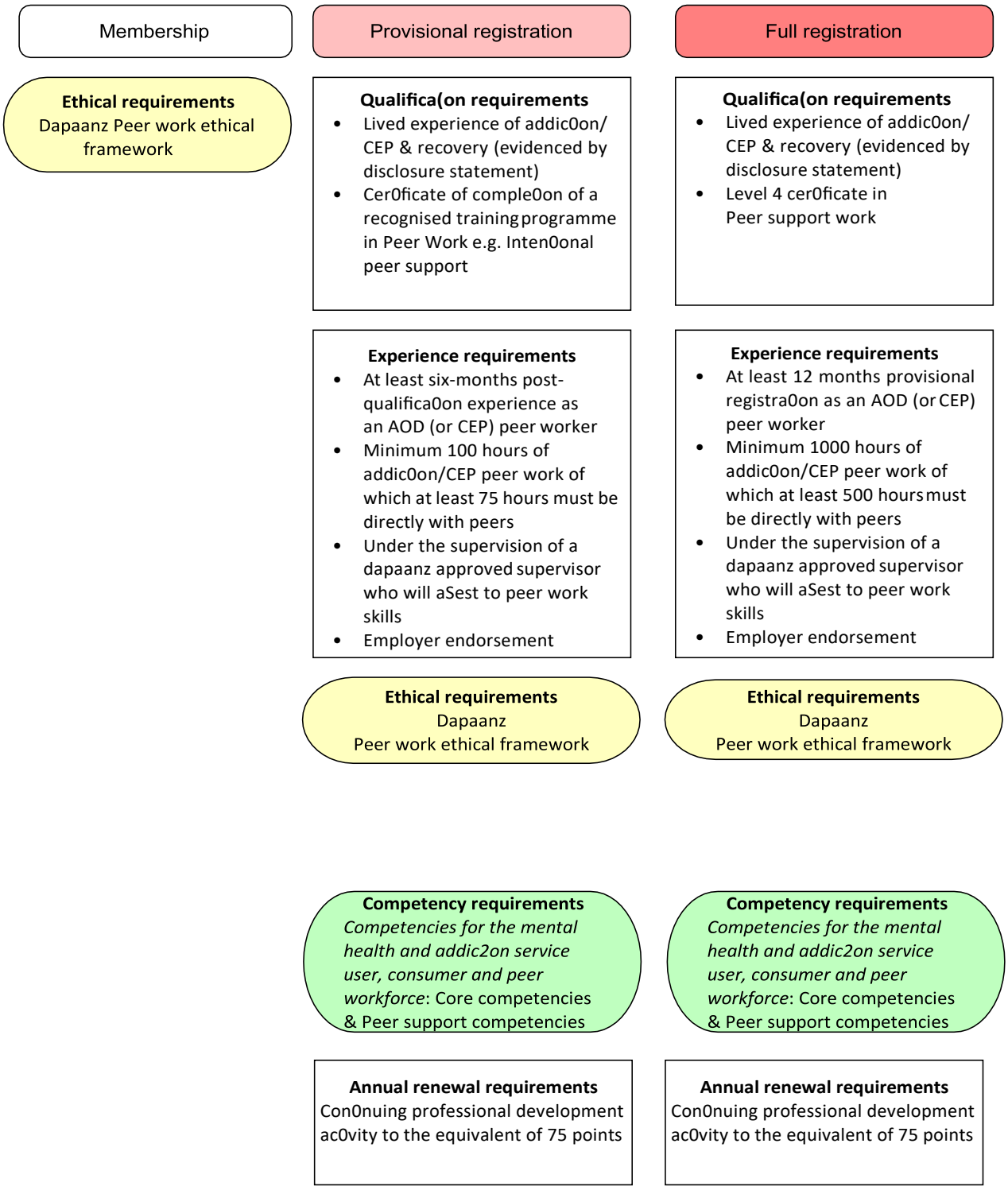
3. That dapaanz supports the AOD peer workforce by educating the non-peer AOD workforce, including dapaanz membership, about AOD peer work.

4. That dapaanz:

- Advocates for organisations to support standards and professional development for the AOD peer workforce for example, by meeting the cost of dapaanz membership or registration fees and ensuring peer workers have professional supervision relevant to the peer work role.
- Advocates for development of AOD peer supervisor training.
- Develops an approved AOD peer supervisor list.
- Advocates for provision of an accessible NZQA AOD peer work training programme. NB consideration needs to be given to access from all parts of New Zealand.

Appendix 1. AOD peer work registration pathway example

Figure 1. Example of registration pathway for AOD/CEP Peer workers



References

AOD Provider Collaborative. 2017. *Recovery Colleges: An Overview Of The International Experience.* Auckland: Counties Manukau Health

Australian peer work leaders. 2017. *Peer Work Leadership Statement of Intent A National Professional Association for Mental Health Peer Workers*. Available at: http://www.iimhl.com/files/docs/IIMHL- Updates/20170618.pdf

Bassuk E. Hanson J. Greene RN. Richard M. Laudet A. 2016. Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review Journal of *Substance Abuse Treatment 63 2016*: 1–9

Health Workforce Australia. 2014. *Mental Health Peer Workforce Literature Scan.* Adelaide: Health Workforce Australia.

International Association of Peer Supporters (iNAPS). 2012. *National Practice Guidelines for Peer Supporters.* Norton, MA: iNAPS.

King J, Panther G. 2014*. Peer Support Themes. Report prepared for AOD Collaborative Group.* Auckland: Julian King & Associates Limited – a member of the Kinnect Group.

Martin E. & Jordan A. 2017*. Substance Use Disorder Peer Supervision Competencies.* United States: Regional Facilitation Center.

Matua Raki & National Committee for Addiction Treatment. 2017. *Growing Dedicated Peer & Consumer Roles in Addiction Services.* Wellington: Matua Raki & National Committee for Addiction Treatment.

Matua Raki. 2010. *Consumer and Peer Roles in the Addiction Sector.* Wellington: Matua Raki.

Mead S.& MacNeil C. 2006. Peer Support: What Makes It Unique? *International Journal of Psychosocial Rehabilitation. 10 (2):* 29-37.

Mental Health Commission. 2012. *Power of Peer Support Services.* Wellington: Mental Health Commission.

Ministry of Health. 2017. *Mental Health and Addiction Workforce Action Plan 2017–2021*. Wellington: Ministry of Health

Opai K. 2017. *Te Reo Hāpai*. Auckland: Te Pou o te Whakaaro Nui.

Reamer FG. 2015. Eye on Ethics: The Challenge of Peer Support Programs. *Social Work Today Vol. 15 No. 4* P. 10.

Rebeiro Gruhl K. Sara LaCarted S. & Calixte S. 2016. Authentic peer support work: challenges and opportunities for an evolving occupation. *Journal of Mental Health, 2016 Vol 25:* 78-86

Reif S. Braude L. Lyman DR. Dougherty RH. Daniels AS. Ghose SS. & Delphin-Rittmon ME. 2014. Peer Recovery Support for Individuals With Substance Use Disorders: *Assessing the Evidence. Psychiatric Services 2014 65(7):* 853–861.

Repper J. 2013. *Peer support workers: theory and practice. London: Implementing recovery through organisational change.* (ImROC), Centre for Mental Health, Mental Health Network NHS Confederation.

Substance Abuse and Mental Health Services Administration(SAMHSA) & Center for Substance Abuse Treatment (CSAT). 2012. *Perspectives on the Evolution and Future of Peer Recovery Support Services*. Rockville, MD: SAMHSA CSAT.

SAMHSA. 2013. *Establishing Ethical Practices for Peer Recovery Support Services Within the ATR Model ATR 3. SAMHSA Technical assistance package.* United States: SAMHSA

Scott A. 2015. Gaining acceptance: Discourses on training and qualifications in peer support *New Zealand Sociology Volume 30 Issue 4 2015*: 38-57.

Scott A. Doughty C. & Kahi H. 2011. *Peer Support Practice in Aotearoa New Zealand*. Available at: http://www.hdc.org.nz/media/199065/peer%20support%20practice%20in%20aotearoa%20nz.p df

Sunderland K. & Mishkin W. 2013. Guidelines for the Practice and Training of Peer Support. Calgary, AB: Mental Health Commission of Canada.

Tandem & Carer Consultants Network Australia. 2015. *Position Paper - The Mental Health Peer Workforce*. Victoria: Tandem Inc.

Te Pou, Northern Regional Alliance and Midland HealthShare Limited. 2014. *Competencies for the mental health and addiction service user, consumer and peer workforce.* Auckland: Te Pou.

Tracy K. & Wallace SP. 2016. Benefits of peer support groups in the treatment of addiction. *Substance Abuse Treatment 2016 2-16:7* 143- 154

Vandewalle J. Debyser B. Beeckman D. Vandecasteele T. Van Hecke A. Verhaeghe S. 2016. Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies 60 (2016) 234–250*

Western Australian Association of Mental Health (WAAMH). 2014. *Peer Work Strategic Framework.* Perth: WAAMH.

White W. 2007. *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* United States: Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS) & Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT).