Time for Change Te Hurihanga
Developing Peer-Governed Services
Co-design Workshop

Dunedin, 12 December 2022

Meeting notes

On 12 December 2022 a codesign workshop was held to discuss peer-governed mental health and addiction services in Dunedin. 24 people attended.

This document presents the feedback received at that workshop. It is based on notes recorded by two Te Whatu Ora staff members who attended the workshop (Gemma Griffin and Chris Crane). It has also been reviewed by one of the workshop facilitators (Emma Hunter).

If you attended the workshop and would like to comment on these notes, please contact chris.crane@southerndhb.govt.nz

Time for Change

In 2021 there was a review of the mental health and addiction sector in Southern. A report was produced, called **Time for Change Te Hurihanga**. This report made a number of comments and recommendations about growing peer services and the peer workforce. **Developing peer-governed[1] services is one of the projects to implement Time for Change Te Hurihanga.**

Introduction

The workshop was facilitated by Emma Hunter and Wade Kake. **Both Emma and Wade have lived experience.** Wade has cultural expertise.

The workshop began with **whanaungatanga** – all attendees were invited to introduce themselves to the group. The space was then moved from tapu to noa with karakia, and the sharing of food.

A brief introduction was given, covering the history of the Time for Change Te Hurihanga review, and the project progress so far.

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[1] Peer governed means services where at least half of the governance members (trustees, board members, directors) have personal lived experience of mental distress and/or addiction. All of the staff also need to have lived experience of mental distress and/or addiction.

Background

Two peer projects have been running at the same time. One is about **developing peer-governed services**. The other is about **developing the consumer, peer and lived experience workforce**. The two projects are connected.

A **workforce survey** was run in October across the district (Otago and Southland). It was based on Te Pou's **Competencies** for the Consumer, Peer Support and Lived Experience Workforce. The survey captured a snapshot of who is doing this work currently (including information like location and ethnicity), and what their training needs are.

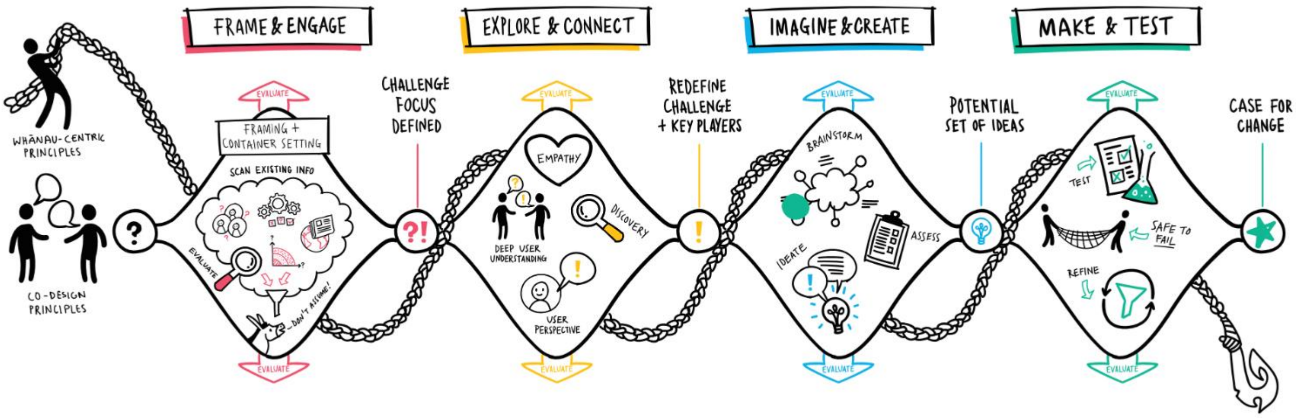
Two background papers were then produced using the survey results and other key documents. These papers provided background information for a series of workshops that were held in November. **Eight workshops** were held in Invercargill, Dunedin, Cromwell and Oamaru. At each location one workshop was held for lived experience only and one workshop was held for the community.

A **draft model of care** was then produced based on the survey results, background papers, and the feedback provided by those who attended the workshops. A 'model of care' is a way of describing what type of services we need, and how they should work.

The draft model of care was distributed through the Ōtākou network the week before this workshop. It was also sent to people who attended the November workshop for people with lived experience in Dunedin.

Co-design process

A powerpoint slide was presented from the Auckland Co-design Lab[2] summarising the co-design process. This graphic is included below:



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[2] Auckland co-design Lab
Collected Resources: Co-design Capability and Conditions Framework — The Lab (aucklandco-lab.nz)

It was explained that the project has completed the “frame stage” and the“explore stage” (pulling together background papers etc). We are now at the “imagine stage”. The aim of this workshop is to imagine **how the draft model of care could be implemented in Dunedin**, to meet the needs of the community here. The feedback from this workshop will also be used to develop the **final version of the model of care.**

After the workshop, Te Whatu Ora will develop concepts further (the “testing stage”) and will co-ordinate a process to fund a peer-governed service in Dunedin.

Values

The key components of the model of care are the values, principles and objectives.

A facilitator read out the values statements and asked for feedback.

Feedback included:

- Regarding the value about **equity for Māori**, someone said that the value should not include “I have the right to be Māori”. They felt that this didn’t need to be said, and that it excludes people from other cultures. In response it was noted that this was part of **honouring Te Tiriti o Waitangi**, and that **significant inequities for Māori still exist**. It was said that the feedback had been heard, and would be discussed with Māori colleagues.

- Regarding the **holistic** value, it was asked if this could include whānau as well. This was agreed.

What does mana-enhancing look like?

A facilitator referred to the “mana-enhancing” value, and asked the group – what does mana-enhancing look like?

Responses included:

- Ask the person – how would you like this to work? What do you need from me?

- Offer something to eat and drink.

- Get to know each other.

- Dont assume anything.

- Be respectful.

- Be strengths-focused, not issues-focused.

- Look for similarities.

- Cultural awareness.
- Find a way to talk to each other.
- Important to have diversity and connection.
- Important to acknowledege when people identify as Māori and be able to explore what is available, if they have not explored that for themselves.
- Understand that two families can have the same cultural background but be very different.
- Allow space for exploration of whānau. Consider if they would like more whānau involvement.
- Enable self-determination. What does the person want and how can we move towards that together?
- Cultural supervision is important at all times.
- Involve kaumatua and kuia.
- Get back to the moana and whenua.

Principles and objectives

A facilitator read out the principles and objectives and asked for feedback.

Feedback included:

- It was noted that the draft model of care does not discuss a a **lifecourse approach** - not dividing people up into age groups. It was then suggested that the model of care should support people across the continuum of life from young people to the end of life.
- It was suggested that the concept of **safety** is important and should be included.
- Clarity was sought about the **age range** covered by the model of care. Gemma explained that the model of care is for youth and adults (including 65+). Youth is not currently defined, but it could be 12 years and over. It is important to remember that this is a high-level model of care. **Services for young people might look quite different to services for adults, but they could be based on the same values, principles and objectives.**

  - It was suggested that other voices need to be at the table to design a service for youth. In particular, there is **inadequate representation of young people at the workshop.**

  - Providing services to people aged 12+ would be something new and could be great. The model of care is trying to do something **transformational**.

  - One service explained that they **already support people aged 13+,** some of whom are doing really adult things. This service supports anyone, and doesn't turn people away.

General feedback

The group moved into a more general conversation about how the draft model of care could be implemented in Dunedin.

During this conversation it was clarified that the resource available for the upcoming RFP (request for proposals) is 6-8 FTE.[3]

The following is a summary of the feedback and discussion.

Access

Feedback included:

- The service should be accessible for **all people – those with mild, moderate and severe needs.**

- The service should be accessible to **all cultures.**

- **Flexibility** is important.

- The **service needs to be available** at the point of access – people should not be sent elsewhere or made to wait a long time.

- People should be able to **self-refer, and drop-in.**

- **Any door should be the right door.**

- **Services should be open on weekends and public holidays, and at Christmas** (the loneliest time for some people).

- Services need to **reach rural communities.** They could partner with rural support trusts.

- It is important to **define the geographic area** covered.

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[3] Equivalent to 6 – 8 people working full-time.

Cultural needs

- Someone suggested that a tau iwi peer support model will not work for Māori, it needs to be **tuakana-teina**. It can't be Intentional Peer Support.

Trauma-responsive

- Feedback included that many tāngata whaiora have trauma histories. The service needs to be **responsive to trauma.**

Infrastructure

- It was suggested that peer support workers need to be able to access a **database** of all of the available services and supports in Dunedin. The database could also include information on all available peer support workers.

- The physical building/environment of the service is important, and feedback included:

    - The **"Homeground" model** run by the Auckland City Mission should be looked at. It is a trauma-informed space.

    - It would be good to have a **space where other groups could gather.**

    - The service needs **multiple rooms**.

- Someone sugested that the service needs to have a **vehicle.**

- Feedback was received after the workshop that **new services should not be established** to deliver peer support. They suggested that:

    - funding should be given to organisations who are already providing peer support and doing intentional peer support training.

    - It is important to **partner and collaborate with organisations already working** in the community.

Relationships with other services

Feedback included:

- How the new service **interacts with existing services** will need to be considered.

- It will be important to **educate** other services (including primary care), tāngata whaiora, and the public about the new service.

- Sometimes clinical support will be needed. **Getting access to clinical support** can be problematic, for example, access to Emergency Psychiatric Services (EPS).
    - One service said that they found it very easy to get access to EPS. They had spent twenty years building relationships with them and found that talking about relapse plans and getting clinicians on board is important. They said that peer-governed services will need to rely on EPS and the Police.
    - One service said that they have experienced difficulties accessing EPS, and that it was not only their service who had experienced problems.They've had multiple conversations with other people who have had similar experiences. Sometimes people are turned away and some people wont go to EPS because of a previous poor experience. Sometimes this is because the person is perceived to have behavioural issues and addiction. It was suggested that solving this issue requires resourcing, better understanding of peer support, and clear pathways between peer services and clinical services.
        - Further discussion included that:
            - Community services are often rebuffed by clinical services.
            - Peer services are not respected. **Peer workers need to be acknowledged.**
            - It might be important to **have a connector role** to ensure that services are well-informed and there is a pathway between them.
            - There is a particular **need for a pathway for those with addiction**. Services sometimes refuse to see people because they are under the influence of alcohol or drugs.
            - Multiple people shared experiences of going to the Emergency Department/EPS, or supporting someone else to go, and waiting a long time.
            - A person said they had both positive and negative experiences of EPS. They suggested that it was **important for the network to discuss pathways**, because all services need clear pathways. They also suggested that more values and attitudes training could help.
        - **It was suggested to elevate the need for clear pathways to other services/clinical input as a risk, and to add it to the wider system changes section in the model of care.**

Specific service ideas put forward by the group

Feedback included:

- A peer support service in the **Gibson Day Unit** is needed.
- A service like **Moana House** is needed for women and youth.
- There should be a focus on having peer support specialists, for example peer support workers supporting people who are using/have been **using methamphetamine.**
- An example was given of the **Hope Centre**, specifically how the Hope Centre is working as an **alternate waiting room** for EPS.
  - If the Hope Centre is supporting someone who needs to be seen by a clinician, they will ring ahead to EPS. If there is a long wait, the person waits at the Hope Centre, where there is less sensory overload.
  - If the person comes back to the Hope Centre after they are seen at EPS and discharged, the Hope Centre put a plan around them.They involve whoever is in their life, so they go back to an environment where there is support. Follow-up support is very important.
- A peer support service at **Artsenta**. The 6-8FTE could be used for co-ordination and training, and resources could be shared with other services.

Type of service

Feedback included:

- Peer support isn't just about peer to peer. It can be **peer to group.** That's where natural social connections are built.
- Peer support doesn't need to be in a space/office. It can be outside **in the community.** This can work better. Peers can connect with the service first at their office, but then meet outside for future appointments.
- It would be good if people could have peer support all the way through the system (EPS, Emergency Department, on the wards) and **not be left alone in clinical situations.**
  - Multiple people spoke of the need to have **peer support in the Emergency Department.**
  - Another person said that it was **not the role of a peer service** to be providing support in the Emergency Department. They said that this should be Te Whatu Ora's responsibility.

    - Someone mentioned the work of Corstorphine Baptist Community Trust’s **peer worker on the inpatient ward**, and suggested that there was potential to have more people in these types of clincial spaces.

- The possibility of a **crisis cafe** was discussed by multiple attendees.

    - This might require **access to clinical advice outside of 9am – 5pm.** This is the responsibility of clinical services. Responsiveness is important.

    - It is not possible to run a 24/7 crisis cafe service on 6-8 FTE. There could be an **on call roster** and other organisations could come in to help out.

    - If all the existing peer support workers worked together it would be possible to have a 24/7 service.

    - A **crisis clinic** attached to EPS was also suggested.

- Two people identified a **respite service** as a priority.

- Taking a wellness approach rather than a crisis approach was discussed. Someone suggested that the Time for Change document said that Dunedin’s priority was a **wellbeing hub.**

    - It was suggested that a wellbeing hub could be established that had extended hours a few nights per week. This should be close to the hospital and the hours should be aligned to the co-response team and EPS (ie, start later in the day and open untill 9pm).

    - The vision could be to keep people well and outside of crisis services.

- **An education service** – available to educate other services on peer support, and/or to support people to become peer support workers.

- It is important to focus on **doing one service well.** It is not possible to do everything in 6-8FTE.

- Have a **phone line.** This doesnt need to be 24/7.

Whānau involvement

Feedback included:

- It is important that **whānau is defined by the person**. A lot of tāngata whaiora have unsafe whānau environments and they build their own. People from the wider community become their whānau.

- Whānau can also include **relationships with neighbours.**

Workforce

Feedback included:

- The peer support worker should be as close as possible (in experience and characteristics) as the person they are supporting. They **need to be relatable.** It was suggested that this needs to be clear in the document or it could be easily forgotten.
- What will the process be for **police vetting** of peer support workers? There are additional considerations if peer support workers are going to work with children and young people.
- There need to be **multiple people on each shift** to provide support for each other.
- There needs to be **someone who is resilient to oversee the service** and maintain safety.
- There needs to be support to **make sure people don’t get traumatised** by the work, or experience **burnout.** There is also a risk that peer support workers will feel **marginalised** and **unsupported**.
  - Support is **especially important for youth peer support workers.**
  - **Work needs to be a safe space.**
  - **Supervision and ongoing professional development is critical.**
    - Some services noted that they **cannot find supervisors** for peer supervision and cultural supervision.
  - Peer support workers need **someone alongside them.**
  - The RFP should **require services to provide peer supervision.**
  - **Peer support workers need to be well trained in understanding themselves, trauma-informed practice and neurodiversity.**
- **Safety of staff is important.**
  - De-escalation training might be needed.
- It is important to **get the right people in these jobs.**
  - The **interview process should be by peers, for peers.**

    - If people are not ready to work yet, there should be a **pathway** for them to develop.

- It may be useful to have **students on placement.**

Youth services

Feedback included:

- **Most young people want young peer support workers.**
- A **seperate service for youth** would be appropriate.
- First impressions when young people walk into a youth service are important. **They need to feel like it is a youth space and that they belong there.** Colours, music, posters etc can all help.
- Youth peer support workers may need **additional support.** This could include:
    - **Supervision**
    - **Mentoring**
    - **A buddy system**
    - **Older peers as role models**
- Some feedback was that the people at the workshop today are too old to design a youth service, except [name of youth advisor].
- Youth services need to be **created by youth.**
- **Tuakana-teina** may work for youth.
    - **Teina-tuakana** (older people learning from young people) is also important.
- Feedback was received after the workshop that **rangatahi would benefit from a peer support model of practice alongside 1:1 wraparound casework.**
    - A wraparound approach can keep young people connected to their community, consider the wider determinants of health and promote wellbeing across whānau and communities.

Other feedback

- Where does **social isolation** fit in the model of care?

- **Think of future development** – 6-8FTE is just a start.

Questions

Two questions were asked at the end of the workshop.

Is the service for mild to moderate, or moderate to severe?
Answer: The model of care does not talk about a level of need. It says that services are open access, by self-referral.

Are there any barriers or limitations on which services can apply for the RFP?
Answer: The RFP documentation has not been written yet. No limitations are anticipated at this stage, but if there are any they will be explained in the RFP documentation. Organisations should look at the draft model of care,[4] which outlines the components of a peer-governed organisation. These are:

- 50% or more peer governance
- operating under the Ngā Paerewa Health and Disability Services Standards
- policies that adhere to peer values
- a clear peer support practice
- based on the CPSLE Competencies.

Whiteboard

The following points were noted on a whiteboard by the facilitators:

- Pathways and access
- Self-refer / any door the right door
- Available outside 9-5
- A central network but PSW to reach into the community
- Pathway/access to secondary and primary services
- Robust supervision/peer supervision/ kaumatua/ cultural supervision
- Tuakana-teina model
- Observing/engaging in tikanga.
- Services that are holistic/whanau support/or not
- Interface and education for staff to understand the service
- Vehicle-transport
- Risk/managing trauma
- Locality
- Phoneline

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[4] See page 17