In The First Person: Peer Worker: Expert by Experience

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Host (00:00):
Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Dr. Ruth Vine (00:18):

Hello everyone, and welcome to this episode of Mental Health Professionals' Network Presents: In The First Person. It's a podcast series that provides you, the listener, with the privilege of hearing people's stories in their own words. My name's Ruth Vine. I'm at the present, in the interim role of Chief Executive with the National Mental Health Commission. But my usual role is Deputy Chief Medical Officer with the Department of Health and Aged Care, and I'm a psychiatrist by background. In today's episode, I'm absolutely delighted to be joined by Tim McDonald, who is a senior peer worker with Barwon Health in Victoria. Welcome, Tim.

Tim McDonald (00:56):

Hi Ruth, thanks. It's great to be here.

Dr. Ruth Vine (00:58):

And Tim, it's lovely for me to be chatting with you today. I know Barwon Health moderately well, but haven't had a lot to do with it in recent times. But I'm really interested in hearing more about your experience of being a peer worker, if you can, how you got into that line of work. And we'll sort of work through over the next bit of time around some of your own experiences, both in providing support as a peer worker and any challenges you might have in your role. Tim, can you just start, just for the purposes of our listeners, just outlining your take on peer support, what is it?

Tim McDonald (01:33):

Peer support, and we're talking of course about lived experience peer support here. It's about connecting with people with similar experiences in a way that helps us to learn and to grow together. You know, we work within the system with our peers.

Dr. Ruth Vine (01:51):

I guess peer is a broad term, isn't it?

Tim McDonald (01:54):

Yeah.

Dr. Ruth Vine (01:54):

So, who are the peers who you would work with on a daily basis, Tim?

Tim McDonald (01:58):

I think it's important, even at this early point, to talk about language and the different terms that are used. And there's a lot of different terms that are contested amongst my peers, the people that do the work that I do. So, my actual role is consumer peer worker. So, I work with people who are currently defined as being consumers of the mental health service. A lot of people, myself included, have a bit of trouble with that word. I think historically they started out as patients, and then became clients, and now referred to as consumers. We find that problematic because it's as if we're consuming something. And when I hear consumer, I think of marketing.

Dr. Ruth Vine (02:50):

Yes.

Tim McDonald (02:51):

And, you know, retail and things like that. And I guess the main point there is that as a consumer, you are consuming the service. So, it's a one way interaction. We don't have anything to give back to the professionals that are working with us. We only take what's given to us, and what we're told to do. And this is one of the core concepts of peer work, is that it's a mutual relationship. When we're working with the people that we're working with, that we try to work on a level with them. And normally when I meet someone, I try to define my role, and it depends on who I'm working with. And it's been said that there are as many different types of peer work as there are peer workers.

Dr. Ruth Vine (03:42):

Yeah.

Tim McDonald (03:43):

But there are some core principles, like that mutuality. And I often describe it in terms of what it's not, as well. So, despite, we might get into this later, my education in psychology, I'm not a psychologist, because as a psychologist you are trained to give away nothing about yourself. Whereas, as a peer worker, you share anything which is relevant with the people that you're working with. And the person can ask me anything about what I've been through, how I've managed to get through it, or any techniques, or what I'm going through at the moment. And we can work together to try and learn and grow through that exchange.

Dr. Ruth Vine (04:29):

Firstly, I'm going to say a very big thank you, because you've just raised about three lovely areas for us to explore together. And, just as purely a coincidence, one of the things I was doing earlier today was being part of a launch of some guides put out by Every Mind called "Our Words Matter".

And you've just highlighted just how important language is, and how important understanding is. And I have to say that I think the whole terminology across lived experience, or lived and living experience, or peer work, or consumer or carer or family or supporter or kinship, there's a lot more to be explored there. And of course in the UK, the term service user was prominent, because people didn't like the term consumer. So, there's lots of different language, but the other thing you've raised there is that mutuality. And it seems to me that that mutuality is a pretty core component of your work and how you work. Can you tell me a bit more about how you see that mutuality working in your current work?

Tim McDonald (05:36):

Yeah, so I guess when you're actually doing the work, the most important thing is to find a connection with someone, to connect with them on a relatively deep level, or just on a rapport kind of level. IPS is intentional peer support, which is kind of the most well known philosophy, or paradigm, or training that people do in peer support. And the first step of that is connection. If there's no connection, you can't get through to any of the further steps, which is mutuality and then worldview and then moving towards these different concepts in that framework that peer work is defined as. So, the mutuality is that shared experience. I also like to point out to people and that hopefully, obviously not, that we don't share the same experiences, specifically the same experiences. We share similar experiences, and it's those similar experiences that allow us to connect and allow us to work together.

Dr. Ruth Vine (06:44):

Yeah, thank you Tim. One of the other things you touched on just before was that difference, if you like, between the expectations that someone who's trained in psychiatry or psychology might have from the expectations that you as a peer worker might have around that sharing. And you're right, I guess my training, I'm gonna share with people my name, I've clearly shared with people what I look like, or where I work, but I'm not gonna share, except perhaps in very particular circumstances, issues about my personal life or struggles, or my political or sociocultural views or things. Because as you said, there's a expectation of a certain neutrality. How do you decide in your work as a peer worker what it is okay to share, and even right and proper to share, with things that are not gonna be of help to the person that you are working with, because there's a difference there.

Tim McDonald (07:42):

Yeah, this is a really important point, Ruth. The intentional and intentional peer support is that we share intentionally. We don't just share anything about our stories that we'd like to talk about. We are sharing what we think will be useful to the mutual learning and everything, also useful to ourselves. There are certain boundaries as well, about things that we shouldn't be talking about. Yeah, so, we make a decision based on those sort of things.

Dr. Ruth Vine (08:13):

Well, and Tim, I reckon one of the, perhaps, one of the commonalities, if you like, between the sort of decisions you are making when you're talking about that and the decisions I as a clinician, or colleagues might be making, is this is an area of work where it's quite important to have a degree of, we might call it supervision, or we might call it our own supports or, you know, the opportunity to talk through, talk through the work we are doing. Do you think that aspect is also part of peer work? If you like, that individual support and supervision for you as a peer worker in your work?

Tim McDonald (08:52):

In a general sense? Yeah, we do absolutely reflect with each other about how we're doing the work that we're doing. But what we talk about with the person that we're working with is mostly confidential and we, we need to have that in order for people to be able to share honestly with us. Obviously we've got, you know, if someone's about to commit acts of violence or harm to themselves, we have a duty of care to disclose that. And we talk with the people that we are working with about what they would like us to share with the team, so often, you know, I'll record what what sort of football team, which football team someone barracks for, or things that they're interested in, that will help others to build a rapport as well that don't touch on any of those really, deeper sort of aspects of the experiences they might be going through.

Dr. Ruth Vine (09:53):

That's right. There are certain things that are just part of social engagement, part of understanding who a person is and what their interests are. And then, as you point out, there's a whole layer that people might choose to give to one person, but not choose to give to another. Tim, your work at Barwon Health I think is in a particular team. I think, when we caught up a while back, you said you were in Hospital in the Home. I don't want to spend our time learning particularly just about Hospital in the Home, but can you just explain for our listeners a little bit about the model that you're working in? Because I think we can then talk about just how important peer work is within that model. But how would you describe Hospital in the Home to our listeners?

Tim McDonald (10:35):

Firstly, we refer to it as "The award-winning Hospital in the Home." <laugh>

Dr. Ruth Vine (10:39):

Excellent <laugh>, yay, award-winning!

Tim McDonald (10:43):

But basically, Hospital in the Home is part of the acute services at Barwon Health and provide what we call "bed equivalent care". So, people are looked after, seen in their home environment rather than in the psychiatric ward. So, they're people who possibly would otherwise be in a psychiatric ward, if they weren't being seen by us, and we have a fantastic team and we give people quite intensive support. We have consultant registrar psychiatrists, we have a team of psychiatric nurses, social worker, OT, myself. So, people get seen at least daily, sometimes more, and yeah, it's been really successful. Most people don't like being in a psychiatric ward. It can be a very, very challenging environment. I haven't personally been in a psychiatric ward as a service user or whatever for a very long time, and I only spent a minimal amount of time there. But what I have seen with Hospital in the Home has been great, and the responses have been really positive. People do like it, they like the service in general, and we see a lot of really good results.

Dr. Ruth Vine (12:12):

That's great to hear, no wonder you're award-winning! But it, I mean, it is a really important part of, I guess, the spectrum of types of care. And if you're in Hospital in the Home, I'm guessing that people stay with you, I don't know, not for very long, maybe for a week or two weeks, but in that week or two weeks you get to know them pretty intensively.

Tim McDonald (12:37):

Average length of stay is about eight to 10 days, nine days or so. Some people do stay for a number of weeks, and obviously some stay a bit longer, a bit shorter, but that has been one of the things in my role that has been difficult and frustrating at times. So, I don't get to see people as often as I would like, or for as long as I would like. So, as I was saying, there's different types of peer work. So, at Barwon we also have post-discharge workers who engage with people when they're on the ward, and then after they're discharged they follow them up for about a month, and see them regularly over that month and get to work with them and form, I think, a good relationship over that time. Whereas, I might often only get to see someone a couple of times while I'm there.

Dr. Ruth Vine (13:28):

Yeah, that is a difficulty. I mean, it's also, well you would know Tim, that services are sometimes pretty stretched, and there's always another person needing the service, which means there's that need for people to come in, get the treatment and support they need, and then move on. I guess that's just the deal, if you're going to work with a team like Hospital in the Home, there has to be that, sort of, people moving through. How long have you been doing that now, for the hospital?

Tim McDonald (13:58):

About a year now. Just over a year, yeah.

Dr. Ruth Vine (14:01):

So, you're pretty familiar with it. Do you think it's still evolving, in terms of how that team use you, or how you contribute to that team?

Tim McDonald (14:11):

Ah, definitely, yeah. When I came into Hospital in the Home, I was the first peer worker in the team, and sort of had a bit of an idea what I'd be doing, but the position wasn't really well defined. And so, that's evolved over time, part of my job has been to design my job, in a way, as well. So, we've recently had a few more peer workers come on board, which is fantastic. So, we're working on how we're going to integrate with each other, and continue developing the way that we deliver what we're doing. I mean, I guess earlier on I was very unsure of what impact I was having, if any, and really wanted to be able to do that longer term work with people, follow them out of Hospital in the Home and see them on a longer term basis.

But that's not how it works. But I have received a lot of really positive feedback from some of the other clinicians on the team, that what I'm doing has had a positive effect. And it's in simple things, but not necessarily as simple as you would think. Like, just providing hope. I remember when we were speaking about this with one of our peer meetings, we were talking about what we do, and providing hope, and I was like, yeah, hope's all good and everything, but what are the practical results that we're going to get? And one of the more senior peer workers pointed out that hope actually is a major thing. When you are feeling very low, you feel hopeless and you can't see any way out of it. And to meet somebody who's been through something similar to you, come out the other side, so to speak, provides them with hope that it is possible.

Dr. Ruth Vine (16:04):

I think that's incredibly potent, Tim. I think, you're right, when you're hopeless, that's the word, isn't it? You're without hope. One of the attributes of being human is that life doesn't always go according to plan. And that sometimes, it's very hard to see that things will change. But what you're talking about there is that ability to bring a realism, if you like, to that, to the fact that things do change, that people don't stay where they are. And that with change can come that reemergence of hope, and a feeling of optimism. I absolutely agree with you. To be able to instil hope is an outcome in itself. It's part of what people will bring.

Tim, you also sort of talked about that role evolving, and you've talked a bit about your interaction with other peer workers, both consumer and I presume also carer and other. Can you talk a little bit about how you think your relationship is with the clinical members of your team? I know your consultant psychiatrist an ex-colleague of mine, Dr. Yeatman. How do you think you contribute to the clinical team, in the team meetings when you're talking about, I don't know, discharge planning, or how family work's going, or whatever comes to mind.

Tim McDonald (17:22):

Yeah, I was going to mention before, that part of the role is working with the people that we're working with, the service users, consumers, people. And also part of the role is working with the team, and educating the team, and advocating on behalf of people within that. So, once again, we can pick up on language, there's just all sorts of what might seem like little things, like talking about the side effects of medication. And I once heard someone say that there are no side effects to medication, there are just effects, and it's just a matter of perspective. There are some antipsychotic drugs which are great for weight gain, but they also have the side effect of reducing symptoms of psychosis. So, we should perhaps call them adverse effects.

Dr. Ruth Vine (18:20):

I hope you're not going to say that the reduction in symptoms of psychosis is an adverse effect. But, I agree there are multiple effects. So, sort of bringing that balance to the clinical meetings, and that balance of what might be important to the person might be one of those other effects, rather than the intended therapeutic effects, in relation to medication. But you also mentioned back at the beginning, Tim, that you'd studied in psychology. Do you bring some of that learning to your current role?

Tim McDonald (18:55):

I don't feel like I bring it explicitly to the role. I think there's probably things that I've learned that I know without being aware of knowing, if that makes any sense. But coming into the role, having done those studies in psychology was almost irrelevant to getting the role. I can see it almost being counterproductive in some ways as well. And I first studied psychology straight out of school, and that was because I was interested in the mind and the brain, and I'd been doing a lot of reading in early psychoanalysis and existentialism, and all this kind of stuff that you do. But the experiences that I had during uni and around that time didn't really allow me to progress. So, I got my degree, but that was about it. And I went away, and different things happened in my life.

I worked elsewhere, I was overseas and I came back and I realised that, I'm getting old, and I had to make a decision about something serious that I wanted to do, and I could go back and study in the field of where I'd been working, and I'd get a stable job and I'd probably do quite well. But I had these experiences that you couldn't study for, you couldn't buy. And they were something which I could use to be a benefit to other people. So, I went and studied psychology, because I saw that as the path to doing that. After my honours year, I needed to get experience to potentially do some post-grad work, and there was a peer role advertised. After these years of study and everything, I didn't even know that such a position existed. It was only in preparing for the interview that I really understood what it was, and realised that this is what I wanted to do all along. But I still believe that my intentions of going into psychology were to be a psychologist who understood what people were going through. There's differing opinions on psychologists, but a lot of people that I've spoken to in this kind of area of services would love to have a psychologist or a psychiatrist who had what we call lived experience.

Dr. Ruth Vine (21:21):

Thank you Tim. In a way it is, it's partly how you position that. I mean, if we accept that one in four or one in five of us are going to experience a significant mental illness, or period of psychological distress,

and maybe more than that, if you looked lifetime, then there'll be many people who have had professional training in the area of mental health who will also have had a lived experience. But, I guess it's a question then of how they use that. And your comment earlier about intentional peer support is very intentionally using that. That does bring me, Tim, to this is not a new workforce, but it is an evolving workforce. And I think over time I think there's gonna be a lot more discussion, and hopefully clarity, around things like scope of practice, leadership, where the person in various roles sits within that sort of team hierarchy. Do you see yourself as a future leader, Tim?

Tim McDonald (22:23):

Yeah, I do sometimes. Yeah. Obviously I love doing the work, and I really believe in the work, and I hear often from people who've gone on to higher management positions that they miss doing the work, and a lot of people who do not want to progress differently to what they're doing. But there's definitely a need for it and obviously as the workforce increases, it's inevitable that that's gonna happen.

Dr. Ruth Vine (22:50):

I think it is. I think too, I mean, you commented earlier on, in your particular team, you get the positives of people really benefiting from getting treatment and care, but not having to be in hospital. You get the challenges of not necessarily being able to follow a person up longer term, or stay with a person longer term. Part of that I think is about, different people generally find their area of greatest comfort in different parts of a service, be it inpatient work or community work or, for some, leadership and management work. Do you sort of think, oh, when I've been with Hospital in the Home for, I don't know, a while longer, it will be time to look at a different role within Barwon Health to give myself that breadth?

Tim McDonald (23:34):

Oh look, it is in my mind, but I'm committed to staying there for, I'm not sure exactly how long, but at least a few years. Having that work as well as it can, and being involved with it. Yeah, it's a great place to work. I hear a lot of stories about the challenges that people in peer work face, with teams that don't appreciate who they are, or why they're there, what they can do. And it, yeah, it can be really difficult, but, you know, from the get go, I've been welcomed and appreciated.

Dr. Ruth Vine (24:13):

Yeah. No, well workplace culture is pretty important. And sorry, I neglected to ask you, Tim, you've talked to us then about your tertiary training in psychology, but have you supplemented that with particular training in relation to peer work? Be that through tertiary, or Certificate IV, or have you topped yourself up, so to speak?

Tim McDonald (24:31):

Yeah, well like I said, I did the intentional peer support training, and I did the Mind training as well. It's another organisation.

Dr. Ruth Vine (24:41):

And did you think that was good? Did you think that was useful?

Tim McDonald (24:44):

Yeah, I did. Yeah, I do, yeah. I'm currently, just to branch off of that, I'm currently doing the Cert IV in mental health and peer work, which I think is very useful as well. I wasn't sure about it going in, I sort of just wanted to get that qualification, because it looks like that's going to become a requirement for working in peer work in the future in Victoria. I think it already is in New South Wales, in a way. Yeah, so I've done as much training as I can do.

Dr. Ruth Vine (25:16):

Well hang on, hang on. There's always a doctorate! You would always, you could always go for the PhD, just to top off the letters after your name.

Tim McDonald (25:24):

So, I did actually do, there was a program for regional research, so I was involved with that, and I designed a protocol for evaluating the contribution of peer work to the service, particularly Barwon Health. It started off with me just wanting to do some research for Barwon Health so that we could evaluate where, and how much, what to do to improve the peer work. But yeah, the academic that I was working with, who was my mentor, and they assigned us all mentors, told me, Tim, this is a PhD. So, I got all excited, telling everyone I was going to be a doctor <laugh>, but unfortunately weren't.

Dr. Ruth Vine (26:05):

<laugh>. Tim, what you've just talked about is, I think, some of the breadth and scope and potential that can come from roles like your own. And I have to say I think Barwon Health is very fortunate, and your team is very fortunate. So, I'm going to wrap us up, but firstly-

Tim McDonald (26:27):

I haven't had a chance to ask you any questions.

Dr. Ruth Vine (26:29):

Oh, well quick now's your big chance. Ask me a question!

Tim McDonald (26:34):

So, when I first heard about this, and this was a little while ago, I sort of did some very brief research, who is this Ruth Vine? And I came across, I think, if it was the submission, or one of your submissions to the Royal Commission that we talk about so much, like when there's a group photo, you go through and

look at yourself, see how you look. So, I did a couple of keyword searches. One thing that struck me, and that it was only two, "Mental health services must be delivered by skilled workforce, even if peer workers may be helpful in some ways". Which clearly implies that peer workers aren't skilled.

Dr. Ruth Vine (27:17):

Yeah, that's a big no on my part, isn't it? Look, I think what I was trying to get across there was the importance of not losing sight of clinical expertise. But Tim, I can only say I'm sorry that I said something in a way that implied that, because what you've just been talking about this last half hour or so, is precisely the opposite, is how skilled peer workers are. I guess we can say not all psychiatrists are that good at their trade, and I'm sure there's variability in every profession, but, no, well, ask me another question, because I'm going to apologise for that one.

Tim McDonald (27:51):

I do feel a bit of an imposter sometimes, and I do feel like, I'm working with people who've got 10 years, six years, of training, and I come into this team and they treat me like an equal, but am I really? But, an anecdote I like to recite is, we're in the office one day and a few of the more senior nurses were talking about this, I think it was a raffle that we were going to have, but they decided that only clinicians with more than five years of service could be involved in it, because they didn't want to have too many of the younger nurses in it as well. And they turned to me and said, oh, sorry Tim, you can't be in it, you've only got one year of experience. And it just came out of me, I said, I've got over 30 years of experience, 24 hours a day, of managing mental healthcare.

Dr. Ruth Vine (28:43):

Yeah, well, there is that term, isn't there, called expert by experience. And I guess you were demonstrating you might be an expert by experience, when you talk like that.

Tim McDonald (28:53):

But I also agree that education, like more formal education, is I think required, people debate that within the peer community. Some people think it should be a lot more organic and realistic.

Dr. Ruth Vine (29:07):

I guess it depends what your experience has been, I guess. And my experience has been that some people have terrible experiences, and terrible things happening in their lives. And that without access to really skilled treatment and care, I'm going to put "and care", that their lives would've been very different. But you're also highlighting that intervention, that care, that support and interventions can come from a range of professionals. Tim, we probably do need to wrap it up. So, I will say a very big thank you to the listeners for listening, and to you for being part of this episode of MHPN Presents: In the First Person. You, the listeners have been listening to me, and-

Tim McDonald (29:48):

And me, Tim.

Dr. Ruth Vine (29:49):

I've absolutely enjoyed our conversation and it's also been a bit provocative, and a bit questioning. And I think that that's really important. And I thank you for your generosity, and your courage, in sharing your story and your insights. I think I've learned quite a bit about the merits and opportunities to peer work, particularly in your neck of the woods. And I'm very grateful again for your time.

If you want to learn more about Tim or myself, our bios can be found on the landing page of this episode. You'll also find the link to MHPN's feedback survey. I absolutely know that MHPN value your feedback. Please follow the link and let us all know how you found this episode. Was it helpful? Was it interesting? Any comments or suggestions to help shape the future of MHPN Podcasts is very welcome. To stay up to date with future episodes of In The First Person or other MHPN podcasts, just subscribe to MHPN Presents. So, thank you all for your commitment to interdisciplinary, person-centered mental health care. It's goodbye-

Tim McDonald (30:51):

from me

Dr. Ruth Vine (30:51):

-and from me too. Thank you very much. Bye-bye.

Host (30:54):

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