Service user, consumer and peer workforce

A guide for planners and funders

Contents

Purpose of this paper 3

Definitions 3

National policy and frameworks 3

The benefits of focusing on the development of the peer workforce: the evidence 4

The service user, consumer and peer workforce 5

Peer values 5

Service user, consumer and peer roles 6

Types of peer services 7

Peer practices 7

Organisational context 8

Recent developments in New Zealand 9

Some issues for planners and funders 10

Recommendations 10

Further information on the peer workforce 12

Examples of peer work and services in New Zealand 13

Purpose of this paper

The service user, consumer and peer workforce is a diverse and rapidly growing workforce in today's mental health and addiction services in New Zealand. It includes all roles that require lived experience, for example, consumer advisors and peer support workers. In many parts of New Zealand people's understanding and definitions of peer work vary considerably.

This guide has been written for planners and funders of mental health and addiction services. It defines the major types of peer work, policy context, its values, evidence-base and development needs. It finishes with a list of resources planners and funders can refer to for more information.

It is designed to be used in conjunction with the **Competencies for the mental health and addiction consumer, service user and peer workforce** available from www.tepou.co.nz.

Definitions

For the sake of brevity in this document the term ***peer workforce*** has been chosen to describe the workforce that includes **all** service user, consumer and peer roles.

A peer is a person who has had similar experience to another person or people, such as lived experience of mental distress or addiction that has had a significant impact on a person's life.

The service user, consumer and peer workforce (peer workforce) includes all people with openly identified lived experience of mental distress or addiction and recovery. They can be in paid or unpaid employment, and use their experience to benefit others with mental distress or addiction in the work they do. Most work in mainstream agencies in the mental health and addiction sector but some work in peer-led networks or in agencies outside the sector, such as primary health organisations or social services.

National policy and frameworks

The Ministry of Health's *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* expects district health boards to reprioritise funding to further develop peer support services and self-management education for young people, adults and older people, in primary and specialist services. Self-management education includes peer-led programmes. *Rising to the Challenge* also affirms that peer support education and training programmes need to be put in place in response to the expansion of the peer workforce. This policy echoes policy developments in other western countries such as Australia, England, Scotland, Canada and the United States of America.

The National Service Framework provides the Ministry of Health's minimum expectations for service coverage and specifications for specialist mental health and addiction services in New Zealand. It outlines six peer service specifications introduced in 2009 under the heading 'Services providing Consumer Leadership', http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/501 .

- **Consumer leadership, consultancy and liaison** for mental health and addiction services.
- **Consumer advocacy services** for advocacy with individuals.
- **Consumer resource and information service** for information, education and networking.
- **Peer support service for adults** for support and community involvement.
- **Peer support service for children adolescents and youth** for age appropriate peer support.
- **Community phone service** for peer support via phone lines.

It is not currently mandatory for district health boards to fund these services but any services that are funded must use the service specification provided by the Ministry. The Ministry acknowledges that consumer service specifications are likely to expand and that the current list does not prevent district health boards from funding other 'consumer leadership services' if they fall within the overarching specifications for mental health and addiction services.

The benefits of focusing on the development of the peer workforce: the evidence

Peer work benefits the people who use the service, the peer worker and the organisation.

The formal evidence in both mental health and addiction is growing and shows high satisfaction from services that use all kinds of peer support as well as positive outcomes for people who receive peer services. Outcomes from peer services are as good if not better than conventional services[1].

Indications for service users include:

- reduced symptoms and or substance use
- reduced use of health services, including hospitals
- improvements in practical outcomes, for example employment, housing and finances
- increased sense of self-efficacy
- increased social support, networks and functioning
- increased ability to cope with stress
- improved quality of life
- increased ability to communicate with mainstream providers
- reduced mortality rates, particularly for suicide in people with addiction.

Indications for people who provide peer services include:

- creating jobs, learning new skills, developing routines and increasing income

[1] National Coalition for Mental Health Recovery- Peer Support, why it works. April 2014

- assisting with recovery and staying well
- satisfaction of using challenging life experiences to make a positive difference.

Indications for organisations include:

- reduced inpatient admissions for shorter times
- improved engagement due to improved communication
- making recovery visible.

Peer workers can benefit organisations by modelling recovery to people who use the service and to staff.

The 'Competencies for the mental health and addiction service user, consumer and peer workforce' are an ideal resource to inform the service design or improvement process. These articulate the expectations for peer workforce roles, management and leadership. http://www.tepou.co.nz/library/tepou/competencies-for-the-mental-health-and-addiction-service-user-consumer-and-peer-workforce

The service user, consumer and peer workforce

It is important to understand what makes this workforce different from other workforce roles and consider what unique skills that this workforce brings.

What's the difference between peer and non-peer workers?

The essence of peer work is not so much what kind of service is provided but who provides it and how. The '**who'** must be a person with lived experience of mental distress and/or addiction and recovery. The '**how'** must be built on peer values, especially the values of mutuality and the sharing of lived experience knowledge. Peer workers also provide a role model for recovery and inspire trust for people who use the service. They have a unique place in the mental health and addiction workforce.

Understanding the values, roles, types of service, infrastructure and practices is pivotal in supporting the peer workforce to work effectively and sustainably.

Peer values

All peer workforce roles are defined and underpinned by values intrinsic to the consumer rights, self-help and recovery movements spanning mental health and/or addiction. Six core values necessary for the peer workforce are presented below with the values of mutuality and experiential knowledge being particularly important.

- **Mutuality** – the authentic two-way relationships between people through 'the kinship of common experience'.

- **Experiential knowledge** – the learning, knowledge and wisdom that comes from personal lived experience of mental distress or addiction and recovery.

- **Self-determination** – the right for people to make free choices about their life and to be free from coercion on the basis of their mental distress or addiction.

- **Participation** – the right for people to participate and lead in mental health and/or addiction services including in the development or running of services as well as in their own treatment and recovery.

- **Equity** – the right of people who experience mental distress and/or addiction to have fair and equal opportunities to other citizens and to be free of discrimination.

- **Recovery and hope** – the belief that there is always hope and that resiliency and meaningful recovery is possible for everyone.

These values provide a strong foundation for peer work.

Service user, consumer and peer roles

Peer workforce roles include, but are not limited to, the following.

- **Peer support workers** work alongside individuals and groups of people who experience addiction or mental distress to help restore hope and personal power and to inspire them to move forward with their lives. *Peer support worker* is used in this paper as an umbrella term for several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist.

- **Consumer advocates** work independently of the systems they advocate in with individuals to resolve their experiences of unfairness or injustice, or at a systemic level to resolve collective injustices.

- **Consumer advisors** work mainly within mental health and addiction organisations to provide operational and strategic advice based on peer values and recovery principles, and to ensure the voices of people who experience mental distress and addiction influences the direction of the service. Consumer advisor is used in this paper as an umbrella term for other roles and job titles with similar functions, such as consumer consultant, consumer leader and client engagement facilitator.

- **Consumer, peer and service user educators** provide education from a lived experience perspective for other peers, mental health and addiction workers or community members.

- **Consumer, peer and service user researchers and evaluators** do research and evaluation from a lived experience perspective in partnership with their peers.

- **Consumer and service user auditors** provide a service user perspective in teams that audit mental health and addiction services, amongst other areas they lead the audit of service user participation and leadership.

- **Service user, consumer and peer supervisors** provide coaching, mentoring or supervision to other peer workers or to clinicians using their lived experience perspective and peer expertise.

People with lived experience who are employed in non-peer roles such as a community support work do not fit the definition of peer support worker, even if they openly identify their lived experience and use it in their work. This is because lived experience is not a pre-requisite for these other roles and they are not supported by peer training and supervision.

Types of peer services

There is a huge variety of peer work resources, responses and services around the world.

Many of these are delivered by mainstream providers. The difference for the peer workforce lies in the values and the way peers work using their own experience.

Peer support services may include:

- support to access housing, education and employment
- support in crisis, for example accident and emergency, acute wards and crisis houses
- artistic and cultural activities
- recovery education for peers
- social and recreational activities, including drop-in centres
- mentoring
- cultural peer services especially with indigenous people
- system navigation, for example case coordination
- material support, for example food, clothing, storage, internet, transportation
- reconnecting people with their communities and resources.

Other peer services provide:

- individual and systemic advocacy
- advice and consultancy in policy development and mainstream service funders and providers
- research and evaluation
- supervision of peer workers and clinicians from a lived experience expertise.
- workforce training and education
- research and evaluation
- auditing of services
- information services.

Peer practices

Professional peer work practices are still developing but are most developed in peer support work. Some of the oldest methodologies that equate to peer support probably come from indigenous traditions, such as peoples' sharing circles. Practices in mental health and addiction peer support are emerging and more are needed. The following practices or models are all used in New Zealand.

Twelve step fellowships (AA, NA, Al-anon, GA, OA, SLAA)
These are support groups that operate independently and have a set of guiding principles for recovery from addiction, compulsions, or other behavioural problems. The Twelve Step process involves the following: admitting that one cannot control one's addiction or compulsion; recognising a greater power that can give strength; examining past errors with the help of a sponsor (experienced member) making amends for these errors; learning to live a new life with a new code of behaviour and helping others that experience the same addiction or compulsions.

Wellness Recovery Action Plan (WRAP)
WRAP is a self-administered template that provides a structure for people to monitor their distress and wellness, and to plan ways of reducing or eliminating relapses. Peer support initiatives and some mainstream mental health services train people to do their own WRAP in a number of countries, including New Zealand.

Intentional Peer Support (IPS)
IPS is a philosophy and a methodology that encourages participants to step outside their unwellness story through genuine connection, mutual understanding of how they know what they know, redefining help as a co-learning and a growing process, and helping each other move towards what they want. Training in intentional peer support is available in a number of countries, including New Zealand.

Peer education programmes
There is a number of peer education programmes available in New Zealand including the Certificate in Peer Support (Mental Health, Level 4), an NZQA approved qualification by Mind and Body and PeerZone developed in New Zealand, Peer Employment Training, Intentional Peer Support and other locally informed mixed model trainings. These programmes are entirely peer designed and focus on personal development. Some programmes also focus on peer professional development. While these programmes have been predominantly developed within a mental health context they have increasingly become more inclusive of and responsive to an addiction perspective.

Other practice methodologies have been developed.

- The New Zealand Needle Programme's dedicated needle exchanges are recognised as a peer-based initiative driven by people who inject drugs.

- SMART Recovery – a non-spiritually based self-empowering addiction recovery support group, with tools for recovery based on the latest scientific research.

Some existing generic self-help and clinical methodologies are consistent with peer values. These can be incorporated into mental health and addiction peer work where appropriate to the role, such as mindfulness, meditation, trauma informed approaches, the strengths model and motivational interviewing techniques.

Organisational context

There are a range of organisational structures that the peer workforce and peer run initiatives can sit within. Examples of all these kinds of organisational structures can be found in New Zealand and many other countries.

- Informal grass roots networks run by volunteers with lived experience of addiction or mental distress such as twelve step fellowships and hearing voices groups.

- Funded independent peer run organisations staffed and governed by people with lived experience such as Mind and Body and Mental Health Advocacy and Peer Support (MHAPS).

- Mainstream service agencies with peer support workers, teams or initiatives within them such as the peer support teams in the Counties Manukau DHB mental health service, the Waitemata DHB community alcohol and drug service and Key We Way within Richmond New Zealand.

Recent developments in New Zealand

The peer workforce has grown enormously in New Zealand over the last decade and is likely to grow even more in the next. Te Pou and the Northern and Midland regions have recently completed a set of workforce competencies for use by planners and funders, service managers, training providers and workers themselves.

'Competencies for the mental health and addiction service user, consumer and peer workforce' outlines the expectations of the peer workforce in New Zealand. The competencies are positioned at a high level to describe how people work rather than what they do. They encompass the wide range of jobs the peer workforce does, even within one role such as peer support worker. They will be used to inform a range of processes including the development of job descriptions, performance management systems and training curricula. The competencies will clarify the expected behaviours associated with different tasks in job descriptions and help define the content and levels of part or all of training curricula.

There are 13 competencies.

- Seven core competencies that underpin all service user, consumer and peer workforce roles.
- Three competencies specifically for peer support workers.
- Three competencies specifically for consumer advisors.

Each competency is organised into levels derived from '*Let's get real: Real skills for people working in mental health and addiction'* plus an additional level for managers.

- **Essential** – people when they start work or after an agreed induction period needs to demonstrate this level of competency.

- **Peer practitioner** – people who have worked at least two years in their role need to demonstrate this level of competency.

- **Peer manager** – team leaders and other line managers need to demonstrate this level of competency.

- **Peer leader** – organisational leaders need to demonstrate this level of competency.

http://www.tepou.co.nz/library/tepou/competencies-for-the-mental-health-and-addiction-service-user-consumer-and-peer-workforce

Some issues for planners and funders

Lack of access and referral to peer support
Many people who could benefit are unaware of peer support options. There are very few statistics on the use of peer support in New Zealand but overseas studies estimate that less than five per cent of people who use mental health services have access to peer support. In addition to this, mental health services can be slow to refer people to peer support initiatives, even when they are available, because they don't understand the value of peer support, or discourage people from associating with other people with mental distress or addiction.

Inadequate planning and funding
Most peer support initiatives have an insecure, modest funding base. Peer workers and peer teams in mainstream settings are generally in a more viable situation, though peer employees tend to be low paid and/or work part time. There is good evidence for the cost-effectiveness for peer support but it needs to be sustainably developed and funded, with planned growth strategies, well-defined career pathways, and equitable pay and conditions.

Misunderstandings in accountabilities
There can be a tension between non-government organisations staying true to their values and mission while meeting planner and funders' needs for accountability. This tension is even greater for peer run initiatives grounded in peer values. Peer run initiatives have reported feeling that funders try to reshape their services and give them the same reporting requirements as mainstream services. This is possibly because planners and funders may not always understand what they are purchasing. Because peer run initiatives differ from mainstream services in some of their values, priorities, methodologies and relationships, mainstream accountability arrangements do not always fit well with them. For instance, peer run initiatives do not always engage with a well defined 'client group', they do not all deal with National Health Index (NHI) numbers or diagnoses and they do not all keep notes on people. The accountabilities within peer run initiatives tend to be framed in terms of reciprocal participation rather than professional-client relationships and boundaries. The outcomes they seek are personal rather than clinical or related to use of services. Funding and accountability arrangements could be discussed and adjusted to accommodate these differences.

Recommendations

There is much work that can be done to ensure this workforce becomes a unique and highly valued member of the mental health and addiction sector. This work needs to be co-led by peers in partnership with other leaders in mental health and addiction.

Potential national developments:

- refined national service specifications
- a full description of peer ethics and boundaries
- a national qualification
- recognised peer supervision processes
- career pathways
- the development of peer practice tools.

Potential planner and funder developments:

- targets for increasing the peer workforce
- reprioritised funding to the peer workforce and services
- explicit contract requirements to employ peer workers
- tailored accountability requirements to suit the nature and values of peer services
- further investment in the peer workforce via additional funding when this is possible.

Potential service developments:

- preparation in the sector for an increase in the number of peer workers
- create clear job descriptions
- adjust recruitment criteria and processes
- flexible work conditions
- ensure peer workers have peer colleagues and if possible peer line management
- provision of supervision and training.

Further information on the peer workforce

Major research papers

Davidson, L., Bellamy, C., Kimberly, G. and Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of the evidence and experience. *World Psychiatry* 11, 123–128.

Doughty, C., and Tse, S. (2011). 'Can Consumer-led Mental Health Services be Equally Effective? An integrative review of CLMH services in high income countries'. *Community Mental Health Journal* 47:3, 252–266.

Janzen, R., Nelson , G., Trainor, J. & Ochocka, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part IV – Benefits beyond the self? A quantitative and qualitative study of system-level activities and impacts. *Journal of Community Psychology* 34*,* 285–303.

Rogers, E., Teague, G., Lichenstein, C., Campbell, J., Lyass, A., Chen, R. and Banks, S. (2007). Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. *Journal of Rehabilitation Research and Development,* 44 (6), 785–800.

White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evidence.* Chicago: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

Guidelines

Ashcraft, L., Anthony, W. (2007) Adding peers to the workforce. *Tools for Transformation, 27*(11), 8-12.

Basset, T., Faulkner, A., Repper, J., and Stamou E. (2010). *Lived Experience Leading the Way: Peer support in mental health*. London: Together.

Centre for Excellence in Peer Support. (2013). *Considerations when operating a peer support service.* Victoria: ARAFEMI.

Daniels, A., Fricks, L., Tunner, T. (Eds). (2011). *Pillars of Peer Support -2: Expanding the role of peer support services in mental health systems of care and recovery.* Available from www.pillarsofpeersupport.org

Faulkner, A. and Kalathil, J. (2012). *The freedom to be, the chance to dream: Preserving user-led peer support in mental health.* London: Together.

National Committee for Addiction Treatment and Matua Raki. (2013). *Consumers contribute to the addiction sector in more ways than one.* Author.

Peer Work Project. (2009). *Employer tool-kit: Employing peer workers in your organisation.* South Australia: Baptist Care and Mental Illness Fellowship of SA.

Repper, J. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health and Mental Health Network, NHS Confederation.

Sunderland, K. and Mishkin, W. (2013). *Guidelines for the practice and training of peer support.* Calgary, AB: Mental Health Commission of Canada. Available from: http://www.mentalhealthcommission.ca

Examples of peer work and services in New Zealand

Peer-led organisations

Mind and Body is an Auckland and Christchurch based peer-led organisation that provides peer support services and peer support training, as well as research anti-discrimination work.
http://www.mindandbody.co.nz

Mental Health Advocacy and Peer Support (MHAPS) is a Christchurch peer-led network providing a variety of peer support services and peer advocacy.
http://www.mentalhealthadvocacypeersupport.org

Balance Whanganui provides peer support, education and advocacy for people with mental distress and addiction.
http://www.balancewhanganui.org.nz

Centre 401 in Hamilton provides peer support, peer-led workshops, gardening, social gatherings and employment support.
http://www.centre401.co.nz/

Peer teams within NGOs

Connect Supporting Recovery is based in Auckland and employs 29 peer support workers in mental health and addiction, including a peer led crisis house in Rodney.
http://connectsr.org.nz

Richmond Services runs a peer-led warm line in Wellington for people with mental distress from 7pm to 1am Tuesdays to Sundays.
http://www.wellink.org.nz/warmline.html

Pathways runs Tupu Ake a peer-led alternative to hospital admission in South Auckland.
http://pathways.co.nz/support-services#peer

Peer teams within DHBs

Counties Manukau District Health Board employs nearly 30 peer support workers in its clinical mental health and addiction services.
http://www.motionpacific.co.nz/?p=3856

Waitemata District Health Board community alcohol and drug services consumer advisor team.
http://www.cads.org.nz/More/Consumer.asp

Waitemata District Health Board community alcohol and drug services pregnancy and parental service.
http://www.cads.org.nz/Pregnancy.asp

Peer programmes and practices

Intentional Peer Support is a framework for creating peer-to-peer relationships in which both people learn and grow together and provides a training course for peer support workers in several countries including New Zealand.
http://www.intentionalpeersupport.org

Wellness Recovery Action Plan (WRAP) is a self-administered template for people to monitor their distress and wellness, and to plan ways of reducing or eliminating relapses from the USA. It is used in New Zealand.
http://www.mentalhealthrecovery.com

PeerZone is a series of peer-led workshops in mental health and addiction that are delivered in Australia and New Zealand.
http://www.peerzone.info

Toka Tu is an evaluation and research project involving 11 mental health and addiction NGO peer support programmes with the aim of enhancing and evidencing peer support in New Zealand.
http://www.tokatu.org.nz