

**PEER SUPPORT IN MENTAL HEALTH AND ADDICTIONS
A BACKGROUND PAPER**

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THE BENEFITS OF PEER SUPPORT

What are the benefits or peer support to you?

Knowing you are not alone. Seeing that you are able to live with a mental health diagnosis and still go to school, get degrees, have a job, have a relationship and family. Feeling you are more 'normal' or 'okay'.

If it were not for peer support, I wouldn't be alive.

My life was turned around.

Peer support got me through when I got nothing from the formal system.

I can tell peers stuff without fear of being committed.

It was my passage way to getting better, pretty much the only one.

Peer support contributed to 80% of my recovery.

Every visit I walked away better and better.

Beautiful, wonderful, lovely – words can't actually describe it.

Peer support saves lives PERIOD!

(O'Hagan et al, 2010)

1. Introduction

This paper provides a brief international overview of peer support in mental health and addictions – its origins; definitions of peer support; its values; the types of provision, practices, participants organisations and helping relationships involved in peer support; the evidence base for peer support; as well as the issues and challenges facing peer support at the definitional, attitudinal, systemic and organisational levels. One of the striking features of peer support is how universal the issues are; although this is an international overview, all the issues raised are relevant to all western countries with developed mental health systems.

2. Origins of peer support

2.1 Self-help and advocacy movements

The earliest known peer support and advocacy organisation in mental health was the Alleged Lunatic Friend Society established in England around 1845. Its founder John Perceval, a tireless advocate for the reform of the Lunatic Asylums, referred to himself as ‘the Attorney-General of all Her Majesty’s madmen’ (Podvoll, 1990). Some mental health peer run groups also formed in Germany in the late nineteenth century, which protested on involuntary confinement laws. In addition, peer support and self-help groups have been traced back to the 18th century (Robertson, 2009).

The most well developed peer support community was established in 1937. Alcoholics Anonymous has spread to every country and the twelve steps have been adapted for other addictions and for mental health problems. GROW, a 12 step program started by a priest in Australia in 1957, has also spread to many countries. These forms of peer support are all apolitical.

A new wave of peer support and advocacy in mental health emerged out of the international consumer/survivor movement which began in the early 1970s, around the same time as the civil rights movement, gay rights, the women's movement and indigenous movements. All these movements have in common the experience of oppression and the quest for self-determination. This new wave was based on a critical perspective of psychiatry and society, rather than just the need to ‘reform’ oneself (Chamberlin, 1978). It has been shaped by the limitations and harm done by the mental health system, therefore one of its motivations is to change the system as well as provide alternatives to it (Archibald, 2008; Burstow et al, 1988; Everett, 2000; le Blanc, 2008; O’Hagan, 2004). Many consumer/survivor run initiatives have elements of both peer support and political action.

In the last decade or two in western jurisdictions, many consumers/survivors have started to take up new opportunities to work within the mental health and to a lesser extent the addiction service system, in various roles. It could be argued that we are in a third wave of development in peer support – the use of peer support within mainstream mental health services, where peers are contracted or employed, usually to provide one-to-one support for people using the service. This development gives new opportunities for the growth and funding of peer support, but there is some concern within the movement that the traditional controlling values still operating in many mainstream services may compromise the ‘role integrity’ of peer support (Scott, 2011).

2.2 Recovery philosophy

The recovery philosophy underpins mental health policy in all English speaking jurisdictions (Compagni et al 2006). Recovery evolved out of the consumer/survivor movement and progressive thinking in psychosocial rehabilitation in the late 1980s (O'Hagan, 2001). It is a philosophy where:

- Hope for and self-determination of people with a diagnosis of mental illness is paramount.
- Madness is seen as a valid and challenging state of being rather than just an illness.
- There is recognition of the multiple determinants and consequences of mental health problems.
- There is recognition of the broad range of responses needed.
- People with a diagnosis are the major contributors to their own recovery.

(The Future Vision Coalition 2008; Mental Health Advocacy Coalition, 2008; New Freedom Commission, 2006; Sainsbury Centre for Mental Health, 2005)

The concept of recovery has a longer history in the addiction sector. It was originally identified with Twelve Step model which requires abstinence for recovery. This contrasts to the meaning of recovery in mental health, which does not focus on the elimination of symptoms. However, more recent peer leaders in addiction argue that abstinence should not be a requirement for recovery; the harm reduction approach introduces a recovery continuum in the reduction of drug related harm, with abstinence at one end (Lenton & Single, 1998). This brings the concept of recovery in addiction and problematic substance use much closer to recovery in mental health.

2.3 Trends in health

The growth of the recovery approach parallels changes in general health care and health promotion in western countries. The virtual elimination of deadly infectious diseases in the 20th century substantially increased the average lifespan, but left a vacuum for the proliferation of chronic lifestyle related conditions, such as depression, cardiovascular disease and diabetes. Good sanitation and antibiotics will not fix these conditions. The answers lie in the reduction of relative poverty and early intervention, as well as health promotion which encourages individuals to self-manage their health and well-being (Mental Health Advocacy Coalition, 2008). Peer support encourages self-management. At the same time Western populations are ageing and there is pressure on health budgets. Peer support offers a cost-effective alternative to traditional health care (Dennis, 2003).

When it comes to mental health treatment there is evidence from longitudinal studies that the new drugs that began to emerge 50 years ago, such as the anti-depressants, anti-psychotics, anti-anxiety drugs and mood stabilisers, have not improved outcomes in the population of people with a diagnosis of serious mental illness (Warner, 2004; Moncrieff, 2008; Bentall, 2009). In addition to this, two WHO studies have found that people with a diagnosis of schizophrenia in low income countries have better outcomes than people in high income countries (Hopper et al, 2007). In the addictions field, it has been stated that addiction peer based recovery services are growing out of the failure of addiction services to provide much more than crisis stabilisation (White, 2009).

All the above developments and evidence in health suggests we need to focus more on our personal, community and economic resources to restore and preserve health and wellbeing. In the area of peer support, we see this already happening in the USA at least, where there are more self-help groups and consumer operated services than mainstream mental health services (Goldstrom, 2006).

3. Definitions of peer support

A broad definition of peer support is any organised support provided by and for people with similar conditions, problems or experiences. Peer support is sometimes known as self-help, mutual aid or mutual support.

Peer support initiatives are the workers, groups, networks, programs, agencies or services that provide peer support. They can be:

- Funded OR unfunded.
- Use volunteers OR paid staff OR both.
- Operate out of user/survivor /consumer run organisations OR other agencies.
- Delivered by a group of peers OR by an individual peer in a team of professionals.
- A primary activity of the initiative OR a benefit from another activity eg in a user/survivor advocacy group or small business.
- Part of an indigenous healing ritual.

4. The values and fundamental concepts in peer support

Peer support is an explicitly values driven activity. The two values that are most unique to peer support are reciprocity and experiential knowledge. The other values in peer support can and should be pursued by mainstream mental health services and are consistent with recovery based policy directions. However, peer support does not readily subscribe to the competing implicit values of risk management and control that help to drive mainstream, particularly clinical services. Therefore the following values and fundamental concepts are always in the foreground in genuine peer support (Campbell et al, 2003; Holter et al, 2004; Janzen et al, 2006; O'Hagan et al, 2010; Segal et al, 2002; Van Tosh et al, 2000, White, 2009).

4.1 Self determination

Self determination describes the right to make free choices about your life without external coercion. Peer support is based on the principle that people are free to make their own decisions (Scott, 2011). This rated top in one survey of people in peer run initiatives which attempted to isolate the critical ingredients of peer support (Holter et al, 2004).

4.2 Participation and equality

Self-determination within a peer support initiative is often expressed through participation and equal relationships. Independent peer support initiatives are often set up as participatory democracies – where there is direct participation of the members in the organisation's decision making processes (Brown et al, 2008; Segal et al, 2002). They are characterised by a lack of hierarchy (White, 2009). Peer support workers in independent and mainstream organisational contexts value transparency and the participation of peers receiving the service in all information sharing and decisions (Scott, 2011).

4.3 Reciprocity

Reciprocity describes the honest and genuine two-way helping relationships that occur in peer run initiatives (Campbell et al, 2006; Van Tosh et al, 2000; HUG, 2008; Scott, 2011), through 'the kinship of common experience' (White, 2009). Sometimes it is referred to as the peer principle – 'relationships based on shared experiences and values that are characterised by reciprocity and

mutuality' (Clay, 2005). 'In the course of helping others, one's own problems diminish' (White, 2009). However, it's not always possible to achieve total reciprocity, particularly if one of the people in the relationship is paid to be there. This makes the explicit negotiation of power very important in peer relationships.

4.4 Experiential knowledge

Peer support initiatives place high value on experiential knowledge which is subjective as well as 'concrete, specific and commonsensical' (White, 2009), as opposed to theoretical and scientific knowledge. High respect for experiential knowledge means that peers can share their problems and solutions with each other in a non-judgemental way. Knowledge is not controlled as it is in the professional sphere; it is shared (White, 2009). Experiential knowledge may allow people to arrive at a different understanding of themselves and their place in the world than the knowledge they have absorbed through traditional mental health and addiction services and wider society. Peer support initiatives may promote critical learning and the reconstruction of people's experiences (Mead, 2001; MacNeil & Mead, 2003).

4.5 Recovery and hope

Over the last decade or two the recovery approach has increasingly underpinned mental health and addiction policy in many western countries (Compagni, 2006). In this context recovery emphasises, not recovery from symptoms but the recovery or discovery of a life worth living of one's own choosing. It has been claimed that 'peer support is the only mental health role to emerge that is grounded intrinsically in recovery' (Orwin, 2008). This is partly because all other roles pre-date the emergence of the recovery approach. Hope is a foundational principle in recovery and in peer support; recovery cannot take place without it (Mead & Copeland, 2000; Van Tosh et al, 2000).

5. Typologies in peer support

One way of understanding the scope and diversity within peer support, is to view it in various dimensions, including the different types of provision, practices, participants, organisational structures, and helping relationships.

5.1 Types of provision

There is a huge variety of peer support resources, responses and services around the world. The most common are self-help support groups, such as twelve step fellowships where peers meet regularly to provide mutual support, without the involvement of professionals.

However, in recent decades there has been a big increase in the types of peer run service provision to meet specific needs, especially in mental health. Many of these types of provision can also be delivered by mainstream providers, though arguably with a different style. Mental health peer support services available include:

- Support in housing, education and employment.
- Support in crisis eg 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, counseling and befriending.
- Traditional healing, especially with indigenous people.
- System navigation eg case management.

- Material support eg food, clothing, storage, internet, transportation.

Not all peer run services have peer support as their primary function, although peer support is still an important component of them. There is some debate about whether the following types of peer-led services should be called peer support services or not:

- Peer run systemic and individual advocacy.
- Small businesses staffed by peers.
- Peer run paper and online information development and distribution.

(Brown et al, 2008; Campbell et al 2006, pp 18-210; Chamberlin et al, 1996; Goldstrom, 2007; Janzen et al, 2006; Mancini et al, 2009; O'Hagan et al, 2010; Trainor et al, 1997; White, 2009)

5.2 Types of practices

Some of the oldest methodologies that equate to peer support probably come from indigenous traditions, such as Maori healing rituals or Canadian Aboriginal peoples' sharing circles and sweat lodges (Lapsley et al, 2002; Kirmayer et al, 2008). Some Western practices in mental health and addiction peer support are emerging and more are needed. Perhaps the best known ones are Twelve Step groups such as Alcoholics Anonymous, Wellness Recovery Action Plan (Copeland, 1997) and Intentional Peer Support (Mead, 2005). The following is not a comprehensive list and its intention is to identify discrete practices rather than organisational brands, which may be associated with the development and use of a number of different practices.

Twelve step programs

These are 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 suffer from 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 (Copeland, 1997).

Intentional Peer Support (IPS)

IPS is a philosophy and a methodology that encourages participants to step outside their illness and victim 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 (Mead, 2006).

Other practice methodologies have been developed, such as:

- Personal Assistance in Community Existence (PACE) Recovery Program– workshops to assist individuals and providers apply practices that support recovery and hope (Ahern & Fisher, 1999).
- Recovery education courses, such as Peer Support Whole Health and Resiliency Training developed by Larry Fricks in the USA and Wellbeing Recovery Learning developed by Mary O'Hagan in New Zealand
- Self-stigma workshops.
- Needle exchange schemes run by injecting drug users.

- Rational Recovery – an addiction recovery support group.
- 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 can be incorporated into mental health and addiction peer support, such as Cognitive Behavioral Therapy, mindfulness meditation, the strengths model and motivational interviewing.

5.3 Types of participants

Peer support in mental health and addiction has been accused of being geared to white, privileged people who do not have severe mental health or addiction problems (Chamberlin et al, 1997). The evidence does not really support this view. Studies have found that people who use mental health peer support are comparable, in terms of the severity of their problems, with people who use specialist mental health services (Goering et al, 2006; Hodges, 2007).

There is however, some feeling among ethnic minority groups in England (Begum, 2006) and Canada (O’Hagan et al, 2010) that the user/survivor movement in mental health does not represent their views and can be overtly racist. Indigenous people and others from non-western cultures sometimes indicate they feel more comfortable in a support setting that involves the whole family rather than previously unconnected individuals (O’Hagan et al, 2010). In New Zealand this preference is encapsulated in the policy and practice of whanau ora (strong, healthy families).

Some peer support initiatives for people with addiction and/or a diagnosis of mental illness serve specified populations:

- Life stage eg young people, new mothers.
- Gender eg women.
- Sexual orientation.
- Ethnic groups eg Pacific people, Asian people.
- Indigenous eg Maori, Aboriginal
- Diagnostic groups eg depression, bipolar, schizophrenia, ‘dual diagnosis’
- Addiction groups eg alcohol and other drugs, gambling, Kaupapa Whānau, injecting drug users, and more recently overeating
- Occupational groups eg armed forces and veterans.
- People involved in the criminal justice system
- Faith based groups eg Christian

(Campbell et al 2006; Dennis, 2003; O’Hagan et al, 2010, White, 2009)

5.4 Types of organisations

There are a range of organisational structures that peer support 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 health problems eg twelve step networks and bipolar support groups
- Funded independent peer run organisations staffed and governed by people with lived experience eg Mind and Body and Psychiatric Consumers Trust.
- Mainstream service agencies with peer support workers, teams or initiatives within them eg the peer support teams in Counties Manukau DHB mental health services, and Key We Way, a service within Wellink Trust.

The distinction between these three types is not always clear cut. For instance, there are some examples of:

- Funded peer run initiatives that are run by volunteers.
 - Peers who are employed by independent peer run agencies but work in mainstream settings.
 - Peer run initiatives that have a minority of staff or board members without lived experience.
- (Campbell, 2003; Soloman, 2004; O’Hagan et al, 2010)

5.5 Types of helping relationships

Davidson et al (2006) proposed a continuum of helping relationships in the mental health arena – from one-directional (as in a traditional professional-client relationship) to reciprocal (as in a volunteer based support group relationship). Davidson places paid peer support workers in the middle third of this continuum.

Dennis (2003) proposed a similar continuum of helping relationships from lay (such as family and friends) to professional (such as doctors or social workers). She placed peer support relationships between the two ends of the continuum, with volunteer self-help groups towards the lay end and paid peer support workers (paraprofessionals) towards the professional end.

This implies that paid peer support workers are a new and unique group who are not friends but who have a different kind of helping relationship with people than the rest of the clinical and support workforce. In this sense the peer support workforce has been described as ‘neither fish nor fowl’ (Davidson, 2006). Peer support leaders often discuss the challenges of keeping equality and reciprocity in the paid peer relationship, especially in traditional mental health and addiction services where these values may be trumped by risk management and coercion (Pocklington, 2006).

6. The evidence base for peer support

6.1 General evidence

There is an emerging but incomplete evidence base for the various forms of peer support in mental health and addiction. Unfunded self-help groups are the oldest form of organised peer support and have attracted much of the research. Most of the evidence for addiction peer support comes from twelve step networks (White, 2009). The evidence base for peer run organisations is increasing but there is less evidence on peers working in mainstream services. Much of the research into peer support has been descriptive, exploratory or qualitative with small sample sizes. These studies are difficult to make generalisation from (Campbell et al, 2005; Rogers et al, 2007; White, 2009).

However, the evidence in both mental health and addiction does show high satisfaction from people who use all kinds of peer support as well as some positive outcomes:

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

(Brown, 2009; Campbell et al, 2003; Chamberlin et al, 1996; Cook et al, 2010; Doughty and Tse, 2005 & 2010; Greenfield, 2008; Griswold, 2010; Humphreys et al, 2004 Forchuck, 2002; Lawn et al, 2008; Magura, 2008; McLean et al, 2009; Norman, 2008; White, 2009; Vederhus, 2006;)

A review of the evidence base from 20 studies of mental health peer support published from 1995 to 2002 show some promising results (Campbell, 2005 pp. 46-57). A systematic review focusing on international, primarily quantitative studies (Doughty & Tse, 2005) concluded that 'overall, research on consumer services reports very positive outcomes for clients'. Some studies have shown no effect for peer support (Pistrang, 2010), but no studies have shown an adverse effect (Doughty & Tse 2005).

Four randomised trials of peer delivered services and non-peer delivered services showed few significant outcome differences in three and 'fewer hospitalisations and longer community tenure' for those who used the peer delivered service in the fourth study (Davidson et al, 2006). However, three of these studies focused on peers in case management roles, not peer support roles.

6.2 Unfunded grassroots networks

Self-help groups in mental health and addiction are well researched but 'despite the large and growing literature on mutual help groups, many [are] of variable quality in terms of design and reporting of results.' (Pistrang et al, 2010). The strongest findings from two randomised trials of mental health self-help groups show outcomes that were equivalent to those of substantially more costly professional services (Pistrang et al, 2010). Studies also show that people with addiction who joined twelve step groups in addition to receiving treatment had increased their abstinence rates by 25% to 100%, and reduced downstream health costs by thousands of dollars per person (Humphreys, 2007, cited in White, 2009, p 118).

6.3 Funded independent peer run organisations

Peer-run organisations offer a range of support and advocacy assistance. In mental health, some peer run organisations have evolved from self-help groups. However, twelve step networks are not enabled to develop in this way. The quality of research conducted with and on peer-run organisations has significantly improved over the last decade. There is now increased confidence in the effectiveness of peer support delivered by peer run organisations. (Campbell & Leaver, 2003; Doughty & Tse, 2005 & 2010; Forchuk et al., 2005; Rogers et al., 2007). Few studies have been done on the effectiveness of funded peer-led addiction organisations (White, 2009).

An analysis of funders' reports in the USA showed that peer run organisations demonstrated organisational competence and were cost effective (Brown et al, 2007). It has been suggested that the positive outcomes from peer support could be potentially greater for people receiving them from consumer run organisations than mainstream services (Doughty & Tse 2005). In one study participants were randomized to a traditional mental health service or a traditional service plus consumer operated program providing either drop-ins, mutual support, or education/advocacy. The people using the drop-ins showed the best outcomes (Campbell, 2005).

6.4 Mainstream services that employ or contract peers

The initial research on peers working in mainstream services focused on peers working in mainstream roles such as case managers. Much of it was concerned with determining if there was any risk to clients in employing peer workers (O'Hagan et al., 2010). The evidence shows that there is no additional risk to clients and that client outcomes are similar for people receiving services from both peer and non-peer workers (Chinman et al., 2006; Davidson et al., 2006).

In recent years research has placed more emphasis on the unique value peer workers bring to their work, and on the structures and cultures in mainstream organizations that will increase positive outcomes from the use of peer workers. Research is looking at the potential internal and external barriers that peer workers face integrating into the mainstream mental health workforce, such as

stigmatising attitudes and conflicting values (Davidson et al., 2006; Gates et al, 2007; Mancini et al, 2009). Preparing the organisation has been found to be a crucial factor for success in employing peer workers in mainstream services, in addition to training and support for the peer workers themselves (Franke, 2010).

6.5 Benefits for peer support workers and volunteers

The benefits of peer support to workers and volunteers are recognised in the 'helper's principle' which asserts that working for the recovery of our peers facilitates personal recovery for both. (Clay et al, 2005). Evidence is emerging in support of the helper's principle. In several studies peer support workers and volunteers have consistently described the ways in which their roles are of personal benefit to them:

- Creating jobs – learning new skills, developing routines and increasing income.
- Restoring confidence, and increasing self awareness, fulfilment and friendships
- Assisting with recovery and staying well.

(Bouchard et al, 2010; Lawn et al, 2008; Mowbray & Moxley, 1998; Scott, 2011)

7. Unresolved issues and challenges in peer support

Clarity in some aspects of peer support at the definitional level is still evolving and there is much work to be done in establishing good practice based on peer support values and a sound evidence base.

7.1 Definitional issues

There are many unresolved debates at a philosophical level. These concern:

- The difference in role between friendship and the peer support relationship.
- The degree to which being a paid peer support worker compromises reciprocity.
- How peer supporters can keep permeable boundaries and avoid the burnout that can come from over-involvement.
- How peer support workers frame and deal with 'risk'.
- How peer support workers deal with information and privacy issues.
- The risk that peer support qualifications will erode the 'natural' peer support relationship and deny employment opportunities to some people who have not completed school qualifications.
- The need to build an evidence base using methodologies and outcome measures consistent with its values of empowerment, participation, recovery and hope.
- How to manage the tensions between peer support values and the values played out in the mental health system and stay true to peer support.
- How peer support workers should avoid slipping into the old ways, they learnt in the mental health system, of thinking about and treating people.

(Bracke et al, 2008); Chinman et al, 2006; Coatsworth-Puspoky et al, 2006; Davidson et al, 2006; Gates et al, 2007; Mancini and Lawson, 2010; Nelson et al, 2008; O'Hagan et al, 2009; White, 2009)

7.2 Attitudes and culture

Perhaps the biggest barrier to the development of peer run initiatives around the world has been the longstanding inequality and marginalisation of people who have received a mental illness diagnosis and its impact on consumers/survivors as well as the people who work in and run the mental health system. In a Canadian review of peer support (O'Hagan et al, 2010), some people believed government officials, planners and funders may have lower expectations of peer support initiatives than of professionally led services. If this is the case, the impact of this attitude cannot be

overstated. Lower expectations, at whatever level of consciousness, can lead to an oscillation between neglect of peer support initiatives and too much interference when things go wrong.

The people running mainstream mental health system do not often understand consumer/survivor history and values (Chinman et al, 2006; Chinman et al, 2006; Gates & Akabas, 2010). This means they are likely to regard peer support initiatives as either second-rate or just like mainstream services that happen to be run by consumers/survivors. Peer support leaders have asserted that consumer/survivor initiatives need to be regarded as 'equal but different' by mental health services (O'Hagan et al, 2010).

One rationale for placing peer support workers in traditional mental health services is so they will help bring about culture change (Ashcraft & Anthony, 2007; Gates & Akabas, 2007). This is perhaps a tall order for people who are usually at the bottom of the hierarchy. About half of the respondents in a Canadian review (O'Hagan et al, 2010) said their presence had helped to create culture change, through role modeling, informal dialogue, education and creating the conditions where some professionals have felt safe to 'come out' as consumers/survivors. People said it was much harder to change staff if they had other priorities and rigid beliefs.

7.3 Systemic issues

Lack of access and referral to peer support

Many people who could benefit don't know about peer support and may not live near a peer support initiative. Therefore, a very low percentage of people with mental health problems use peer support. There are very few statistics on the use of peer support in New Zealand. In a Canadian review (O'Hagan et al, 2010). Vancouver Coastal Health in British Columbia, which has one of the most developed peer support services inside community mental health teams in Canada, noted that under 5% of their community mental health clients have access to a peer support worker. 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 health problems (O'Hagan et al, 2010).

Inadequate planning and funding

Peer support is the most rapidly growing service in mental health in western countries today. Funders need to either allocate new money to peer support or find funds from existing resources. Like many non-government service providers, independent 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 for low hours. Although there is good evidence for the cost-effectiveness for peer support, it needs to be sustainably developed and funded, with planned growth strategies, well-defined career pathways, and reasonable pay and conditions (O'Hagan et al, 2010).

Poorly targeted accountabilities

There is a tension between non-government organisations staying true to their values and mission while meeting their funders' needs for accountability. This tension is even greater for peer run initiatives as they have 'historically struggled with cooptation' and 'consumer control is an essential organisational characteristic' (Brown et al, 2007; Nelson et al, 2008). In one survey, conducted with American peer support initiatives, 40% of the initiatives said that collecting data from members would discourage people from using their services. Some peer run initiatives have also reported that they felt over scrutinized by funders, who seem concerned about 'crazy people screwing up' (O'Hagan et al, 2010).

Peer support initiatives often state that funders try to reshape peer support services and gave them the same reporting requirements as mainstream services. Funders do not always understand what they were 'buying'. Because peer support initiatives differ from mainstream services in some of their values, priorities, methodologies and helping 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 keep notes on people, the accountabilities within them tend to be framed in terms of equal participation rather than professional-client relationships and boundaries, and the outcomes they seek are personal rather than clinical or related to use of services (Brown et al, 2007; Nelson et al, 2008). Funding and accountability arrangements need to be adjusted to accommodate these differences.

Lack of workforce development

There are limited professional development opportunities for most peer support workers around the world. Barriers include lack of funding and/or failure to create a budget for staff development. Some peer workers have felt uncomfortable and excluded when they have attended mainstream training. Currently in New Zealand peer support workers have occasional access to short peer courses originating in the USA (Recovery Innovations and Intentional Peer Support). A New Zealand based qualification provided by Mind and Body is available but they are the only approved provider.

There is broad agreement that some standardisation and formalised training in peer support is needed if peer support initiatives are going to grow and become an integral part of the mental health system. But some peer support leaders also express concerns about these developments. 'Professionalising' peer workers could erode the reciprocal relationships in peer support initiatives, and standard workforce training could steer peer workers into taking on the language and culture of mainstream mental health services (The Herrington Group, 2005; Scott, 2011).

Some topics in peer support training are not covered in mainstream curricula but even when there is overlap in topics with other occupational groups, the emphasis may be quite different in peer support. New peer support curricula need to be developed. Standards and training curricula in peer support are in development in several countries including Australia, Canada, Scotland and parts of the USA. New Zealand has recently stalled plans to develop a peer support qualification (O'Hagan, 2011).

7.4 Organisational issues

Poorly fitting mainstream organizational structures

In a Canadian review (O'Hagan et al, 2010) peer respondents said the best types of agencies to 'house' peer support services are small, non-profit, community or peer driven with a flat hierarchy and consensus decision making. However, these organizations need to be structured, with plans and procedures, training and supervision, and with clear boundaries such as confidentiality (Wituk et al, 2008; O'Hagan et al 2010). In recent years more peer support workers have been employed by large, hierarchical mainstream agencies that do not provide the best fit for peer support values. This has been controversial among peer support leaders in all countries (Pocklington, 2006). In order to minimize this lack of fit, respondents in the Canadian review believed peer support workers who work inside mainstream agencies should never work alone in a team of professionals, due to the differences in philosophy and power and the sense of alienation this can set up for the peer support worker. People were also emphatic that supervision and performance appraisals of peer workers inside mainstream agencies should be done by other peers and not professionals (Ashcraft & Anthony, 2007; O'Hagan et al, 2010). Another strategy for improving organisational fit is preparing and training the existing staff for peer support workers (Ashcraft & Anthony, 2007; Franke et al, 2010; Gates & Akabas 2007).

Governance and management problems in peer run initiatives

Some independent peer run initiatives have difficulty finding the right mix of financial, legal and peer, community skills and experience from the local consumer/survivor community. Internationally, some boards have a minority of people who are not consumer/survivors. There are also boards that don't observe the strict separation of governance and operations that exists in the corporate and large non-profits contexts; some of these boards have a mixture of members, volunteers and staff on them, while others are just governed by the members, or users and survivors from the wider community. At the very least, the board of an independent peer run initiative should have a majority of consumer survivors on it (O'Hagan et al, 2010).

Many independent peer run initiatives are well managed especially under the difficult circumstances of poor funding and workers with fluctuating health (Brown et al, 2007). Successful managers lead through empowering the staff and members and upholding the values of peer support. But managers are vulnerable to a cascade of problems, starting with poor funding. Peer support initiatives are often unable to afford or train managers with the required skills, particularly in the area of finance and fundraising. Burnout is a major problem. Occasionally, people recruited into management roles are not the best people for the job; they could be inconsistent, have blurred boundaries or be self-serving and treat others badly (O'Hagan et al, 2010). One study found that the most common forms of assistance requested by 25 independent peer run initiatives in Kansas were in order – grant writing, quarterly reporting, board development, business management, staffing issues and conflict resolution (Wituk et al, 2007).

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APPENDIX 1

Some examples of good practice

There are many thriving peer support initiatives around. Below are just a few of them, selected to show the diversity of peer run initiatives.

Independent consumer/survivor initiatives

Peer Support and Wellness Center, Georgia, USA

This service has been operating for one year and provides alternative wellness supports. They aim to keep people from going to the hospital and have three beds where people can stay up to seven nights. The program also allows people to come during the day and access varied programs. People can self-refer. Evaluation results already show the program has cut hospitalization significantly (Darnell, 2008). Programs include:

- Talking the taboo.
- Aromatherapy.
- Computer training.
- WRAP (Wellness Recovery Action Planning).
- Negotiating peer relationships.
- Food.
- Double trouble in recovery (for people with 'dual diagnosis').
- Trauma informed peer support.
- Sport and recreation.
- Music and wellness.
- Sacred space.
- Creative writing.
- Arts.
- A 'give back' group.

www.gmhcn.org/wellnesscenter

CAN Mental Health, New South Wales, Australia

CAN Mental Health was awarded money from the Commonwealth government to deliver an innovative new service, a 'hospital-to-home' transition team. The team receives referrals from the hospital and works with people on whatever is needed for the first 28 days after their discharge. A peer led external evaluation tool has been developed by Victorian Mental Illness Awareness Council, a state wide consumer network, to evaluate the service. Run by paid staff who are required to complete a peer support training program (developed by Australian and American consumers), they undergo regular supervision. The service also runs a recovery centre and a national 'warm line' telephone service.

www.canmentalhealth.org.au

Mind and Body Ltd., Auckland, New Zealand

Mind and Body is a limited company. It provides:

- One-to-one peer support work.
- Anti-discrimination work.
- Consumer advisors to mainstream statutory services.
- Certified training for peer support workers.
- Consumer led research.

Mind and Body has a strong philosophy that underpins everything it does. It invests in a lot of training and supervision for staff.

www.mindandbody.co.nz

Opportunity Works, Calgary

Opportunity Works is a peer delivered service that provides self-employment and mental health support to any individual in the Calgary community who identifies as a mental health consumer. It offers:

- A holistic and integrated approach to business development.
- Employability and mental health self-management.
- One-to-one coaching supplemented by group learning.
- Flexible, self-paced, self-directed and participant driven timelines.
- A graduated approach to achievement of long-term goals.

www.opportunityworks.ca

A-WAY Courier, Toronto

A-WAY is a social purpose enterprise courier service which was established over 20 years ago. It employs 70 full and part-time people, all survivors. The Board is made up of a majority of C/S. They cover the whole metropolitan area of Toronto, doing same day delivery of packages for their over 1000 customers. The service is like any other courier company providing a same day service guarantee. Couriers use public transportation rather than vehicles or bicycles and are paid on a commission basis per delivery. For this, each courier receives a monthly bus pass that they can use any time. They have a strong business ethic.

At the same time, A-WAY is a model of mental health accommodations in the workplace. Employees work flexible hours and varied hours, depending on their choice. Peer support is a big part of keeping this organization running. New hires are trained by peers and much time is taken to support each individual C/S, not only in maintaining their employment but in assisting with issues such as housing, community supports, pensions and all kinds of other advocacy issues. Social events and informal get-together are a big part of making this organization the tight team that it is. Donations of food and clothing are always available through their many partnerships.

www.awaycourier.ca

Sound Times, Toronto

Ten years ago Sound Times, a consumer operated service, had a budget of around \$200,000; it now has funding of over one million dollars. Sound Times has been supported by government via capital funding to buy the building they are located in. They provide:

- The opportunity to learn from peers to give and get support.
- Support to find food, clothing, and other essentials.
- Advocacy.
- Service co-ordination and referral.
- Education for members.
- Social and recreational opportunities.
- Support for consumers and survivors in contact with criminal justice.
- Harm reduction for drugs and alcohol.
- Community support.
- GAM (Gaining Autonomy with Medication) approach.

Sound Times has been heavily involved in providing a consumer/survivor voice in the current health system changes. Staff are expected to work from consumer/survivor informed practice.

www.soundtimes.com

Peer support programs within mainstream organisations

Leeds Survivor-Led Crisis Service, England

This service is part of mental health network in Leeds but maintains its own identity. The service operates:

- A help line in the evenings
- A house that is open in the evenings at the weekends, which can arrange transport for people who come, and includes a family room where people can come with their children

The service is staffed by paid employees and volunteers who have regular supervision and a monthly reflective practice group. Staff are trained in a variety of issues, including working with self harm, suicide, hearing voices, loss and bereavement. There is also a small emotional support budget for staff which includes counselling, gym membership and so on.

www.lslcs.org.uk

Recovery Innovations, Arizona

Recovery Innovations is a mainstream agency that has established services in four other American states as well as their home state of Arizona. The service creates opportunities and environments that empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves, others, and meaning and purpose in life. Some of its major programs are:

- Crisis support.
- Peer support & self help.
- Recovery education.
- Peer training & employment.
- Community living.

www.recoveryinnovations.org

Laing House, Halifax, Nova Scotia

Laing House is a youth-driven, community-based organization for youth with mental illness between the ages of 16 and 30 years with diagnoses of mood disorders, psychosis, and/or anxiety disorders. Many staff employed by the agency self identify as consumers, including some working as peer support workers. Laing House programs, including employment, healthy living, education, outreach, and peer and family support, are designed to help youth recognize and develop their own strengths, talents, and resources. Laing House describes itself as the first and only organization of its kind in Canada.

<http://www.lainghouse.org>

Certified Peer Support Specialists, Georgia

Certified Peer Specialists are responsible for the implementation of peer support services, which are Medicaid reimbursable under Georgia's Rehab Option. They serve on Assertive Community Treatment Teams (ACT), as Community Support Individuals (CSI) and in a variety of other services designed to assist the peers they are partnered with in reaching the goals they wish to accomplish. The training and certification process prepares Certified Peer Specialists to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve. Certified Peer Specialists are part of the shift that is taking place in the Georgia Mental Health System from one that focuses on the individual's illness to one that focuses on the individual's strength.

www.gacps.org

Learning and Recovery Center, Maine

This sits under the umbrella of a mainstream mental health service. The recovery center respite service allows people to stay between three and seven days. As well, the service provides peer support in emergency rooms, weekly peer meetings and ongoing education to mainstream staff. The service has worked through many issues in its partnership with the mainstream service that it is a program of, including a successful challenge of human resources policies that excluded people with a criminal history working for the Center. There has also been mistrust and lack of referrals between the Center and mainstream services which is now largely resolved.

The Center has been engaged in narrative evaluation of the service since it opened.

www.sweetser.worldpath.net/peers.aspx

Craigmillar Peer Support Service, Scotland

This is a recovery orientated service staffed by peer specialists who build a relationship with people to assist them in finding a way forward in life, as well as involving them in social activities. The staff have worked hard at gaining the trust of professionals, but this is still a challenge. An evaluation of the pilot showed that people who use the service were very satisfied with it and had been able to exceed their own expectations of recovery.

www.penumbra.org.uk/craigmillarpeersupport.htm

APPENDIX 2

A synthesis of international peer support curricula

Peer support curricula and qualifications have been developed in parts of the USA, Scotland, England and New Zealand, and are in the process of being developed in Australia (Peters, 2010) and Canada through the Mental Health Commission of Canada. Of these countries, Scotland, Australia and Canada are developing a national curriculum and qualification. Australia's curriculum covers all peer roles for consumers and family members in the mental health system, including advisory roles.

A synthesis of the content of the peer support curricula follows. No single curriculum includes or emphasises everything in this list. All the curricula emphasise lived experience of major mental distress and recovery as foundations for peer support. None of these curricula have a primary focus on addiction peer support, although Recovery Innovations has a separate addiction peer support curriculum. These items were taken from the following curricula descriptions:

- Katz, J., & Salzer, M. (2006). Certified peer specialist training program descriptions. University of Pennsylvania Collaborative on Community Integration. Available online.
- Mind and Body www.mindandbody.co.nz
- Recovery Innovations of New Zealand. (no date). *Peer Employment Training: New Zealand edition*. Unpublished manuscript.
- Intentional Peer Support www.mentalhealthpeers.com
- Scottish national curriculum <http://www.sqa.org.uk/sqa/42943.html>
- Australian national peer worker competencies www.cshisc.com.au/index.php?option=com_content&task=view&id=545&Itemid=162

The synthesised curricula headings

Personal development

- **Whole of life personal development** eg understanding own distress and recovery and personal skills
- **Work related personal development** eg understanding and planning for stress, burnout and vicarious trauma

Knowledge development

- **Wellbeing, mental distress, addiction and recovery** eg determinants of wellbeing and mental distress and addiction, and recovery and the process of recovery.
- **Helping systems** eg mental health and other systems, occupations, diagnoses and treatments, legislation.
- **Critical perspectives** on mental health and addictions eg power, coercion and re-traumatisation, consumer perspectives and experiences of helping systems.
- **Communities and cultures** eg discrimination, community development and cultural diversity
- **Values and key concepts** in peer support.
- **Peer support practices** eg WRAP, PACE, intentional peer support, recovery education.
- **Peer support ethics** eg autonomy, reciprocity, accountabilities, self-disclosure, boundaries, shared risk taking.

Skills development

- **Process skills** eg self-help management tools, collaborative note taking, strengths assessment
- recovery planning, organisational policy and procedures.
- **One to one skills** eg ability to share story for benefit of others, developing trust and rapport
- active listening, empowering and motivating others, assisting others to problem solve
- **Group skills** eg group dynamics, group facilitation, presentation skills, conflict resolution
- **Cultural and diversity skills** eg biculturalism and multiculturalism, The Treaty of Waitangi
- competence in Maori protocols, greetings in Maori and Pacific languages
- **Workplace skills** eg Working in challenging situations, workplace communication and culture
- advocating in the workplace
- **Community skills** eg networking, finding and working with community services and resources