Thematic Review of Peer Supports

Literature review and leader interviews

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Disclaimer

The Mental Health Commission is looking at how the development of peer support services can be supported, and commissioned this thematic review to stimulate discussion about the range of ideas being considered within the mental health and addiction sector. This paper does not necessarily reflect the views of the Mental Health Commission.

Every care has been taken in the preparation of the information contained in this document. The Mental Health Commission cannot accept any legal liability for any errors or omissions.

Conflict of Interest Statement

The author is employed by Mind and Body Consultants Limited, which was one of the groups interviewed. This organisation provides advisory, research and peer support services. The author is not involved in the delivery of peer support services.

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Executive Summary

This review identifies themes relevant to the further development of peer support for users of mental health services in New Zealand. It looks at what might be called formalised peer support, that is, support provided by paid peer support workers (PSWs) with personal experience of mental illness to other people with experience of mental illness. It examines definitions and models of peer support, common aspects of successful peer support, issues of integration or collaboration of peer support with traditional mental health services and the needs of special populations. The review makes four recommendations.

Definitions of peer support

Peer support can be defined as a relationship grounded in shared experiences. It is mutual, reciprocal and equal and can promote relationships that foster responsibility and critical self-awareness. It assumes no medical model of mental illness, challenges traditional deficit-based approaches to mental illness and asks service users to reflect critically and move on with their lives. Peer support roles differ from other roles in mental health because they are based on different philosophical assumptions. They carry no assumptions of deficit or historical baggage about the social support and maintenance of the disabled. Peer support is the only mental health role to emerge that is grounded intrinsically in recovery.

Effectiveness of peer support and service user-provided services

An evidence base for the effectiveness of peer support and other service user-provided services for people with experience of mental illness is still to emerge. Most studies are descriptive. The literature, however, is largely positive.

Models of peer support

Peer support can be based on several structural or theoretical models. Structural models of peer support in New Zealand often centre on the difference between so-called "integrated" and "independent" models. The former denotes peer support provided independently of traditional mental health services, usually by service user-run organisations, and the latter refers to peer support integrated within traditional District Health Board (DHB) or non-government organisation (NGO) clinical or non-clinical mental health services. There is some controversy over "integrated" models of peer support within the service user movement and the literature, with claims that insensitive integration or

collaboration with traditional DHB or NGO mental health service providers can compromise the integrity of peer support.

Common aspects of peer support

A review of the relevant literature coupled with interviews with experts found that successful peer support services share six aspects.

- A clear philosophy and guiding principles to ensure focus and differentiation from traditional support roles, ease of supervision, key performance indicators for PSWs and determination of outcomes.
- Integrity. Peer support is most effective when it is operationally independent, led by service users, not tokenistic or viewed as just another contract, supported by mental health managers, well supervised, based on understanding relationships with funders and has outcomes consistent with the role. It may be more difficult for peer support to maintain integrity when integrated within traditional mental health providers such as DHBs or clinical or non-clinical NGOs.
- Effective recruitment processes.
- Training consistent with the role. It is of concern that some service users working as paid PSWs receive no training.
- Effective supervision structure. Participants identified capacity-building peer support supervision as an urgent need.
- Fully developed organisational structure. Organisations providing peer support must be credible and able to provide effective peer support. The mental health sector has a responsibility to build capacity and capability among service user organisations.

Relationships with clinical and general mental health services

Relationships between peer support and clinical or general mental health services do not create particular problems. As with any emerging mental health role, relationships take time to develop but are helped by promoting and maintaining the integrity of peer support, supervision of PSWs, and training of clinicians and mental health service managers at all levels in peer support and the PSW role.

Uptake of peer support

The self-referral nature of peer support affects its uptake. Engagement is voluntary, and peer support services take time to become known among service users.

Peer support for specific groups

Māori, Pacific and Chinese participants say peer support translates well across cultures, but requires adaptation to the cultural needs of each group. Peer support for specific groups or populations should have sufficient operational independence to ensure the unique cultural aspects of the service are respected and preserved

Recommendations

The four recommendations are as follows.

1. Maintain a choice of peer support services. There is enough scope for a variety of different peer support philosophies and service structures to be maintained. The key consideration when choosing a provider is whether the provider offers safe, effective, clearly defined and credible peer support that will benefit service users. The success or otherwise of a service is ultimately determined by philosophical, organisational and individual factors that transcend particular models.

2. Ensure that PSWs receive credible training consistent with their role. The sector is strongly urged to engage in a debate about how to develop a minimum level of competency and a career pathway for PSWs.

3. Ensure that there are effective supervision structures for PSWs. This may be possible only with active support from funders. Building capacity and capability in peer support supervision should be a sector priority.

4. Develop organisational capacity and capability. Insufficient management and organisational capacity and capability are serious obstacles to the continued development of service user-run peer support. Peer support should be provided only by credible organisations that can demonstrate both capacity and capability. The sector has a responsibility to help to actively develop capacity and capability.

Introduction

This thematic review was produced to help the Mental Health Commission and others make informed decisions about the development of peer support for users of mental health services within New Zealand. The review covers the nine broad themes of:

- definitions of peer support
- models of peer support
- efficacy of peer support or peer-run services
- common aspects of successful peer support
- issues of collaboration and integration of peer supports and general or clinical services
- uptake of peer support
- consideration of the needs of specific groups
- differences and commonalities in peer support for various population groups
- expert and leadership insight and understanding of the above points.

This review is solely concerned with "formalised peer support", which refers to peer support provided by people with experience of mental illness, with clearly defined structures, assumes training specific to the role and which involves paid work for formally employed peer support workers (PSWs). The term "peer support worker" is used because it is probably the most commonly used title for the role in New Zealand. Some organisations use the term "peer support specialist". This review's focus on formalised peer support necessarily excludes peer relationships such as those found in peer-run drop-in centres, mutual support groups such as GROW and voluntary buddy systems. This is not to deny the value of these services, which are valued highly by service users, but they have few mental health workforce development implications and they rarely receive health funding.

Methods

Literature search

In 2004 the Mental Health Commission sponsored a systematic review on the effectiveness of peer-provided services (Doughty & Tse 2005). One purpose of this review is to look at literature published since then to assess any changes in the evidence of the effectiveness of peer support and peer-run services.

Medical and social science databases – PsychINFO, Medline, Cochrane Library, Sociological Abstracts and Google Scholar – were searched for relevant articles. An Internet search was conducted for relevant grey literature.

Interviews

A list of individuals and organisations, including both District Health Boards (DHBs) and non-government organisations (NGOs), with experience or expertise in peer support in New Zealand and internationally was drawn up. Those on the list were asked if they wished to take part in telephone or, where permitting, face-to-face interviews. A small number of organisations declined to participate. In total, 20 individuals individually or in their organisational capacity agreed to be involved. Participants were either experienced peer support providers, experts in some aspect of peer support such as training or supervision, service managers or funders and planners.

Table 1. Participants

Te Pou – service user mental health workforce development overview.	Ivan Yeo, New Zealand Mental Health Foundation, Asian Like Minds Like Mine – expert on Chinese peer support.
Mind and Body Consultants Ltd – service user-owned and -run provider of advisory, research and peer support services. Peer support services in Auckland, Waitemata and Canterbury DHB. Intensive support service in Auckland DHB.	Dean Manley, New Zealand Mental Health Foundation. Formally Case Consulting and Walsh Trust – peer support provider and expert.
Counties Manukau DHB – peer support provider, DHB-wide peer support training.	Jane Briscoe – peer support trainer and supervisor.
Appalachian Consulting Group in association with the Depression and Bipolar Support Alliance (United States) – United States peer support consultants, development and training.	Shery Mead – Shery Mead Consulting. United States-based peer support trainer and expert.
Mana Mental Health Services – service user-run peer support provider.	Chris Hansen – Shery Mead Consulting. United States-based peer support trainer and expert.
Affinity Services – NGO peer support provider.	AMHS (Action for Mental Health Society) – NGO peer support provider.

Definitions of Peer Support

When asked to define peer support, service users often mention expressions such as autonomy, self-determination, belonging, a shared understanding of experiences, hope, voluntary rather than coercive, feeling safe and having choices about services and their lives (National Consumer Forum, 2006). Some studies have sought the "critical ingredients" of peer support (Clay, 2005; Solomon, 2004; Salzer, 2002) and found they include several structural qualities (absence of coercion and hierarchy, rejection of medical models of mental illness) and beliefs and values (relationships based on shared experience, empowerment, mutual help, taking responsibility, choice and decision making). These critical ingredients provide the psychosocial processes within peer relationships that, it is argued, benefit people with experience of mental illness (Solomon, 2004).

Put another way, peer support challenges at a fundamental level traditional notions of mental illness and its treatment by posing a new interpretive framework to understand and recover from mental illness. Moreover, it challenges those who experience mental illness by promoting critical self-awareness. Shery Mead (2003), in perhaps the most comprehensive definition of peer support, defines peer support as:

> a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others whom they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles.

Most participants in this review defined peer support in similar terms. The assumptions inherent to peer support, they argued, fundamentally challenge traditional mental health systems and beliefs. It was felt that peer support should lead mental health services from

deficit-based to recovery-based approaches to mental illness, and that it should challenge service users to critical reflection and to move forward in their lives. On such terms, peer support roles differ from other roles in mental health because they are based on different philosophical assumptions. They carry no medical assumptions of deficit or historical baggage about the social support and maintenance of the disabled. Peer support is the only mental health role to emerge that is grounded intrinsically in recovery.

Efficacy of Peer Support and Service User-Run Services

The Mental Health Commission-sponsored study by Doughty and Tse (2005) looked at the effectiveness of service user-provided services, which were defined as a programme, project or service planned, administered, delivered and evaluated by a service user group based on needs defined by service users. It found positive service user outcomes from use of service user-run services. These included reports of higher levels of satisfaction with services, general wellbeing and quality of life. Other studies reported no significant differences in outcome between service user-run services and traditional mental health services. No study reported harm to service users from use of service user-run services or concluded they were less effective than equivalent traditional services. Doughty and Tse (2005) issued a caution about interpreting results from a limited range of services. Many studies are of services where service users work alongside clinicians or as members of case management or crisis teams. There are few studies of purely service user-run services.

This review of literature published since the middle of 2004 does not substantially alter Doughty and Tse's (2005) conclusions, and the same caution applies to interpreting results from a limited range of studies.

One study, a four-part longitudinal examination of consumer initiatives using a quantitative, qualitative and participatory action research framework (Nelson et al, 2006a, 2006b; Ochocka, et al, 2006; Janzen et al, 2006), looked at both individual and system impacts from use of consumer initiatives in Ontario, Canada. The qualitative component of the study used a non-equivalent control group design to compare new, active participants in consumer initiatives with non-active participants at baseline, nine-month and 18-month follow-up intervals. The two groups were comparable at baseline on a wide range of demographic variables, self-reported psychiatric diagnosis, service use and outcome measures. At nine months, there was a significant reduction in the utilisation of emergency room services by active participants, but not by non-active participants. At 18 months, the active participants showed significant improvement in social support and quality of life (daily activities) and a significant reduction in days of psychiatric hospitalisation, whereas the non-active participants did not show significant changes on these outcomes. Active

participants were significantly more likely to remain in employment (paid or volunteer) and/or education over the 18-month follow-up period than were those who were not active.

A study by Rivera et al (2007) compared consumer-assisted and non-consumer-assisted case management with standard clinic-based care. The consumer role focused on the development of social support by using peer staff who matched the profile of participants. A total of 203 clients were randomly assigned to one of the three conditions and followed for 12 months. Results failed to find any one programme to be categorically superior.

Rowe et al (2007) compared the effectiveness of two interventions in reducing alcohol use, drug use and criminal justice charges for people with severe mental illnesses. An experimental group used community-oriented group intervention with citizenship training and peer support that was combined with standard clinical treatment, including jail diversion services. The control group used standard clinical treatment with jail diversion services alone**.** The experimental group showed significantly reduced alcohol use in comparison with the control group. Results also showed a significant group-by-time interaction, where alcohol use decreased over time in the experimental group and increased in the control group. Drug use and criminal justice charges decreased significantly across assessment periods in both groups**.**

Corrigan (2006) looked at the cross-sectional relationship between participation in consumer-operated services and measures of recovery and empowerment. A total of 1,824 service users indicated whether they had participated in a peer support programme during the past four months in addition to two five-factor measures of recovery and of empowerment. Results showed that participation in peer support was associated with 9 out of 10 factors generated by the recovery and empowerment instruments and remained significant when commensurate demographic variables were controlled for. Participation in a peer support programme did show a significant association with multiple outcome and recovery subscales, but the magnitude of the effect was small. The associative nature of the data, however, precluded stating that peer support caused the observed improvement.

Overall, the literature on consumer-provided services is largely positive, but there is almost general agreement that consumer-provided services and, in particular, peer support, is a developing approach in mental health and further research is required.

Models of Peer Support

"Models" of peer support can refer to structural models or theoretical models of peer support. Both encompass a range of different service configurations and philosophies that defy easy categorisation. Distinct, replicable models of peer support exist only in a very broad sense. Many participants in this review argued that the "model" is perhaps less important than the constituent parts of a peer support service. Most successful peer support services have common aspects that transcend structural or theoretical characteristics. The one certainty, especially in New Zealand, is that the subject of models of peer support is controversial.

Theoretical models

One participant in this review who is familiar with the range of peer support providers in the United States identified three broad theoretical models of peer support.

- Peer support that does not assume any framework of understanding or medical model of illness. This model is usually, but not exclusively, favoured by service user-owned and -operated providers.
- A loose model based on hope and recovery rather than illness. It uses tools like Wellness Recovery Action Plan (WRAP) but often spurns definition or description as a model. It can have a range of provider types.
- A model tied to the traditional medical model but distinguished by more disclosure in the relationship. Like the clinical model it is uni-directional. It is peer support only in that stories are shared. For some, it embodies good clinical practice.

No doubt other theoretical models exist but most New Zealand peer support providers can be placed within at least the first two models. Other models may include peer support with a primary focus on advocacy or education of service users (Woodhouse & Vincent, 2006).

Structural models

In New Zealand, and especially within the service user movement, models of peer support are often stated as a dichotomy, a pair of opposites, with ownership or control of peer support the demarcation. Discussion often focuses on a central structural distinction between the "integrated" model and the "independent" model.

- An "integrated" model implies some degree of organisational integration of PSWs within a larger non-service user-run organisation. PSWs are employees of this larger

organisation. Often there is a further division of this model into the type of organisation, either formal clinical mental health services such as DHBs or NGO providers of clinical or non-clinical services. The degree to which peer support has operational freedom varies greatly between organisations as does the extent of service user influence or presence at management levels.

- An "independent" model implies independence from traditional providers of mental health services, whether DHB or NGO, and almost always within entirely service user-owned and -operated organisations.

Service users, in particular, often express a strong preference for "independent" peer support. This may reflect two important factors: a declaration of ownership of peer support by service users and an underlying fear that peer support integrated within traditional service providers will result in the capture of PSWs or the corruption of peer support values. In New Zealand, service users view the mental health system as primarily medically and deficit focused despite official adoption of recovery approaches. Therefore, peer support is considered to have more integrity the further it is from the control of clinical services.

The "integrated" versus "independent" demarcation proved to be the only contentious subject encountered in a review that demonstrated broad consensus on almost everything else. This may reflect to some extent the structure of peer support within New Zealand – a small number of providers of limited size (few have more than 10 full-time equivalent (FTE) PSWs) but a wide variety of provider types.

Table 2. Providers of peer support to users of mental health services in New Zealand

Type	Provider
Service user-run	Mind and Body Consultants Ltd – peer support, Auckland DHB, Waitemata DHB, Canterbury DHB. Intensive Support Service, Auckland DHB.
	Mana Mental Health Services – peer support, Lakes DHB
	Wellington Mental Health Consumers Union – peer support, Wairarapa DHB
Non-government organisation	Pathways Trust – crisis house, Counties Manukau DHB

Type	Provider
	Wellink Trust – crisis house, Capital & Coast DHB
	Affinity Services – peer support, Auckland DHB
	AMHS – peer support, North Shore, Auckland DHB
	WIT – peer support, Hawke's Bay DHB
	Walsh Trust – peer support, Waitemata DHB, Auckland DHB
District Health Board	Counties Manukau DHB – peer support, the Cottage (Community Mental Health Centre), Counties Manukau DHB.

There are a small number of service user-run peer support providers such as Mana Mental Health in Rotorua and the dominant service user-owned and -operated provider Mind and Body Consultants Ltd based in Auckland Central and with branches and peer support services in Waitemata and Christchurch. There are larger numbers of NGO providers such as Wellink, AMHS (Action for Mental Health Society), Affinity Services, WIT and Pathways. These NGOs provide a wide variety of peer-provided services, including crisis houses that employ PSWs but are not peer run. Of the DHBs, Counties Manukau employs PSWs within one of its community services as part of a multi-disciplinary team.

Development of peer support is growing rapidly and this has highlighted a lack of capacity among some service user organisations. One result is a fear that, beyond a small number of established service user-providers, the provision of peer support will be dominated by non-service user organisations. The emergence of Counties Manukau DHB's peer support service using the META Services model from the United States concerned some service users when it was announced as it integrated PSWs within clinical services. Some feared funders would favour this model because it appeared to place PSWs under clinical control. Those who were aware of these concerns within the service user movement tried to promote a range of different peer support services to encourage choice and innovation.

Clay (2005) reports similar concerns in the United States where consumer leaders stress the inherent dangers of partnership with traditional providers: peer-run programmes will lose their emancipatory and caring functions, become linked with coercion and involuntary treatment, be locked into inherently unequal partnerships, and have little real power and responsibility. Hodges and Hardiman (2006) looked at collaboration, defined as mutually

beneficial interactions, between traditional services and consumer-run agencies. They found no conclusive answer on whether collaboration was occurring or the qualities that engender it. Interestingly, they state that collaboration is not always recommended where the relationship may result in loss of identity, where philosophical incompatibility precludes compromise or where an inherent power imbalance necessitates cooptation of service user-run services.

Similar views were expressed by most participants in this review, and almost unanimously by the service user participants. One service user-run provider argues that its independence from traditional services has a profound influence because it does not have to engage in relationships that might be unequal or might involve compromising its principles. The same provider points to anecdotal evidence from service reviews and three-monthly service user reviews of one of its services that clients value its independence and that this makes it more effective than traditional support services. The service has a role normally performed by community support workers – level one and level two supports enabling clients to live independently in the community – but uses the same model as the peer support service.

General providers do not entirely agree with service users on this subject. One organisation states that its association with the META Services model occurred because at the time it was looking at peer support little research was available on the efficacy of different models. The META training was the most comprehensive it found. META had competent, well-trained peers and the curriculum was robust. The organisation wanted peer support, and META, in its opinion, offered the best training. Integration and the fact META's training included a module on PSWs working in partnership with professionals were factors, but not primary ones, in its choice. The organisation wanted a good peer support service and an enhancement of the recovery approach sector-wide within its DHB area.

There is tacit acknowledgement that integrated peer support can risk the integrity of peer support but also an awareness that successful peer support of any model depends largely on its ability to maintain its integrity and independence. In addition, service user leaders acknowledge that beyond a small number of service user providers there is insufficient capacity in service user organisations to meet the peer support needs of service users.

Leaving aside this debate, there was broad consensus over the common aspects of peer support.

Common Aspects of Successful Peer Support

Participants identified six aspects common to peer support services that can be judged successful. These aspects are:

- a clear philosophy and guiding values
- the maintenance of the integrity of peer support
- effective recruitment
- training consistent with the role
- an effective supervision structure
- a fully developed organisation structure.

Philosophy and guiding values

The importance of concrete values in peer support emerged consistently as a theme from interviews. A peer support service with a guiding vision or clearly defined set of beliefs or ethics is more likely to succeed than one lacking clear direction. These values should also be clear enough that the organisation can be evaluated against them. One participant, an experienced trainer and supervisor of PSWs, argued that clearly defined ethics and beliefs should underpin everything a PSW does. “Having a philosophy”, she declared, “makes everything easier – job descriptions, supervision, key performance indicators for peer support workers ... everything. Not having a clear philosophy can mean lack of focus. You only have outputs not outcomes”.

Without guiding principles that clearly differentiate peer support, it risks replicating the dependency culture characteristic of so many traditional mental health services. Peer support can become another drop-in service if it does not challenge service users. Service users often seek comfort and it is too easy for service providers to collude in this. To counter this tendency peer support organisations should have a clear outward focus – peer support should support people for a period with an expectation that they then move on if they no longer need the service. Several participants noted how counter-intuitive this is: it goes against the instinct to, in the words of one expert, “mother” service users.

Several participants argued that successful peer support providers are committed to reflective practice – what one participant called a process of “reflection, action, reflection” –

and are able to retain this quality in training and supervision despite the inevitable discomfort that constant challenging engenders. Organisations should be consistent with the peer support goal to support service users to see their own experiences in relation to a larger context and to move on with their lives.

Maintenance of the integrity of peer support

Integrity as an ethical concept means that one's actions are based on an internally consistent framework of principles. A peer support service with integrity has principles and the freedom to follow them. How to maintain the integrity of peer support emerged as a major theme during interviews. Many participants argued that for a peer support service to be considered successful it must maintain its integrity. There was tacit acknowledgement that peer support more closely associated or integrated with more traditional services was at greater risk of compromised integrity than was peer support associated with more independent providers.

Tokenism

Two threats to integrity are tokenism and disingenuousness. A participant from the United States noted that it is common in that country for service users to be hired as PSWs but end up performing the lowest type of case management. Peer support becomes a bottom-of-the-heap job. The provider's motive behind establishing peer support may, in fact, be disingenuous with service users a token presence to enable providers to fulfil their service user participation requirements. Often peer support is an add-on service or one component within a suite of services but with little to distinguish it. Service users, one participant noted, often cannot tell the difference between a PSW and other types of support worker. Participants observed that this was a problem mostly with NGO providers.

Participants suggested several strategies to guard against tokenism. Peer support team leaders should be peers and members of senior management teams. This may prevent the peer support service becoming tucked underneath other services and little more than a tacked-on service. Some participants argued that funders should see proof that there is peer leadership of peer support, that the service is credible and not just a contract. If a peer support team is integrated within a larger organisation it should, ideally, retain operational independence.

Leadership support

Leadership support and leadership understanding of the peer support role was also cited as essential to help maintain the integrity of peer support. One NGO peer support provider noted that its integrity had been maintained within the organisation because the peer support service's independence had direct support from the chief executive and the board. It believed that this would have been much more difficult had the chief executive and board not been so directly supportive. A DHB peer support provider also stressed the importance of leadership support. It argued that the DHB's general manager funding and planning manager and line managers support and believe in peer support and some were involved in its development. The same provider stated that it was important to train all managers across the organisation from the chief executive to the front-line managers of peers in the peer support role, the philosophy of the peer support service and the recovery approach.

The integrity of peer support can be undermined by what one participant called "systems erosion" whereby peer support is subjected to mental health system requirements developed with a different underlying philosophy and value base. Without a clear understanding of its role, peer support will have difficulty relating to other professions and boundaries will be unclear. Similarly, peer support can lose integrity if it is not clearly differentiated from other support roles. Peer support is radically different from other support roles; how and why should be made clear.

Supervision

Effective supervision will also help maintain integrity. A skilled supervisor, knowledgeable about the peer support role, can help PSWs to "stay peer". External supervision, especially, can help PSWs to step out of their role to understand and reflect on what they do. Effective supervision is crucial to the development of emerging roles like peer support.

Build relationships with funders

One of the clearest ways to undermine peer support is to demand inappropriate outcomes or have expectations that peer support can never meet. Peer support should never have to meet clinical outcomes or, for example, be asked to show a direct relationship between the use of peer support and reduced inpatient admissions.

Participants noted how important the relationship is between peer support and funders. Funders should understand how different peer support is from other mental health

services, that the role is developing and that agreement on outcomes and how to measure them will take time to emerge. The expectation of reporting can greatly influence the success of a peer support service. One NGO provider had initial problems while its funder developed an understanding of just how different peer support is as a service. It has yet to find a formalised structure for reporting with which everyone is happy, but it has established a good relationship with its funder.

Funders might set indicative outputs such as contact hours, types of activity, number of people using the service, range and average time spent in the service, but should not attempt to dictate things like caseloads that may force peer support to mimic clinical services. One service user provider's experience with caseloads is illustrative. To maintain its integrity as a service user-centred and service user-driven service it initially refused to work with caseloads. This made its funder nervous but the provider was able to negotiate not initially having a caseload requirement. As it gained experience, however, it judged a caseload of 7 to 10 service users per full-time equivalent PSW to be reasonable. Its new peer support and additional support service contracts now specify a caseload of 7 to 10 and an expectation that its PSWs will spend 60 percent of their time working with or on behalf of individual peers. To build relationships with funders it is essential to be "proactively honest", as one service user provider put it. Be candid about successes and failures; funders hate surprises.

Outcomes consistent with the philosophy of the peer support service

The outcomes to measure from peer support and how to measure them are still in the early stages of development. There is broad consensus that any outcomes from peer support should be agreed, stated in the contract with the funder and consistent with the philosophy of the service. Peer support should never be judged by clinical outcomes. Outcomes will most likely emerge from qualitative measures that capture the impact of peer support on service users' lives. This will involve thinking more broadly than mental health. Most peer support providers are yet to consider outcomes seriously beyond regular satisfaction surveys.

The exception to this is Mind and Body Consultants Ltd. Since the intent of its service is to promote the autonomy of those who engage the service, it seeks to measure whether the autonomy of its service users has increased. It has tried to demonstrate this with perception of service surveys that measure whether PSWs respect and promote autonomy

and exit surveys (which have low returns) and by measuring goal achievement after three and six months. It has begun to explore the two more sophisticated measures of:

- three-monthly reviews, similar to clinical reviews but more user centred, which will use a client interview process
- a standardised quality of life measure – the WHOQOL (World Health Organisation Quality of Life Assessment) – as an outcome measure to be used every three months.

Table 3. Strategies to maintain the integrity of peer support

Factor affecting integrity	Strategies to maintain integrity of peer support
Tokenism	Peer support team leader should be a peer Team leader should be a member of the senior management team Peer support should be operationally independent Funders should ensure there is peer leadership Funders should ensure the service is credible
Leadership	Explicit support for peer support from all levels of leadership Training of all managers, from chief executive to line managers, in peer support
Systems	Clear understanding of the role of peer support Peer support clearly differentiated from other support roles Policies and procedures adapted to support development of peer support workers (PSWs)
Supervision	Skilled, knowledgeable supervisors help PSWs to “stay peer” External supervision Active development of peer supervision capacity
Funders and outcomes	Understand that peer support is different form other forms of support Build mutual understanding between peer support service and funder Ensure outcomes consistent with the philosophy of the service Never demand clinical outcomes Accept that outcomes from peer support are evolving Look for qualitative measures that can capture the impact on lives Look for outcomes that are broader than just mental health outcomes

Effective recruitment

Qualities needed in effective peer support workers

Peer support is a challenging job. Successful PSWs are "grown-up", intelligent, thoughtful and emotionally mature. Experienced peer support providers suggested five qualities are required in effective PSWs. PSWs should:

- have integrated their experiences of mental illness into their lives so they see value in their experiences and do not feel ashamed
- be able to think critically and reflect on what they do and why they do it, and be capable of making judgements based on reasons
- have values consistent with the peer support service for which they work
- have a good understanding of marginalisation issues, stigma and discrimination
- be emotionally mature and objective.

Recruit people who can do the job

The most consistent insight, however, is for providers to recruit only those people they think can do the job (Chinman, et al, 2006; Carlson et al, 2001). One experienced provider declared that a "special recipe for disaster is the belief that you should employ someone because you think it will do them good. That might be a secondary gain, but it is not the reason for employment and should never be". The helper principle much cited in the literature as a provider benefit of peer support (for example, Salzer & Shear, 2002) should only be a secondary consideration during recruitment.

Minimum size for a peer support service

The service should be of sufficient size that it does not place undue strain on PSWs should one or more leave or become unwell. To recruit just one PSW places too much pressure on one individual (Chinman et al, 2006).

Another consideration, especially for smaller organisations, is to have sufficient PSWs to cover overheads and establish a critical mass. A service user provider believed that a desirable minimum is a service of four FTE PSWs. A service of three FTE PSWs is the bare minimum to get synergies and economies of scale to cover overheads. The same provider suggested that a PSW attrition rate of 20 percent per year is acceptable. In his

experience, no matter how careful the recruiting process neither the PSW nor the employer will know for certain if a PSW is suited to the role until they are doing it.

Training consistent with the role

Training of PSWs in New Zealand is evolving rapidly. While some PSWs complete well-developed and robust training programmes before they begin work and receive ongoing training and support, some PSWs receive no training at all and some no training consistent with the role. The quality, level and content of available training varies enormously from none to Counties Manukau DHB's 72 hours (with an additional 16 hours WRAP training), to Mind and Body's (in application) New Zealand Qualifications Authority accredited, 820-hour, one-year Certificate in Peer Support (Mental Health) (level 4).

Models of training

Two broad models of training are available in New Zealand: in-house training and generic training programmes.

In-house training

Some peer support providers recruit and then train PSWs using an in-house-developed training programme. Several service user and NGO providers train in-house, with proponents arguing that such training is flexible and adaptable. One service user provider, for example, says its training creates an ideal feedback loop – practical experience and supervision feeds directly and quickly back into training. It can be highly responsive to the needs of a developing role and follow-up training is relatively easy to implement. This type of training, however, can be expensive to develop and deliver; not every organisation has the capacity or resources to develop sufficiently robust in-house training. The quality of training within some organisations is difficult to assess.

Generic training programmes

Generic peer support training programmes prepare people for employment in peer support or other peer roles but provide no guarantee of employment. The training has often been developed in the United States and uses visiting facilitators. Some programmes also train service users to facilitate training. Shery Mead and Chris Hansen (www.mentalhealthpeers.com), for example, offer regular week-long peer support training and train-the-trainer programmes in intentional peer support. A DHB provider uses regular

training from Recovery Innovations in the United States. This training was developed by META Services in Arizona.

Generic peer support training provides some consistency in training between different providers. One provider says generic training makes recruitment easier because it can draw from a pool of trained candidates who already understand peer support concepts and aspects of the role. There is, however, a continued need for ongoing training and support that is usually provided in-house. This model of training can be inflexible, slow to feed back from practice, and may require significant adaptation to local needs. Critics of generic training programmes argue that such programmes limit the peer support recruitment pool to those who have the time or resources to complete the training, so may miss highly qualified potential candidates. In addition, service users may complete peer support training and be employed by organisations that provide little support or further development in the role.

The appendix provides examples of training modules from Mind and Body Consultants and Counties Manukau DHB. Mind and Body is applying for its training to be an NZQA-recognised qualification with a large practical component. Counties Manukau provides a generic training programme based on and facilitated by Recovery Innovations. Details of certified peer support training programmes in the United States have been assembled by Katz and Salzer (2006).

Competencies

Several participants argue strongly that the non-professional character of peer support – such as mutuality and equality in relationship – should not be lost with the emergence of a trained and paid peer support workforce. Peer support by definition is non-professional support. One provider, for example, adopts META Services' motto "experts at not being experts" to describe the role. Few in the sector would want peer support taught within tertiary institutions by tutors who may have little or no practical experience in providing peer support. There is strong support for peer support training to rest with service users.

Considerable concern was also expressed that some PSWs receive little or no training and no supervision, and that peer support providers should demonstrate that their PSWs receive some level of credible and appropriate training. There was some argument in favour of minimum competency standards for PSWs in New Zealand to ensure safety and

provide value for service users, but there was little consensus about how to proceed with this. Some suggested national training or the completion of approved training programmes. The Ministry of Health's Let's Get Real project to build essential knowledge and skills in the mental health sector was one suggested possibility. There was also wide support for maintaining innovation and choice in peer support training and avoiding a one-size-fits-all approach.

One of the key insights from this review is that training on its own is insufficient. It must be accompanied by continuous support and supervision. One provider pointed out that "if you are entering intentionally a supportive relationship then potentially you are getting into deep water – revelation of trauma history, suicidal intent, hearing something that is distressing". The nature or depth of the peer relationship has no bearing on the potential for a PSW to get out of their depth. Peer support encompasses a range of potential relationships from buddy systems in inpatient or community settings to highly purposeful and structured relationships. There is equal potential in each type of relationship for PSWs to be exposed to suicidal intent or experiences that are distressing or traumatising. "You can't just have a bit", the same provider argued, "just training is not enough. There must be continuous support. Depth of training is probably less important than having a safe structure to work within. That means supervision".

Effective supervision structure

Supervision should ensure safe, ethical and effective practice for all parties. The literature (Gates & Akabas, 2007; Carlson et al, 2001) grants supervision an important but limited role perhaps because it focuses on integration strategies for service user employees. Several peer support providers interviewed for this review admitted they did not understand in the early stages of their service the importance of supervision. Indeed, effective supervision was identified by every participant in this review as the single most important element in successful peer support and one where capacity building is most needed.

All peer support provider participants in this review use some form of supervision, although its structure varies with available resources and suitable supervisors. Most provide one-to-one supervision and almost all use some form of group supervision. Smaller organisations, especially service user organisations, struggle to find suitable, trained supervisors. DHBs and larger organisations have sufficient resources to provide trained supervisors internally

but outside the peer support team. One NGO provider, for example, provides internal line manager supervision and monthly individual supervision external to the team but drawn from within the wider organisation. A DHB provider admits that it did not initially appreciate the importance of supervision and had trouble finding suitable supervisors who understood the role. It provides individual supervision with supervisors from within the wider DHB and one external supervisor, and monthly group supervision where PSWs bring along an issue to discuss. The DHB is building peer support supervisor capacity through supervisor training provided by Recovery Innovations. More than 20 people have completed the training. The most rigorous supervision is provided by one of the service user providers. It has an entirely service user workforce, and admits to initially underestimating the importance of supervision, especially external supervision, but has since developed a supervision structure that it believes is an optimum for peer support. Each PSW receives:

- one-to-one formal line management supervision with their team leader monthly
- one-to-one supervision with an external supervisor monthly
- structured group supervision fortnightly
- less structured group supervision fortnightly.

The provider will also pay for three sessions with a professional counsellor if required.

Local networks in which PSWs from different organisations can meet were described as highly beneficial. One such network exists in Auckland. Participants familiar with local networks recommended that regional and national structures should be developed to foster networking and mutual support as peer support services develop.

Participants unanimously considered supervision critical to the success of peer support and felt this was the process in most urgent need of development. Supervision is a specialised, professional process that needs to be conducted with skill and understanding. Although supervision in peer support is no different in process from clinical supervision, its content is different. This is not just because PSWs already carry vulnerability from their experience of mental illness and use of mental health services, but also because the peer support role is so different from traditional support or clinical roles. Participants suggested that peer support supervisors need:

- an understanding of and belief in the peer support role, the service model and philosophy

- to be, ideally, service users and have undertaken the same peer support training as the PSWs they supervise
- training and experience in supervision
- to be external to the peer support team and, ideally, external to the organisation.

Although external supervision can be expensive and needs considerable sector-wide capacity building, there was almost complete unanimity among participants that external supervision is the ideal. This is not just to establish a safe distance between PSW and employer. It was also noted that external supervision can support the development of an emerging role. Organisations where peer support is integrated or working closely with more traditional clinical or support roles within DHBs or NGOs see external supervision as crucial to help maintain the integrity of peer support.

Suggestions were also made for the development of supervision. It was noted how hard it is for organisations, especially service user organisations, to design a supervision structure if there is little or no supervision capacity. Funders must be sensitive to this and be prepared to help develop supervision capacity in peer support. Many participants argued that arrangements and funding to build supervision capacity be built into peer support contracts and that the sector has a responsibility to help develop peer support supervision.

Fully developed organisational structure

Service user participants argued that building capacity among service users is one of the biggest obstacles to further development of peer support within New Zealand. Wituk et al (2008) in a study on the organisational capacity needs of consumer-run organisations in the United States identify the four core capacity areas as:

- technical (funding applications, information technology, reporting)
- management (staffing, business management, policy development)
- leadership (board development, transition planning)
- adaptive (strategic planning).

They identify the greatest needs in technical and management capacity.

One service user provider revealed how it initially struggled because of a lack of formal management training and an inability to undertake things like strategic planning. It

managed to build capacity by taking advantage of free management courses and bringing in people with specific expertise who could help the company develop capacity.

Service user organisations, however, have some unique characteristics. They often suffer from poor leadership and management, infighting and the pursuit of personal agendas to a greater extent perhaps than other organisations. Their reliance on charismatic leadership is also perhaps unique, but probably also a requisite for success. Service user organisations are social agencies rather than businesses. They are on a mission, and charismatic leadership can prove essential: it helps keep an organisation focused and innovative and it prevents infighting. However, it can leave the organisation reliant on one individual and therefore vulnerable.

Successful service user-provided peer support will succeed if it is provided by a credible organisation (which is different from an organisation having credibility). This means the organisation should be able to demonstrate that it has sufficient technical and management capacity – recruitment policies, a supervision structure, financial systems, and comprehensive policies and procedures – to provide peer support. One service user leader stated that it is time to lose the assumption that to be mad is to be incompetent. Service user organisations should be held to the same standards as other organisations.

Participants had three suggestions for building service user capacity.

- Ideally, assistance with building capacity should come from other service user organisations. The reality, however, is that service user organisations often compete for new funding and are reluctant to share intellectual property that could be used to compete for contracts.
- Make use of free business development workshops and courses.
- Identify and recruit as mentors, people who have management or technical skills but who do not publicly identify as service users.

Several participants suggested that it was incumbent on the mental health sector to fund capacity building among service user organisations and that this should be a priority.

Participants also noted a need to build peer support capacity among DHBs and NGOs especially by training managers to ensure they are fully supportive of the peer support role, can demonstrate how it fits within the business plan, and can adapt their management styles and systems to the requirements of peer support. Human resource

systems, in particular, may need to be reviewed to support PSW development.

Interaction and Relationships with Clinical Services

How peer support interacts with clinical services depends on several factors. The character of relationships between clinicians and peer support service integrated within clinical services are probably quite different from those in more independent services provided by NGOs or service user organisations. Belief systems and philosophies also influence the character of relationships. A peer support service guided by a belief in the inherent incompatibility of peer and traditional professional world views will probably relate differently to clinicians than will providers more open to partnership or integrated within clinical services. The intensity or purposefulness of the peer relationship will further influence this. The more actively service users are supported by PSWs to self-advocate and make their own decisions, the greater the likelihood of PSWs coming into disagreement with clinicians. Yet it is possible to over emphasise the potential for troubled relationships. While this review found significant differences in relationships with clinical services between different models of peer support, it was also clear that the development of relationships have common aspects that transcend models and belief systems.

One NGO provider had not faced tension between PSWs and clinicians because the organisation's peer support service was limited in function and fully integrated within other support teams. The provider expected this to change once PSWs were integrated within the NGO's crisis team and began taking a more active role in the organisation. Other peer support providers, however, gave examples of disagreement or tension between PSWs and clinicians. These tended to occur in two broad areas.

- Disagreements in approach over individual service users. The most common tension, according to one provider, is clinicians claiming PSWs are not consistent with management plans and may undermine what clinicians are trying to achieve with some service users.
- Personal and professional relationships between PSWs and clinicians. Some clinicians feel challenged by peer support. They are not accustomed to service users being actively supported to self-advocate and take charge of their own recovery. Similarly, the response of other professions to the introduction of peer support can create tensions, especially in the early stages of introducing peer support.

One experienced peer support provider believes that disputes over how best to approach a service user arise partly out of ignorance of the peer support role and partly because of what the provider calls “control issues”. Clinicians, the provider claims, “did not know what peer support does, may think that they know what it does but are wrong, or know what it does but want it to do something else”. The provider believes the latter problem is essentially about power and control. A clinician, for example, may want a PSW to help control a service user on the clinician’s behalf, or the clinician wants to control the service user but does not want peer support involved because it may threaten the clinician’s control. Another provider sees something similar in the way clinicians sometimes test boundaries. The clinicians may want to set the role of peer support or simply be very busy and be tempted to “try it on”. A service user-run peer support provider argues that tensions rarely develop between PSWs and service users. The authentic nature of the peer relationship lessens the potential for the relationship to collapse. Traditional support roles are more prone to collapse, one provider suggested, because of a lack of authenticity in the relationship resulting from coercion or unjustified paternalism.

Confidentiality, a consistent theme in the literature on consumer-provided services (Gates & Akabas, 2007; Carlson, et al, 2001), was not raised as an issue by participants in this review. Access to service user information varies considerably. PSWs working within multi-disciplinary teams have all the relevant information about service users. A service user provider required only that the service user obtain a copy of their risk assessment to be given to their PSW. Confidentiality agreements and codes of conduct appear to be sufficient to cover any confidentiality concerns that clinicians may have. Most peer support providers require PSWs to inform service users about confidentiality and what information is gathered about them by the peer support service and what happens to it. Almost all write notes collaboratively with service users. A DHB provider requires its PSWs to write “contact notes” that are prepared collaboratively. PSWs adhere to service users’ requests on what is included or excluded in notes. The only exception is where safety concerns are apparent, and these are discussed with service users and a mutual agreement reached. Safety and mental health law are covered in most peer support training programmes.

As the earlier discussion on definitions of peer support alluded, a key role of peer support is to challenge service users to self-advocate and take responsibility for their own recovery. Several participants in this review noted that good clinicians relish being challenged by peer support. It was further claimed that clinicians will accept being challenged by PSWs

more readily than by other professions because the role is grounded in personal experience, authenticity of relationship and a challenge to traditional models of mental health treatment. Indeed, peer support that is quiescent or merely confirms or validates traditional models of treatment and their rationale is almost certainly not peer support.

The problem of professionals having trouble adapting to the emergence of peer support is at its most intense early in the introduction of peer support. One provider observed that professionals will either embrace peer support from the outset, be completely shut to the idea or wait to see what happens (the most numerous). Those who wait to see what happens, it was observed, will often come over to full support once they see positive changes in service users resulting from their engagement with peer support. Even openly hostile clinicians can be won over with evidence of positive outcomes. One provider gave an example of a clinician who completely ignored PSWs until she had seen service users benefit from peer support.

Participants believe that positive relationships come through the education of clinicians and managers about peer support and through the development of honest, reflective relationships between PSWs and clinical and non-clinical professionals. Presentations to staff in community mental health centres and inpatient units, regular updates to allow professionals to give feedback and raise concerns, and building close relationships with consumer advisors are suggested approaches. Some participants believe it is important for PSWs to receive training in working with professionals. The training used by a DHB provider has one module on working in partnership with professionals. The same provider uses group supervision to discuss relationships with professionals.

Open communication and dialogue also help to build understanding and relationships. A service user provider noted that resolving problems between professionals and PSWs becomes easier once each side has experience of the other. Trust and credibility must be established by both sides. Both individual PSWs and the peer support provider organisation have to establish trust and credibility with clinicians and clinical services. This will be helped by clinicians and other professionals earning respect and credibility among PSWs. The provider noted that PSWs had learnt to respect some clinicians, better understand clinical roles and, especially, the use and context of the Mental Health (Compulsory Assessment and Treatment) Act 1992. A direct line of communication between mental health managers and the peer support service's manager and peer

support team leaders was also cited as important to the establishment of good relationships and understanding.

Again, the need to maintain the integrity of peer support was noted. Successful collaboration, one United States expert argued, comes from allowing peer support its independence. Her favourite example of successful collaboration is a peer support crisis service in the American northeast that had greatly influenced clinical services. This had been possible only because the peer support service had independence and integrity. If peer support has a clearly defined role and established an identity different from other support roles, then its boundaries will be clear, and integrity and honesty in relationships will be easier.

Uptake of Peer Support

Most peer support services use self-referral. The decision to engage peer support should always lie solely with service users. Clinicians have an important role in informing service users about peer support, but should not "refer" in the normal sense. Some service users may need assistance, because of cultural or other reasons, to contact a peer support service for support. Self-referral can result in an initially slow uptake of services until the service is better known among service users and other information providers.

Common strategies to promote peer support include the following.

- Pamphlets and promotional literature in community and inpatient mental health units, service user organisations and community drop-in centres.
- Presentations by PSWs to service users in mental health units, service user organisations and forums where service users are likely to gather.
- Presentations by PSWs to clinicians and other mental health staff in community mental health centres, inpatient units and NGO providers. One participant thought it was important for PSWs to present to clinicians. She had been involved with one peer support service where managers and clinicians had given presentations to staff and believed the service's difficulties in engaging service users resulted from clinicians not knowing the PSWs and how capable they were, so not informing service users about the peer support service.
- Newspaper articles and other favourable media coverage. Informing media organisations about peer support can sometimes result in coverage. Peer support is new and interesting. One service user provider has been the subject of several favourable newspaper features.

The uptake of services is also helped by PSWs building relationships with clinicians. This can help overcome initial scepticism or opposition among some clinicians. One peer support provider suggested that the best promotion was clinicians seeing recovery validated through peer support and service users who had used peer support becoming PSWs.

Most peer support services are limited to providing services to mainstream users within their funder's area. Many providers believe that, ideally, they should be able to take self-

referrals from people who are not users of secondary mental health services. Peer support, they believe, would be helpful to users of primary services and useful to service users discharged to primary care. At least one service user provider has arrangements with its funder to support, for a limited time, service users discharged to primary services. One service user provider in the Auckland region has a pilot project with two Primary Health Organisations (PHO) to provide time-limited peer support with referral by general practitioner. The peer support sessions are paid for by the PHO.

Specific Groups

Māori, Pacific and Chinese participants say peer support translates effectively across cultures, but requires adaptation to the specific needs of different cultures.

Māori

Māori participants state that peer support works effectively for Māori, but with several differences. One Auckland-based PSW says "individualistic" peer support works well for what he calls "urban Māori" who have little connection with their whakapapa or culture. But for Māori connected with their culture, mainstream concepts of peer support require adaptation. He says the concept of "autonomy" is "outside the experience" of some Māori, and he believes this is because of a difference in "power dynamics" between Pākehā and Māori experiences. Māori have experienced loss of power as a result of the loss of land, their culture and their voice. Moreover, some Māori may feel "inferior" because they do not get support from their whānau. He also notes that some disempowering experiences, such as poverty, are the same no matter what the person's culture.

One largely Māori service user organisation that used Mind and Body's peer support training found its emphasis on the Strengths Model and the recovery approach to be sound, but adapted the training to ensure PSWs could work according to Te Whare Tapa Wha model (Durie 1994). The organisation's training is 70 percent classroom and 30 percent practical. Each day the training session opens with karakia (prayer) and waiata (song) and there is a great deal of emphasis on whanaungatanga (kinship or relationships) within the team. To build relations and give a sense of connection, team members' whānau are invited to special events, such as the welcoming of new team members.

The organisation observes several processes when working with Māori service users. Karakia are offered, home customs are observed when visiting a service user's home, whānau can be included in the peer relationship if the service user agrees, the guidance of the kaumatua (respected elders) is sought for service users wishing to connect with their marae (meeting place) and to understand their whakapapa (descent or genealogy), and, when Māori use community services, Māori services receive priority.

One experienced Māori PSW explained that in peer support for Māori, an episode of mental illness carries the unspoken expectation that whānau, or anyone offering awhi

(help, care, support), will be there for that person. It is like a “wrap around” support that includes te wairua (spiritual health), te hinengaro (psychological health), te tinana (physical health) and te whānau (family health) (Te Whare Tapa Wha model). It is expected that the whānau provides the support and love and formal mental health services provide the respite or home care service. This leaves the PSW with the role of surrogate family member until the person is able to connect or reconnect with their own family or community. In this role, the PSW may have to “fill in the gaps” in the service user’s life. The PSW may be seen as a community resource to be used until the service user is ready to reconnect with their community. As a result, a Māori PSW may provide services beyond that expected in mainstream models of peer support. For example, if a PSW was out with a service user they were supporting and the service user asked for a ride home, the Māori PSW would provide that ride because it shows respect for the service user. The Māori PSW said that “to refuse to provide the ride would make me feel whakamā (shy)”.

Māori participants noted that Māori PSWs are expected to build relationships, whanaungatanga, with a service user’s whānau, if the service user agrees. This often happens incidentally, according to one PSW, while, for example, on a marae. All Māori PSW participants said that they would ask service users engaging with peer support if they would like to involve their whānau because whānau are often a source of strength. For others, whānau can be a source of stress. The choice must lie with the service user being supported to make the best possible choice.

Pacific

Pacific peer support workers note that peer support challenges the “old” thinking that recovery is impossible. Peer support empowers peers to make choices about recovery with the love and support of family. Peers can identify with PSWs because they talk from experience, and sharing their recovery stories helps Pacific service users match their culture with their own recovery journey. Participants say that working effectively with Pacific people requires an understanding of Pacific cultures, values, protocols and customs; for example, speaking at least one Pacific language and knowing not to look people directly in the eye. Health professionals can be considered “superior” to service users in some traditional views and PSWs have to balance this in the maintenance of mutual relationships. Participants note that it is important to find a gender match between PSW and service user.

Chinese

An expert on Chinese peer support says peer support translates well to Chinese culture, but is most effective when using a structured approach such as the Strengths Model (Rapp, 1998). They feel the Strengths Model is especially effective because many Chinese are action oriented and can work faster and achieve more than mainstream service users because of their orientation to work, study and family. Chinese PSWs who have overcome difficulties can be effective role models for recovery.

Other differences are apparent. It can take time for a peer relationship to develop and the first meeting is very important in the development of this relationship. Peer support can also take on a wider role, especially in social aspects of service users' lives. PSWs often have to explain to service users and their families the workings of the New Zealand mental health system because other mental health workers and clinicians, especially nurses, do not always do this well. Similarly, PSWs sometimes have to explain the behaviour of clinicians that may seem strange to people from cultures where relationships may be interpreted differently. For example, the lack of contact by mental health workers when a service user is well can be misinterpreted. In a wider context, Chinese PSWs will often provide assistance with integration. Chinese service users want to work and study but often require assistance.

Ideally, Chinese or other Asian peer support should be run by service users from within the same culture. It should have sufficient operational independence and the unique cultural aspects of the service should be respected and preserved. It is no different in this respect from mainstream, Māori or Pacific peer support. The expert participant stated that mainstream culture often has difficulty understanding a collective culture and the importance of the group and its dynamics.

Recommendations

The four recommendations are as follows.

1. Maintain a choice of peer support services. There is enough scope for a variety of different peer support philosophies and service structures to be maintained. The key consideration when choosing a provider is whether the provider offers safe, effective, clearly defined and credible peer support that will benefit service users. The success or otherwise of a service is ultimately determined by philosophical, organisational and individual factors that transcend particular models.

2. Ensure that PSWs receive credible training consistent with their role. The sector is strongly urged to engage in a debate about how to develop a minimum level of competency and a career pathway for PSWs.

3. Ensure that there are effective supervision structures for PSWs. This may be possible only with active support from funders. Building capacity and capability in peer support supervision should be a sector priority.

4. Develop organisational capacity and capability. Insufficient management and organisational capacity and capability are serious obstacles to the continued development of service user-run peer support. Peer support should be provided only by credible organisations that can demonstrate both capacity and capability. The sector has a responsibility to help to actively develop capacity and capability.

Appendix

Example peer support training modules

Two of the most highly developed and mature peer support training programmes available within New Zealand take very different approaches.

Mind and Body Consultants Ltd

Mind and Body's (in application) New Zealand Qualifications Authority accredited one-year Certificate in Peer Support (Mental Health) (level 4) has a large practical component consistent with Mind and Body's belief that peer support is a highly practical endeavour that cannot be taught solely in a classroom. The certificate course has been developed from Mind and Body's in-house training. It consists of six modules taught over 820 hours.

Modules	**Total Hours**	**Level**	**Credits**
1. Philosophy, ethics, values	70	4	7
2. Legislative and cultural parameters	80	4	8
3. Practicum	520	4	52
4. Communication in a team	60	3	6
5. Implementing the Strengths Model	70	4	7
6. Safety and supervision	20	4	2
Total	**820**	**4**	**82**

Mind and Body's New Zealand Qualifications Authority recognised qualification could be used to train PSWs from outside Mind and Body. PSWs would, however, need to be employed as PSWs in a service that meets the requirements of the practicum.

Counties Manukau District Health Board

Counties Manukau District Health Board uses the Recovery Innovations training programme that META Services in Arizona developed. This programme consists of 12 modules delivered over 72 hours.

1. Fundamentals of recovery.
2. The power of peer support.
3. How to build self-esteem and manage self-talk.

4. Honouring culture and creating a recovery environment.
5. How to discover meaning and purpose in work and in life.
6. The fundamentals of emotional intelligence.
7. How to communicate effectively.
8. Conflict resolution skills.
9. Trauma and resilience.
10. Substance abuse and co-occurring issues.
11. Being with people who are experiencing challenging situations.
12. How to partner with professionals.

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