Peer Support Practice in Aotearoa New Zealand

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Executive Summary

1. Introduction

1.1 Recovery and peer support: Every District Health Board in Aotearoa New Zealand currently offers some form of peer support, even if in small amounts. This is part of a growing commitment to place 'recovery' at the heart of the mental health system. There are two types of recovery in relation to mental illness. The first is recovery in the sense of restoring previous functioning and reducing symptoms. Peer support operates with recovery in its second meaning, which comes out of the civil rights, independent living and mental health consumers' movements. This understanding of recovery makes the powerful claim that, regardless of the symptoms one may be experiencing, everybody has the right and the possibility of living well. Recovery in this sense is inherently political, and has a multi-layered meaning. It might be seen as a synonym for 'deep learning'. Recovery doesn't usually 'just happen'. The conditions and environment for this form of recovery have to be actively created. This is a role that peer support plays, within the recovery orientated services of the mental health sector as a whole.

1.2 Methodology: This study was based on individual or group interviews with peer supporters and peer support managers, conducted at fourteen peer support services around Aotearoa New Zealand. The services were based in ten organisations which vary on a number of dimensions, such as size, whether it is consumer-led, organisational structure, services offered, and type of peer support used. Each participant in the twelve mainstream services took part in two individual interviews, one focused on peer support relationships and the other focused on policy and practice. In the two kaupapa Māori services, a tikanga *[correct procedure or custom]*based group interview process was held over a period of two days. The study was approved by the Multi-Regional Health and Disability Committee of New Zealand.

2. Peer Support

2.1 Defining peer support: Peer support was said to be about relationships and mutuality. Part of making those connections rests in understanding peers' worldviews, and in not judging them. Peer support was described as 'recovery focused, not maintenance-focused".

For many organisations, working towards goals set by the peer was a central part of the work of peer supporters. Crucially, this process must be directed by the peer; peer support is not 'expert driven'. Finally, peer support was described by participants as a learning experience. Peer support is about building relationships that create a genuine learning environment; this is a phenomenon with multiple levels, from the practical to the spiritual.

2.2 Self-determination: Self-determination is one of the core aspects of the recovery model. This study found that combating exclusion from decision-making around one's own life was probably the central value for peer supporters in Aotearoa New Zealand. Some peer supporters suggested that this was a point of difference between peer support and community support work, although Community Support Workers do often work in a recovery model. One challenge for peer supporters was to avoid slipping into the role of 'helper' or 'rescuer' and trying to fix problems that peers have. Sometimes peers have become used to depending on services and feel that this help is what they want; this can create a paradox for peer support.

 2.3 Care: While the provision of care is often not seen as part of standard peer support, it was very much in evidence in the accounts given in this study. Providing care is a necessary grounding for people to become self-determining, and to gain the capacity and desire to make their own choices. Thus, in peer support the 'logic of care' and 'the logic of choice' sit in tension with each other, but are also complementary and mutually supporting.

2.4 Understanding and trust: In Aotearoa New Zealand, the peer support movement had its origins in the mid 1970s, when former mental patients voluntarily gave time to help fellow consumers. Peer support is still fundamentally based on that experiential understanding. The capacity to hold some of our darker moments in a shared space is central to peer support. It allows peer supporters to pick up on issues that other mental health workers might miss. Peer supporters work actively to build the connections and trust that makes this understanding possible.

2.5 Kaupapa Māori approaches to peer support: Peer support connections were established in two Māori orientated services through whakawhanaungatanga *[process of establishing relationships].* To relabel this as simply the act of connection misses the subtle understanding of 'intrinsic obligatory things', of traditions and stories passed down through

the generations. Whanaungatanga *[relationship, connection]* is perhaps more holistic than other practices of peer support, as it is inclusive of the whānau *[family]*. The peer support relationship was further understood in one service through the concept of the tuakana-teina *[elder-younger sibling]* relationship, which might be loosely translated as a relationship between an older and younger person of the same generation. Again, this is a subtle, complex and shifting relationship which adds new dimensions to our understanding of mutuality in peer support.

2.6 Effectiveness of peer support: Some anecdotal evidence for the effectiveness of peer support emerged in this study through stories told by participants. The research literature is mixed on whether peer support leads to empowerment of peers. However, participants told stories that suggested empowerment was happening on a variety of different levels. There is growing evidence that peer support leads to a reduction in hospitalisation, improvements in living circumstances and improved quality of life. Our data adds a qualitative dimension to this evidence. Peer support seems to be effective in building greater community involvement, particularly through support groups.

3. Practice Issues

3.1 Risk: Handling the risk of suicide, self-harm or harm to others is a key issue for peer supporters, although about half of our participants suggested that risk might be over-emphasised as a problem in peer support. In every service, great thought had gone into how to keep people safe in suicidal situations. There was a continuum of approaches for handling risk, with some services adopting structured and 'safety first' strategies that involved quick recourse to clinical services. At the other end of the continuum, some services were developing a 'peer support' way to address risk through conversation and relationship.

3.2 Boundaries: In relation to boundaries, we found that some peer supporters experience a tension between maintaining an intimate connection with their peers, and maintaining professionalism. This requires a degree of 'emotional management' on the part of the peer supporter. For example, in most services, peer supporters were not willing to be contacted by peers outside of working hours; this creates space for self-care. A major difference between peer support and other types of mental health work is in the disclosure of one's

own experiences. The question of when to disclose personal stories, and how to craft them, seems to be rather fraught for many peer supporters.

3.3 Honesty and mutuality: Our data suggests that one factor preventing burnout is the mutuality and honesty with which peer support relationships are generally conducted. A focus on authenticity and honesty emerged repeatedly in our interviews, with the implication that these lead to relationships which are qualitatively different from the 'emotional labour' found in many service sector occupations and other helping professions. What began to emerge in our study was a different understanding of 'professionalism', which doesn't see it as requiring emotional distancing so much as self-awareness and the capacity to remove obstacles to authentic relationships.

3.4 Benefits to peer supporters: Peer support has real benefits for peer supporters. It often provides a path back into meaningful employment for people who have experienced mental distress. Strengths-based peer support environments create confidence in the peer supporters as much as in the peers. Supporters discussed many benefits around self-development, such as increased coping abilities, better relationships and greater assertiveness. Peer support work assists supporters in their own recovery. This can involve becoming more open about one's mental illness, or about past trauma and abuse. It can involve recovery from depression or suicidal thinking. It can also involve learning to reframe one's experience as a resource, rather than a deficit. This suggests that rather than peer support exacerbating worker's mental illnesses through stress and burnout, it may assist peer supporters to remain well.

4. Peer support and the health system

4.1 Peer support and the medical model: Peer support differs from the 'ideal type' of medical model in several ways. First, it is more recovery focused. Secondly, it is strengths-based, rather than being based on diagnoses, symptoms and pathology. The purpose of the relationship is directed by the peer, rather than the peer supporter. In these ways peer support is a living example of the way you can take philosophical principles and get positive outcomes without being highly technical. Some peer supporters described a disconnect between what they want to do, and what they are expected to provide within a medical

system that works on different principles. It is unclear how the relationship between peer support and the wider medical system will develop in the future.

4.2 Relationships with clinicians: Two salient issues for peer supporters are the relationship they have with clinicians, and the attitude of clinicians towards peer support. When asked what are the main issues for peer support, almost two thirds of our participants mentioned the need for more recognition of peer support from clinicians and funders. A very large number of participants said that the attitude of clinicians had been a constraint in their work; these problems seem to partially stem from clinicians' lack of knowledge about peer support, although some people also pointed to stigma and discrimination. However, a number of participants said their relationships with clinicians have improved dramatically as they have developed their services. When peer support is practiced within clinical settings, it has led not just to greater acceptance for peer support, but also to a difference in the way that clinicians think about service users and their recovery in general.

4.3 Working with clinical services: While there has in the past been a debate about whether peer support should be offered in conjunction with clinical services, this debate seems to have moved on to **how** they should be integrated. A number of peer support services are already working in close conjunction with clinical services. In this study, services described teaching Wellness Recovery Action Planning (WRAP) to clinical workers, meeting with patients in hospital, accepting referrals from clinicians, working in multi-disciplinary teams and working within a District Health Board (DHB) provider arm. Working within a provider arm allows peer support to be made available to a wider group of consumers, and also leads to cultural change in the service as a whole. However, it brings up the issue of 'role integrity'. A lack of compatibility between peer support ways of working, and a risk averse medical approach, came up in several ways. These include ways of handling information, and audit requirements for certain sorts of information to be collected. Even so, some participants enthused about new possibilities for the integration of peer support within the wider health system.

4.4 Contracts: All the District Health Boards now have some form of peer support provision. In most cases, these are funded through the Planning and Funding arm of the DHB. These Planning & Funding arms have generally been positively enabling for peer-led providers;

most contracts with peer providers are quite loosely defined, leaving services with a lot of leeway to offer services that sit well with their values. However, there were a few contractual problems for peer support providers. In a few organisations, peer support provision was contractually restricted to people receiving community based mental health services. This exclusion of patients in the primary sector denies peer support to the very people who might most benefit from it. A second area in which contracts can be restrictive is in terms of age; contracts for 'adult' services exclude young people and older people. This was particularly problematic for kaupapa Māori services. A third area in which contracts can impede effective peer support is by putting limits on the length of time that the peer relationship can last. One service had a contractual length of only one year.

4.5 Funding: Securing adequate and continuing funding was seen to be the key issue facing peer services in New Zealand by almost every participant. Lack of adequate funding had a number of flow-on effects. One was an inability to advertise services, because of a lack of workers to cover the potential workload. Another problem was that peer supporters are underpaid for their skills and experience; many are also working more hours than they are paid for. Finally, insecurity of funding led to a feeling that peer support has a rather tentative place in the New Zealand mental health sector, which generates anxiety for workers and managers.

5. Organisational Issues

5.1 Professionalisation debate: There is relatively strong support amongst peer supporters for some sort of professionalisation of peer support. Participants felt that professionalisation would bring greater credibility to peer support. Reservations towards professionalisation included the following: it might exclude less academically inclined supporters, peers might be less comfortable accessing a more professionalised service, and it might affect the essence of peer support. There were mixed views on this last point, with some participants suggesting that a more professionalised system for training and supporting peer supporters could actually lead to a greater grounding in a peer support set of values.

5.2 Training and qualifications: The ten organisations have very different approaches to training their peer supporters. Those with peer support training include a self-organised

NZQA qualification in peer support, Intentional Peer Support training, training from Recovery Innovations, and an in-house training programme in peer support. Four organisations rely on the Mental Health Support Worker's Certificate, or offer training through workshops and seminars which are not specifically geared to peer support. We found notable differences in the way that people with different training talked about peer support. In particular, there was a difference between people who have done specific peer support training, and those who have not. A number of participants talked about their training as having been a transformative experience. Participants were united in agreeing that some form of training is necessary, but differed on whether a specific, nationwide, peer support qualification should be created.

5.3 Health and safety at work: Services dealt with health and safety issues for staff in several ways. This includes safety strategies such as panic buttons in meeting rooms, the carrying of mobile phones, and use of teamwork. Some services require a risk assessment to be provided by clinical services before meeting with peers in their own homes. In terms of maintaining wellness, many participants said this was the peer supporter's own responsibility. Peer supporters emphasised the need to develop good awareness of their own states of well-being, and to develop self-care skills. However, services provide support such as supervision, 'mental health days', and informal support from colleagues. Overall, peer support services appear to be good environments to work in.

5.4 Information: Many peer support services challenge traditional ways of collecting information about service users in the mental health sector. Some services place a high value on confidentiality, and collect minimal information about their peers. Collaborative note taking is a discipline developed in some services. A principle of transparency applies to meetings and phone conversations as well as to notes. This can be summed up in the principle that peers own their own information. This creates a tension in relation to information which must be collected for contractual reasons, and to demonstrate outcomes. The Programme for the Integration of Mental Health Data (PRIMHD) has generated debate in some services. It is seen by some as requiring information that is better kept confidential, while others have noted that the time required to collect this information effectively requires a service reduction.

6. Implications and conclusions

6.1 Reflections on this study: This study has strengths in its location as 'insider' research, in its in-depth interviews, its highly articulate participants, and in its mixed methodology allowing kaupapa Māori services to participate on their own terms. It's limitations include the exclusion of service users from the research, the exclusion of Pacifica and Asian perspectives, that it doesn't examine the effectiveness of peer support, the lack of a quantitative dimension and the fact that the mixed methodology produced sometimes incommensurable results between mainstream and Māori orientated services. Future research might include an in-depth look at Pacifica and/or Asian approaches to peer support, a quantitative study of the effectiveness of peer support, an analysis of the way PRIMHD is being implemented in the peer support sector, cross-national research, and a study of clinician's attitudes towards peer support.

6.2 Implications for Practice: Implications for practice include a recommendation that peer support training be made accessible and affordable for services around the country; this should involve a diversity of models and approaches. We advocate finding new ways to integrate peer support with mainstream services, while paying sustained attention to role integrity and 'staying peer'. Contracts should be made more flexible, with time limits on the peer relationship loosened, and ways being found to fund peer support for patients in the primary care sector. Secure and adequate funding for peer support services is needed. We suggest that workshops on peer support be developed for clinicians, and that a national debate on the impact of PRIMHD on peer support services begin.

6.3 Conclusions: Peer support is more than a change of mental health personnel. It is a rich philosophy of practice which brings the abstract concept of 'recovery' to life. It involves, however, new and unique challenges for practitioners. Attempts to address the problems of risk, boundaries, integration and information gathering within a peer support values base may stimulate innovative ways of working in the mental health sector as a whole. Achieving security of funding is a crucial issue for peer supporters, as is achieving greater respect from clinicians. Finally, peer support is in good heart in Aotearoa New Zealand; while concerns for the future remain, we are largely 'getting it right'.

1. Introduction

Peer support is a growing part of the mental health sector. In fact, O'Hagan et al. suggest it may be the fastest growing part of the mental health sector, world-wide, over the next twenty years (2009: 6). In this respect, we can see the arrival of peer support as the next phase of the deinstitutionalisation movement, through which mental health consumers were gradually released back into community life, without being fully integrated. We are seeing a further transformation of the mental health system, called a 'major cultural shift' by Sowers (2005).

If we look historically, we can see three major periods in the development of peer support. First, there is the period of informal mutual support which began in the nineteenth century. Secondly, a period of anti-psychiatric support, provided outside and in opposition to the mainstream mental health system, began in the 1970s. And finally, the integration of peer support into a mainstream, recovery-orientated, health system, which began in the 1990s. (O'Hagan 2011).

Jill Grant argues that there are two, very different and competing, approaches to mental health service provision in the current climate (Grant 2010: 54). The first is scientific, highly technocratic, expert driven, and increasingly focused on diagnosis, medication, and reducing costs via faster throughputs in hospitals and other provision. The second is an emerging approach which puts the philosophy of recovery at the centre, is less hierarchical, strengths-based and places great importance on relationships (Curtis 1997). The two approaches complement each other, but also come into conflict at times.

While the mental health system of Aotearoa New Zealand is based upon 'recovery' in principle (Mental Health Commission 1998; MoH 2006), this is less true in everyday practice, where recovery focused approaches tend to sit on the periphery of service provision. The provision of peer support is highly relevant to this situation, because peer support, as a form of service provision, is based upon the 'recovery' model, and therefore can be seen as the embodiment of this emerging approach to mental health care and treatment (Orwin 2008). Every District Health Board in New Zealand offers some form of peer support at the present time, although this is often a miniscule proportion of total spending.

Because peer support embodies 'recovery' in New Zealand, it is worth looking at what a cross-section of peer supporters in this country actually had to say about their practice. What they said will go a long way towards describing how 'recovery' is actually developing in this context. In this respect, some of what they said is a good fit for international literature on peer support, while in other respects there are some unique aspects to peer support in New Zealand. The question must be asked: Does peer support in New Zealand, as actually practiced, live out the values ascribed to it by international leaders in this movement?

This study focuses exclusively on peer support providers who are funded by District Health Boards, and are thus working within the mainstream health system. It is thus focused squarely on that third phase, mentioned above, in which peer support comes to be supported within mainstream health systems. The question arises: how can we be true to the philosophy and values of peer support while working within a system that has historically opposed those values?

This report differs from most reports on peer support in that it doesn't focus on measuring the impact or effectiveness of peer support, explaining the health system context, or looking directly at the organisations providing this type of mental health service. Instead, it focuses on the talk of actual practitioners of peer support. In this report, we will find the words of peer supporters, peer support managers, and the kaumatua *[elder]* of a kaupapa Māori health service, explaining what peer support means to them, how they deal with some of the unique practice issues which arise, and how they work within the wider health system. We have reproduced short quotes from some participants in this study, but more often we have reproduced longer extracts, which give practitioners a chance to explain, in their own words, what peer support means to them, and how they carry it out.[1]

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[1] There are many terms describing service users in Aotearoa New Zealand. In this report, we generally use the term 'peer' to describe service users. This is a common usage within New Zealand's peer support services, and reflects the equality of the relationship that is being aimed for. On occasion, we have used the Māori term 'tangata whai ora', which is an expression with the literal meaning of 'people seeking wellness'; it is inclusive of people living with mental distress and sometimes, their whānau, or families. Participants in this study have also used the terms 'client', 'guest' and 'whānau', where 'whānau' emphasises that service users are part of a wider 'family' within the service. Where quotations include these terms, we have left them as they are.

1.1 Methodology

This report is based on a study carried out during 2010 in Aotearoa New Zealand. It involved individual or group interviews with a diverse range of peer supporters and peer support managers around the country. We looked only at paid peer supporters/peer support managers who were either running groups and programmes, or providing individual services. The purpose of the study was to answer these three questions:

1) How are peer support relationships conceptualised by peer supporters in Aotearoa New Zealand, in practice?
2) How do peer support relationships affect the lives and recovery of peer supporters?
3) How is the tension between the vision of mutuality and the practical constraints that govern practice managed by peer support programmes within Aotearoa New Zealand?

This study was not designed to measure the effectiveness of peer support.

The project began in January 2010, when we contacted every District Health Board's funding and planning officer for mental health to ask what peer support services they funded in their region. A listing was then made of every peer support service in Aotearoa New Zealand funded by a District Health Board[2] at that time, with some basic information collected about each of these services. This information has been made available to Te Pou.

Once we had this list, we conducted purposive sampling to choose ten organisations offering peer support.[3] Our sampling was done in such a way as to create geographical spread; there were seven organisations chosen in various parts of the North Island and three in the South Island, a division which roughly reflects the spread of population in the

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[2] The District Health Boards (DHBs) are public bodies which own and manage most public hospitals within a region, and fund private and Non Government Organisation (NGO) provided services. There are 21 DHBs in Aotearoa New Zealand.

[3] Purposive sampling is strategic sampling, and is recommended for qualitative research projects like this one (Bryman 2004: 333). It is directed by a number of criteria, rather than being random.

country. Sampling also ensured diversity in terms of the type of organisation offering peer support; all of the various types of providers in New Zealand – such as trusts, clinical providers and private providers – were included in the study. We ensured diversity with respect to the type of service offered, the model of peer support being employed, and the size of the organisation and service. We also ensured that some services known as leaders in the area of peer support were chosen, along with some lesser known services. Because some organisations offered more than one peer support service, we approached ten organisations, but this included fourteen peer support services. All fourteen services invited to participate agreed to do so. Peer support services included in the study offer a variety of types of peer support, including one-on-one peer support, support groups, kaupapa Māori peer support, intensive peer support, a drop-in centre, advocacy, support to inpatients, a telephone support line, and crisis houses/alternatives to hospitalisation.

It is important that knowledge about Māori services is collected and analysed within a Māori framework (Smith 1999). Thus, a mixed methodology was employed, with different data collection strategies for the twelve mainstream services and the two Māori orientated services. In the twelve mainstream services, Anne Scott visited each service over a number of days, conducting two individual interviews each with a peer support manager and one or more peer supporters. This process involved 24 participants in total.

In the two Māori orientated services, a tikanga-based methodology was used. One of these organisations was a mainstream service that self-identified as kaupapa Māori, although it had broader services attached. This service has a Māori manager, a majority Māori staff and majority Māori service users, as well as a kaumatua in operation. The second service was kaupapa Māori. Tamehana Consultants, who have expertise in Māori mental health, designed a process that involved two day visits by themselves and, in one case, Hamuera Kahi, to each service. During these visits, unrecorded whakatau *[welcome]* and mihi *introductions]* was combined with several recorded group interviews, which included peer support managers, peer supporters, kaumatua, a clinical supervisor and volunteers in the two services.[4] Thirteen participants took part in these group interviews. Overall there were 37 participants, participating in this study.

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[4] See the glossary of acronyms and Māori terms at the end of this report for unfamiliar words or terms.

These are 'expert interviews' because the people we interviewed are authoritative sources on peer support practice in this country. While studies such as Orwin's (2008) have looked at what peer support leaders have to say about peer support, we were interested in what peer supporters and peer support managers say and do in practice. We developed a process to produce 'theory-generating' interviews which would focus on the subjective orientations and practical ideas of practitioners in the field of peer support (Bogner and Menz 2009). This involved a 'problem-centred' technique (Scheibelhofer 2008) which combined open-ended narrative at the beginning, with a topic focused discussion later on. For this reason, two in-depth interviews were conducted with each participant in the mainstream services, and with most of the participants in the Māori services. The first interview focused on ways of thinking about peer support relationships. It was rather open-ended, and intended to elicit stories about doing peer support. The second interview was topical, semi-structured, and focused on policy and practice. In the two Kaupapa Māori services, this ordering of the interviews was not followed in quite the same manner.

The study was approved by the Aotearoa New Zealand Multi-Regional Health and Disability Committee. Most participants in this study were quite happy for their participation to be known by all. However, this wasn't the case for every participant. As a result, all names given are pseudonyms, and identifying details have been changed where this is relevant. Where quotes are used from participants in this study, or reference is made to a specific comment they made, the quote is followed by a bracketed pseudonym and the person's role, e.g. (Rick, manager). A specific ethical issue we have encountered relates to occasions when stories have been told by peer supporters about their peers. On the one hand, these stories are extremely illuminating, both regarding the effectiveness of peer support and specific aspects of practice. On the other hand, the peers concerned have not been asked whether they want their stories shared in this way. To address this problem, we have used such stories sparingly in this report and only when they add a great deal of value to the discussion. Where such stories are used, we have checked back with the original participant

or service at draft stage, to ensure that they are willing for the story to be used, and that confidentiality of all parties has been sufficiently protected.

The interviews were audio-recorded on a digital recorder, and transcribed verbatim. Where interviews were transcribed by a professional transcriber who was not present at the original interview, Anne Scott has listened to the recording and carefully checked the transcription. The interviews were then coded using the NVIVO 8 qualitative data analysis package across sixty seven categories. Codes were defined in relation to the research questions, and also in relation to themes that emerged strongly in the data. Some of those categorisations have found their way into this report, although the material was too extensive to include everything. When writing a section of the report relating to a category of data, one of the interviewers has carefully read the material, has made notes about the general mix of responses, and has written a section of the report that represents, as fairly as possible, the range of responses received. Thus, these sections don't necessarily contain 'the best' responses; they contain instead the wide diversity of views expressed. In some cases, we have written about the material in relation to wider literatures coming from sociology and mental health research.

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2. Peer Support

2.1 Defining peer support

The question of what peer support is has seemingly been well addressed in articles written by leaders in the peer support field (Mead, Hilton and Curtis 2001; Mead and MacNeil 2006). However, we believe that there is more to be said on the subject. Indeed, a number of our participants said that the 'fuzziness of the concept' of peer support was an impediment to progress towards creating a national approach, and towards presenting peer support to the public and tangata whai ora (Matthew, peer supporter).

As a starting point, we can look at the outcome of a national forum on peer support in 2009 at which this question was discussed extensively. Te Pou – New Zealand's National Mental Health Workforce Development Agency – developed the following definition of peer support based on those discussions:

> Peer support is person-centred and underpinned by recovery and strength-based philosophies. The life experience of the worker creates common ground from which the trust relationship with the person is formed. Empowerment, empathy, hope and choice along with mutuality are the main drivers in purposeful peer support work. There is great deal of strength gained in knowing someone who has walked where you are walking and who now has a life of their choosing. In this way it is different from support work, it comes from a profoundly different philosophical base (Te Pou 2009).

In this section, I would like to unpack this excellent definition, developing it with a variety of statements about peer support made by participants in this study.

First and foremost, participants emphasised that peer support was about relationships. This was something that was discussed in every interview. "And to be honest, the difference between peer service and non-peer service *is* the relationship. And the relationship creates everything else that's different" (Geoff, manager). Another manager detailed that 80% of what we do comes down to relationships; that's the central thing that peer supporters bring. "I guess our endgame is to be exceptionally skilled at relationship, really" (Rick, manager). In one Māori orientated service, this was described in terms of

whanaungatanga, or the making of connections. Steve (peer supporter) was clear that peer support and whanaungatanga were essentially the same thing. While relationships are important in all mental health services, and not just in peer support, the structure of community mental health services can make it difficult to sustain empowering relationships in those contexts (Townsend 1998).

Part of making those connections rests in understanding peers' worldviews, and in not judging them. "You know, I've met a lot of people in my journey, and I've learned that if you don't judge people, if you **actually** don't, then they know it... it's a difficult thing to understand, but connection is about that" (Melody, peer supporter). Connection is also about genuine love and care. This was mentioned by a substantial minority of participants in this study.

> For us, there's that companionship, that respect and that aroha *[love]* which are really integral to the mahi *[work]* we do. I talked to Egan about that earlier, how we will awhi *[embrace]* and, you know, we have some of our whānau*[peers seen as part of the family]* say they love us and we'll say we love you back (Vanessa, manager).

This participant was clear that this aroha and care was central to treating peers as people, rather than "...as a number or client or diagnosis" (Vanessa, manager). That mutuality, or genuineness in the relationship, was seen as central to peer support by almost every participant. As one manager summed up: "It's a philosophy of equality, isn't it?" (Velda, manager).

A second central aspect of peer support can be summed up by one participant, who came to her second interview and spontaneously began by saying she had woken up at 3 am after the first interview, with something on her mind. She just wanted to make one thing clear: "Peer support is very recovery focused, not maintenance focused" (Stephanie, peer supporter). This point was made by almost every participant in some shape or fashion. Change and development is seen by peer supporters as integral to peer support.

> I think peer support is understanding, a real understanding... that you might
> be ok today and you might be looking after me, and next month it might be

the other way around. We are here supporting the person as they are in a time of need. And understanding that that's not the way it's going to be forever, because you know you've had that yourself. It's really understanding what it is to have that kind of trauma and come out of it as well. (Cathy, peer supporter)

How to support that process of recovery is thus central to the reflections of peer supporters. Self-determination and empowerment are crucial themes, which we'll develop in more detail in section 2.3. One way this is done by some services is through working actively towards meeting goals set by the peer. Whether a relationship which is just providing support, but is not moving the peer forward in this way *is* peer support is a question raised by this manager:

Is that peer support? If the person doesn't have a goal or doesn't want to identify a goal, should we be working with them? And in some situations the answer is 'yes'. It's an interesting philosophical debate (Zoe, manager).

Crucially, however, the process of moving forward must be directed by the peer, and not by the peer supporter. One peer supporter drew on the metaphor of a tree:

It's like a young tree gets blown over, and has a green stick fracture in its trunk. And we put a couple of sticks each side of the trunk, and bandage it round, and put some strings out to some stakes. Now the tree's doing the mending, and the tree's doing the growing, and the bandage and the stakes are only doing supporting. They're not doing any growing. They're perhaps showing the tree, "this is the angle at which you need to grow, and we'll support you to do that and help you not go off at a tangent which is going to be bad for you." But you're going to have to do it. So peer support, for me, is a wee bit like that (Deborah, peer supporter).

Shery Mead and David Hilton described this as a process of "stepping in while stepping back" (Mead and Hilton 2003: 90). Part of the nature of a peer support relationship is that the peer supporter pulls back, and allows the peer to overcome their own challenges. As

one manager said, "I don't want people who are the best, I want people who allow other people to be the best" (Velda, manager).

A third aspect of peer support, mentioned by a number of participants, is that it is a learning experience. Peer support relationships have been said in the literature to be focused on changing unhelpful patterns, getting out of 'stuck' places, and being transformative (MacNeil and Mead 2003: 2). This was echoed by our participants. One manager said that peer support was different from friendship because friends might just go out and have a good time together, "Whereas to me a peer relationship, there's a component of shared learning. You are in that relationship because you share something that you want to learn together" (Lydia, manager).

> Peer support is a very deep thing, you know. And recovery and wellbeing's a very deep thing as well. It's all basically, you know, you could say it's almost like, it's almost like, recovery's almost like a spiritual experience but it's certainly, I would say, it's a critical learning experience. It's an experience of true learning. And if you look at learning environments and recovery environments, they're the same thing (Geoff, manager).

So peer support is about building relationships that create a learning environment, in which the peer can reframe their experience, take risks, undertake challenges and direct their own life. It is a multi-layered phenomenon. On the one hand, peer support is a very practical way to help people change their lives, according to Simon. "But the outcome and result of that is the spiritual transformation that heals them. In which they heal themselves" (Simon, manager). This points to recovery being a phenomenon with multiple levels, and it is to recovery that we now turn.

2.2 Recovery

Larry Davidson, *et al* (2009) define two major types of recovery in relation to mental illness. The first involves recovery *from* a serious mental illness. This clinical concept of recovery involves restoring previous functioning and reducing symptoms. The belief that people can recover from mental illness is itself an advance on previous thinking that mental illnesses

were unremitting chronic disorders (Ramon et al 2007: 108). However, not everybody returns to their former state of functioning after living through life's vicissitudes, which can include experiencing a mental illness.

> 'Recovery', you know, like it's another huge word isn't it? That some people that I support, they're never going to recover like what they had before. Like the 76 year old man that's since had a stroke and God knows how much psychiatric medication; he's never going to recover being a 30 year old auditor. So, to a degree, I don't think you ever recover what you were. It would be like me trying to recover exactly who I was. Like every experience you have leads you to another experience. ... so you evolve as a person anyway (Rachel, manager).

Rachel's conclusion, that you evolve as a person on your way to living a full life, leads us to a second meaning of 'recovery'. This notion of recovery comes out of the civil rights, independent living and mental health consumers' movements, and it relates to 'being in recovery', even in the potential absence of symptomatic recovery (Davidson et al 2009: 11; Deegan 1988; Curtis 1997). This way of thinking about recovery normalises the concept of 'mental illness'. Experiencing the symptoms of mental illness doesn't mean that one cannot also live well.

> Sometimes you hear the voices in your head and you think: 'oh yeah, here I go again'. But after a while of working with other people you realise that most of the people have a voice in their head and most of them don't act on it. Just because there are negative ideas in your head doesn't give them power. And that's a huge thing to learn. And so that's another thing I think that the peer relationship does, is that people don't, people don't ask the clinicians and they don't read the books, they don't really want to know, they're afraid to say, you know, just, 'do you hear voices?' 'Sure, everybody's got a voice in the back of their head.' You know: is it my voice or is it somebody's voice? Is that destructive? Is that tearing me down? Is that belittling me? Is that telling me to do dangerous things? Is it encouraging me to try this, this time because it might work? Is it bolstering my confidence or is it tearing me down? Are

there three or four or five of them? Are they conflicted and do some of them speak in different languages? Ok, let's talk about that one. [laughter] (Brigid, manager).

So as Davidson and his colleagues argue, this concept of recovery is about people who are living with mental illnesses reclaiming their right "...to a safe, dignified and personally meaningful and gratifying life in the community despite his or her condition" (Davidson et al 2009: 11). It is akin, they argue, to the social model of disability, which makes the powerful claim that regardless of impairment, the social arrangements in a community can make a person disabled, or can be inclusive – preventing that disability. So 'recovery' is a radically different philosophical basis from which to view mental illness and mental health. It is inherently political, and is multi-layered in meaning. As Geoff stated in the last section, recovery is a very deep thing, almost spiritual in its transformative quality. "It's a critical learning experience. It's an experience of true learning. And if you look at learning environments and recovery environments, they're the same thing" (Geoff, manager).

Peer supporters in this project had a great deal to say about how you facilitate recovery within peer support services. One peer supporter echoed Geoff's description of recovery as an experience of deep learning.

> I also believe that recovery – the word "recovery" is a synonym for "learning".
> And the medical model doesn't allow for that at all. So to my mind, a person
> in recovery has to make changes in physical and cognitive behaviour. And they
> only do that through a learning process, with a feedback loop. So that they
> can move on to something else, and move on to something else. And often it's
> a trial and error thing for them (Deborah, peer supporter).

She described the way her own understanding of recovery had changed and developed over many years as she had progressed on her journey. It developed from 'get me out of this hospital' to struggling with medication, to being able to go to the supermarket by herself, to having the ability to hold down a job, to self-actualisation on a day to day basis. "So to me, it's more like re-creation, rather than just re-covery" (Deborah, peer supporter).

Geoff made the point that recovery is simply something that humans do. "...and the only times they don't recover is if the environment's too wrong or what they've experienced is so serious that it kills them" (Geoff, manager). So getting the environment right is the crucial step. This is the core of recovery efforts at one of Aotearoa New Zealand's crisis houses:

> It's the same that we do for guests and people who come to our service, by creating a more positive environment where people can recover, literally, their ability to choose, make decisions, change things, be creative, look at other options and actually move on. Do the same within the organisation, for the workers. And that, I think, is my peer support role, just the encouragement and creating a positive environment (Velda, manager).

That positive environment is created through hard work and active intention (Melody, peer supporter). As a manager put it: "Let's face it. Recovery doesn't just happen. You don't just have the conversation (Alexandra, manager). The conditions for recovery conversations have to be actively created. This is done, in part, by refraining from judging, and just sharing a person's experience.

> I think the main thing, the main value that we hold, that's different from other places is that we don't judge why someone's there, we don't really question why they're there. It's, it's about, like actually being part of the journey of recovery no matter where someone's at in that place. And it, I think, by sharing our story and being sort of demystifying a lot of the stuff around having mental illness or having a bad time, it makes a huge difference (Cathy, peer supporter).

A second way that recovery is facilitated is by focusing on strengths rather than deficits. Being recovery-focused involves "...not always talking about what was going wrong and what she couldn't do, but actually forgetting that and moving towards something good" (Stephanie, peer supporter).

Recovery is also facilitated by building hope. This can happen through the simple process of role modelling recovery, by talking casually about one's own experience of unwellness while clearly functioning well now.

It implies that, it gives credence to that theory that this is an episode, this human is a fully faceted, multi-potential human and *today* they need support, and *today* you have them at a disadvantage perhaps, but life is long and people are very flexible and some have resilience and you might see that person working for me some day. And I kind of like that, like, you know, so there's that empathy and there's role modelling in both perspectives (Brigid, manager).

Recovery takes place within a social, political and cultural context. In this regard, Aotearoa New Zealand has been a world leader by placing recovery at the heart of mental health services (Mental Health Commission 1998).

The fact that we've got a recovery philosophy across the whole of mental health services and so forth is very important because it gives a kind of a base level approval for that to be the focus. And that's enabled the contracting environment that we've got. In terms of the contracts themselves, it's been about having good relationships with particular people who understand the purposes of peer support and have an interest in exploring what it's about and how effective it is (Simon, manager).

The recovery basis of New Zealand's health services is itself the ground on which peer support has flowered in this country. However, there are some shortcomings yet to overcome. For example, Geoff described the way audit doesn't yet operate with a recovery philosophy, which generates difficulties for peer supporters. He also pointed to the need to look beyond the environment of particular mental health services. The wider environment matters as well. "It's not about getting the environment right within mental health services, that's part of it, but it's getting the environment right in the whole community" (Geoff, manager). This point was made by a few people in our study. Recovery is something that happens in community, and peer support is about the building of that community.

2.3 Self-determination

Self-determination is one of the core aspects of the recovery model. In his study of 15 consumer provider's stories of recovery, Michael Mancini found that coercion is the most detrimental factor to the recovery process (Mancini 2006: 21). This coercion has been an element of many mental health consumers' experiences. Mary Ellen Copeland described such an experience (Copeland and Mead 2004: 66) in the United States. Such control in clinical settings is also to be found in Aotearoa New Zealand:

> When you're working with any professional as a consumer   I hate that word but I'll use it here – there's always this power differential. Always. I've actually been told by a nurse, "You're not allowed to step past that join in the carpet." I was told when to have a shower. I was told to take my tablets, whether I wanted to or not. I'd say, "What are these tablets, and what are they for?" "Don't worry about that. Just take them." I was told what I should think. I was told what I should be feeling, what I should not be feeling. "Oh, you mustn't be angry." I was told, told, told, told, told. Whereas, with peers, they didn't tell me what to do. They shared their own experience because that was all they knew. And so I could take from that whatever I needed. And share my experience with them. Or I'd hear somebody else's experience and think, "Now that's a good idea. I could try that." So it was empowering, in that I was doing the active choosing and taking, rather than having anything imposed on me. So that, I recognised as a peer support thing, which was just absolutely valuable (Deborah, peer supporter).

Within this study, we found that combating this exclusion from decision-making around one's own life is probably the *most* central value for peer supporters in Aotearoa New Zealand. Almost every participant talked about doing their work in such a way that it empowers peers, and facilitates them in making their own choices.

> When I'm working with somebody, they're the director, and we're the actors and this is their movie, and they direct how they want the movie to go. Whereas if it's a clinician, the clinician will say, 'well I think you should be on these meds, and you should come every two weeks and this is what you

should be doing.' Whereas we would never say you *should* be doing this (Roberta, peer supporter).

One peer supporter described the difference between community support work and peer support as revolving around this capacity for increasing self-determination and empowerment. Whereas community support workers will 'sort stuff out' for tangata whai ora, a peer support worker will encourage the person to make that phone call themselves. They will encourage them to go and find out what's available in the community. Rather than taking a peer supermarket shopping, they will assist them to do their own shopping, by supporting them through the process of facing their fears (Zoe, manager). A peer supporter at a drop-in centre told this story:

> We had a guy at one stage looking for a job. And we had pamphlets on the wall. So I went through a couple of these pamphlets with him... And I sat by the phone because this particular person was a bit nervous about ringing up and making an interview, you know, for trying to find work because that's what basically they were, they were agencies for finding work. So I sat by the phone with him while he made the call, and he was, I thought he was very professional. He got off the phone and I told him how professional I thought he was. And he said, 'yeah, but you were there with me, that's why I was able to do it.' So, yeah, you know, this is I think what makes a difference. And of course you can imagine how good that makes you feel at the end of the day (Jack, peer supporter).

This is not, necessarily, the most natural or easiest way to act. It is far easier to slip into being the 'helper' and wanting to fix things up for peers. One manager said the problem with having very little staff turnover is that the peer supporters become so experienced and knowledgeable that it is very difficult for them to step back from trying to 'fix' problems that their peers have. So this peer support team has regular refresher training around this issue (Velda, manager).

> One of our newer peer support specialists got quite upset about, 'Well you can see where a person's at... say they're at A and they want to get to D. Why do they have to go through B and C to get there? When you know what they

need to do to get to D, and they could avoid all the pain and the learning, and everything, along the way? And it was a really important discussion about: "We can't stop people from learning. Their learning is really, really important to them. People will go through those painful experiences, and our role is not to prevent them from that. It's to support them with that. And to walk alongside them while they're exploring those things, and making choices, and finding that maybe some of their choices haven't worked out for them. And being available to support them with that. Not being there to support people to avoid the pain and the learning in their lives. Because that's not what we're about. And even though you want to say, desperately want to say, 'Don't do that! It's not going to work for you!" You can't say that, because it is judgemental, and it's you bringing your agenda (Zoe, manager).

A number of peer supporters said they struggle with this aspect of the work, and have to work actively not to want to 'save people', or 'fix them' or do everything for them (Brenda, peer supporter). "You know, I'm still a fix it person. I really try not to be in this role, and it's still taking me practice" (Ross, peer supporter). Peer supporters must learn strong boundaries which differ from the boundaries generally in place in mental health practice, because these boundaries are not about creating a professional distance, so much as stepping back and allowing peers to make decisions for themselves (Velda, manager).

Another challenge faced by peer supporters trying to facilitate self-determination by their peers is the expectations of many mental health consumers that mental health services are there to do things for them, and to tell them what to do. This can lead to problems in the peer support relationship:

I think possibly where the service user doesn't understand what service it is that we are providing and expects a rescue service or a "I'll do everything for you, bro" service because that is not what this service is about. It's an empowering service (Tui, manager).

Because peer support is relatively new to many tangata whai ora, they need to be gently encouraged to take responsibility for themselves. One manager of an advocacy service said:

Our clients, they're not used to having a different relationship. They're used to being told what to do, they're used to being guided towards, you know, not even guided gently, but just directed towards a solution. And that isn't what we do. We want to work with somebody, we want to ask them what their options are, we want to present them with 6 or 8 or 10 options and have them make a deliberate choice. We want them to become involved in their own life. And that's pretty unusual in this day and age (Brigid, manager).

One peer supporter said when she was talking with peers, she did a lot of: "*You* need to find your answers. *You* need to go out there and manage that. That's your responsibility. Because it is. It's everyone's responsibility to live well" (Melody, peer supporter).

This brings up an interesting issue. In her classic article introducing the concept of 'recovery', Patricia Deegan advocates for assisting people with psychiatric disabilities into becoming active and courageous participants in their own rehabilitation project (Deegan 1988: 12). However, she notes that "...traditional values of competition, individual achievement, 'independence' and 'self-sufficiency' are oppressive for many mental health consumers. "Programs that are tacitly built on these values are invitations to failure for many recovering persons" (Deegan 1988: 17). So how do we encourage self-determination and self-sufficiency without setting some tangata whai ora up to fail? This was an issue in some of the interviews, as some participants talked about the possibility of disengaging people from the service if they weren't taking a sufficiently active interest in working towards their own recovery. It is perhaps necessary for peer supporters to think about self-determination and empowerment in close conjunction with a less celebrated aspect of the recovery model – care.

2.4 Care

In the modern West, we see ourselves as individualised and autonomous. It is this that is said to *make* us modern (Mol 2008:3). However, we are not actually all that autonomous. We are needy and dependent at various points in our lives, such as early childhood and the end of life. We are also in need when we find ourselves living through periods of mental

distress. During these periods, we find ourselves in need of care. At one crisis house, they are very aware that at times of crisis the peer support goal of empowerment and self-determination isn't the best focus:

> If they're very much in distress when they come, usually people are very distressed when they come in, it's just a matter of TLC, what do you want? Yeah. Make them comfortable, cup of tea, be available. Just make a real nice environment so the person at least can chill out a little bit. And that's what happens. Often people take a day or two and then they can see they're starting to interact, they're starting to come out of their room. Often people just want to be left alone but taken good care of. The fact that there is someone who cares, checks in, asks if you're all right, you know, do you want to have something to eat, can I make you an omelette, we have lots of chickens so we obviously have lots of eggs. Just to keep that, just be, yeah, a bit mummy. [Laughter]. If people are really distressed that's the only thing you can do isn't it, initially? You don't insist on peer support type things instead. You just, you know, whatever you can do to create an environment where a person at least can heave a sigh of relief and can stop worrying. So what we do basically initially is to provide, when people come in, to provide some space and a lot of motherly love. [Laughter]. So you see that's not standard peer support (Velda, manager).

It is interesting that this manager doesn't see their provision of care as part of 'standard' peer support. In fact, care is not written about in the literature on peer support nearly as much as is empowerment, choice and recovery. This is not surprising. The concept of 'care' is fraught with negative connotations in the disability movement in general, where it has been associated with the dependence, segregation and infantilisation of disabled people (Morris 1997; Kröger 2009; Watson *et al* 2004). Peer supporters distinguish themselves from community support workers, partially on the basis that they provide support towards recovery, rather than dependence inducing 'care'. For example, one peer supporter emphasised repeatedly that peer support is different from community support work because "Peer support is recovery focused, not maintenance focused" (Stephanie, peer

supporter). 'Care' is often seen as keeping people in a dependent position, and not supporting their recovery.

> I almost saw the clinicians as being there to pick up the pieces and they nurture people so, so much. I don't see that from the doctors so much as I do from the key workers. The key workers can become so involved with people... they almost wrap people in cotton wool.   And I think from a peer's perspective, having been there, and knowing that these people don't need to be wrapped in cotton wool and sure, they are strong (Brenda, peer supporter).

Does care operate in this way? Does it hinder people's recovery? We would like to suggest that it does not, as long as it is kept in the right relationship to empowerment and self-determination.

Annemarie Mol argues that much healthcare operates with two competing logics, a logic of choice and a logic of care (Mol 2008). The logic of choice is modelled on the idea of service users as rational, as citizens, as people who aren't troubled by their bodies and can make active, autonomous choices about their lives. By contrast, the logic of care starts out with the fleshiness and fragility of life (Mol 2008: 11). It doesn't see everything in life as ultimately being open to our control. It is less focused on being able to make choices about our bodies, and more focused on being kind to our bodies, on simply cherishing them. Mol was writing about physical healthcare, in particular about diabetes care, but much of what she says is applicable to mental health as well. Period of mental distress are periods in which we are brought face to face with our vulnerability. What we need at these times is care.

Care is an important part of what peer supporters do, as evidenced by the way peer supporters and peer support managers in this study talked repeatedly about it. When asked what are the overriding values of peer support, one manager responded with this list, and story:

> Well, pono *[truth]*, manaakitanga *[hospitality]*, awhi, tautoko *[support]*. I mean, again, tikanga, we come from that value base. Love is a big one for us,

and I was talking to you about that aroha because a lot of our whānau don't get treated with aroha. They're a number or a client or whatever. And sometimes they don't even get that from their own whānau. And we felt that that's where we've made our biggest breakthroughs is through never looking at the negative. We pull out the positives that we can, especially with our rangatahi *[youth]*. And I talked to you about that one in particular. He used to roam up and down the streets and was deemed high and complex, and everyone gave up on him. And we brought him into the fold. And we would just remind him about how special he is because he's very creative and really a loving boy but was never given much love. And Emma and I both pretty much had a soft spot for this young fulla. So every chance we'd see him we'd say "you know, if you just scrubbed up a little bit, you are a very handsome boy…" And the next day he turned up and he's brushed his hair a bit. And we'd just say "who is this guy? Who is this handsome dude in front of us?" And, yeah, it was kind of like how... I raised four sons and one of them was the same age as this boy. So it was kind of bringing that out as well, just giving him that awhi. And you wouldn't recognise this boy today, working, back on track (Vanessa, manager).

This service refused to discharge peers, in spite of pressure from their funders to do so, because the peers have become whānau and, applying Māori principles, that means they are whānau for life (Steve, peer supporter).

Mol notes that making choices takes up a lot of energy, which not everybody wants to do, and people often end up choosing remarkably similar things (Mol 2008: 4). Thus, while the ideal of empowerment is crucial to peer support, it must be balanced with the ideal of 'support' – mutual respect, solidarity and care. One participant summed this up as "authentic, unconditional regard. That you're not going to be conditional in the way you treat people" (Rick, manager). At the same time, "Every person is unique. The way we are with them is unique" (Cathy, peer supporter). Providing care involves a kind of 'love labour' (Lynch 2007) in which attentiveness, respect and the practical activity of doing things with and for others intermingle.

[It] is about really honouring the person, and validating who they are. I mean, that is absolutely part of what you're doing. But in a way that is really meaningful for the person. It's not about going and saying, "Oh, you're so fabulous! And you're going to do great!" It's about listening, and finding out what's important to them, and really valuing that. And holding onto it, and remembering. Remembering those things that they've mentioned that they're interested in, and asking about it and exploring it a bit more (Zoe, manager).

This is all so basic to peer support that we don't even think about it as worthy of discussion, but it seems that it needs some emphasis, because the provision of care is as central to peer support as is the facilitation of empowerment. In fact, it is through the provision of care that empowerment can take place. The quote above was summing up the approach this peer supporter took with a young woman, who often avoided appointments. Zoe kept turning up, week after week, and kept believing in her, until this young woman started to believe in herself. That allowed her peer to turn her life around, to find her own place, some work and a good relationship.

Nick Fox has made an important distinction between caring-for, which involves taking responsibility for the other – while maintaining a helper-helpee relationship – and caring-about, which takes the form of a non-possessive, non-controlling gift (Fox 1995). Interestingly, at about the same time as he wrote this, Jenny Morris – a disability activist – critiqued the concept of 'caring-for' while distinguishing it from the more empowering 'caring-about' (Morris 1997: 54). So how do we prevent the process of caring-about somebody from slipping into a dependence inducing 'caring-for'? This was something a number of participants talked about. One manager talked about the way we can get caught up in thinking 'this person depends on me and I've got to do everything for them' (Vanessa, manager). She said she told her staff it was "...about establishing those boundaries from the get-go, that we meet half-way... We've always been here to empower. That's our guiding whakaaro *[philosophy]"* (Vanessa, manager).

Annemarie Mol presents the logic of choice and the logic of care as alternative ways of approaching healthcare provision. However, in peer support they are more complementary than that. The practice of care, in the non-possessive form of 'caring-about' is the essential

ground on which the *ability* to make choices, and the *willingness* to make choices, grows. This involves practical pieces of caring, as in the peer supporter who stretched the 'no taxi services' policy of her organisation to ensure one of her peers without transport could make it to the women's group and develop her social networks (Stephanie, peer supporter). It involves the caring attention that allows peers to start 'tuning in' to what they want and need. One crisis house is different from a clinical environment because "...we actually ask people what they want. We ask people how they feel. We ask people what's happening for them" (Cathy, peer supporter). This allows the connections to be built quickly that lead to genuine movement forward. "The logic of care itself is first and foremost practical. It is concerned with actively improving life (Mol 2008: 89). This is not incompatible with the facilitation of choice, but it might be incompatible with a logic of choice that starts from the assumption that people can be self-sufficient unto themselves. As Mol concludes, the people who figure in the logic of choice "owe their very ability to act to others" (Mol 2008: 62).

2.5 Understanding and trust

Contemporary peer support services had their origins in the desire of consumers/ survivors to build empowering services grounded in a recovery vision which treats people living with mental illness as full human beings rather than 'disease entities'. According to Ahern and Fisher, "the cornerstone of this assistance is the development of trusting relationships" (cited by Campbell 2005: 19). These trusting relationships are the basis for the movement from despair into hope and recovery (Deegan 1988). In Aotearoa New Zealand too, the peer support movement had its origins in the mid 1970s with former mental patients voluntarily giving of their time to help fellow consumers.

> They did make a difference. That was the feedback they got, you know. They were visiting people in hospital and saying, "Hey, you know, don't lose hope, look at me, I've been in this situation and now I'm on the other side and I'm coping well." So there was this dialogue, I think, started happening between people that had gone down that road and people that were kind of still ensconced. And I guess those friendships and alliances were made. Maybe

people had been in hospital together and they'd managed to break free, but there were still people that were kind of trapped. And here was somebody that they could talk to, that kind of knew where they were coming from (Rachel, manager).

In spite of all the trappings of professionalism, peer support is still fundamentally based on that sharing of experience, and on experiential understanding. "Peer support is getting together with people who know what you're on about. And that's basically it, isn't it?" (Cathy, peer supporter).

One manager described a good peer support relationship which took place informally, outside her service:

She said when she rang me and talked to me about what was going on, she felt that she would get a lot more honesty, and the fact is she knew that I'd been there myself. And it's that whole thing about you can't bullshit a bullshitter. You know. So we could, I think what happened was we were able to laugh at each other. I could tell her stories about what happened to me, she could tell me stories about what was happening to her. And what seemed tragic at the time, we could turn that into something as part of the, normal part of life and journey... So that relationship actually worked out really well and she managed to address some of her, some of the things that other people hadn't picked up on. Which were quite significant issues for her in her life. So, that was, that was really really good (Alexandra, manager).

Bursting into laughter at a tragic story isn't something that people can ordinarily do safely, "but most of the time when that happened it was because I had a similar story that I could tell her about" (Alexandra, manager). The empathetic peer relationship allowed both of these women to see the funny side of the difficulties they had faced in their lives, and then to move on.

This capacity to hold some of the darkest of moments in a shared space brings something of the sacred into peer support. One manager said that in the course of some peer support conversations he felt like he was "walking on holy ground" (Rick, manager).

They'll share stuff that they've never told anyone sometimes, and tears will be running down their eyes and so it's totally humbling how people feel totally safe in that relationship. And I think that comes about possibly because I've been willing to share all of me, really. Not just the light side, I've been willing to share the darkness as well as the light, and share the whole of me really, as I own the darkness as well. Yeah and I think being able to disclose in the safety of a, within the relationship really strengthens it. You know I think trust is one thing that changes everything (Rick, manager).

This sharing of experience is done for its own sake, and in this way it is hugely valuable.

However, sharing experiences in a trusting space also allows peer supporters to pick up on issues that other mental health workers may never understand. As MacNeil and Mead (2003: 2-3) note, building trust through shared experiences allows people to move beyond perceived limitations and old patterns. One peer supporter told a story about a man he had been supporting for some time.

"So I was introduced to this fellow and I was told the best way you can support this man is take him to the pub once a week and buy him a beer, and don't expect anything more of it than that. He's a no-hoper, if you like" (Matthew, peer supporter).

Over time, a mutual and respectful relationship grew up, and they shared a number of experiences with each other. After some time, they began meeting outside the pub. Because this peer had difficulties speaking due to a stroke, he was written off by the staff that looked after him.

Some of the mental health support workers really don't have a lot of time for him. And getting them to give him some respect is difficult. Even when he was living in the hospital ward for a long, long time, he would go out of there absolutely dirty and filthy and grubby. ... And the biggest thing that we found made a difference was for them to separate medication from the rest of his support. Because when he was in hospital they, it was just nurses and they would have every role. So they would, his nurse for the day would be the

person who gave him pills in the morning and in theory was responsible for making sure that he was clean and healthy and looked after. He never trusted people who gave him medication. So, because the person who gave him the pills was also the person who did the rest of the stuff for him, they could never build up a good relationship. So we negotiated with the hospital that the person who actually gave out the pills in the morning was a totally different person to the other one. And that was just brilliant (Matthew, peer supporter).

This idea of separating the carer who provided medication from the carer who did other things came out of Matthew's deep relationship with this peer, and the fact that he trusted Matthew enough to tell him about his distrust of people who gave him his pills. The trust built up in this relationship allowed old patterns to be remade.

The empathy and trust that comes from shared experience seems to be natural, and in some senses it is. One peer supporter talked about finding herself in tears, after the peer she was speaking with started to cry. "I suppose she knew that it was real. That she could trust me, because I was coming from a very real place. You can't act this stuff" (Deborah, peer supporter). However, building trusting relationships is also 'emotion work' (Hochschild 1983), and to some degree these relationships are very actively and deliberately created. One peer supporter was spending time in hospital, and trying to build up relationships with the very unwell peers who were there. He would spend time just sitting with people, "but not too close" (Ross, peer supporter), and would put time into letting those relationships slowly and naturally develop. Putting in a lot of time wasn't enough, however. He also needed to think quite actively about his body language:

It can take some time before that person trusts you as a peer. Again it totally totally depends on the person. It totally depends on the person. I've found for example, a lot of people would look and were giving me a lot of sideways looks and really treating me as a clinical staff member. And I kept thinking: what am I doing wrong? You know? And I realised at one point, because I opened up my diary and wrote down somebody's name before I forgot it, and I saw a couple of people just look at me just as I opened my diary. I thought:

shit, that's it, that's what it is. And once I lost the diary, just, I just put it in a safe spot where I could keep an eye on it but not have it with me, that actually changed quite a lot of people's views (Ross, peer supporter).

A number of peer supporters talked about the key elements they needed to build trusting relationships. Stephanie discussed the importance of time, of being prepared to make and remake appointments over a period of several months. Cancelling appointments can be a form of testing; will the peer supporter drop the peer like others have in the past? (Stephanie, peer supporter). Tane also talked about time. At the initial appointment he has to be prepared to stay for as long as it takes to build that connection.

"I have got to sit there and it may be a couple of hours before we even get around to "so tell me, what can I provide for you?" because it is about that whanaungatanga, making that contact and gaining that trust" (Tane, peer supporter).

He described using the process of whakapapa *[geneaology]* to build a connection and create trust. Non-Māori peer supporters often use disclosure of their own life experiences to the same end. While working in a crisis respite service for youth, one peer supporter explained, she would:

Sometimes, you know, open up and share my experiences with people when I decided it was relevant or helpful. Some of those young people actually just completely relaxed and opened up and initiated conversation about what was going on for them that otherwise I don't think they would have.   So I think it was, it's like an extra key to open another door (Melody, peer supporter).

The learning that peer supporters have engaged in isn't based on qualifications, but it is definitely learning, nevertheless.

You know, I think because we have been through the grill ourselves, we've been through the mental health system, we've got a much better idea of where somebody's at or comfort zones or anything else. You know, you can pick up in your little radar. And I think there's a lot of things that you learn as you go through the mental health system, especially if you're locked up in a

ward. There's things that you just slowly learn, it's a school of hard knocks.
That you cannot learn out of a book or out of a classroom, you know. You
have to have gone through it yourself (Ross, peer supporter).

Personal experiences of mental distress and the use of services lead to a potential for empathy and relationship which is particular to peer support. However, we have seen that this potential must be nurtured and developed through self-awareness and the willingness to commit time and active intention to the process of connection and trust building.

I think peer support comes from the fact that, you know, it's a real thing, it comes from, you know, a shared experience of extreme distress. And that's real. And it does bring people together and has an incredible energy for healing and understanding and I think that, yeah, so I think that should be the basis. If we've got that energy there and that real thing there, let's enhance it to make it as effective as possible (Geoff, manager).

This speaks to the need for peer supporters to have appropriate training, an issue that is explored later in this report.

2.6 Kaupapa Māori approaches to peer support

This section of the report relates to how participants perform peer support through a kaupapa Māori paradigm. It focuses on group interviews which took place at one kaupapa Māori service, and one mainstream service which self-identified as kaupapa Māori. Much of the discussion was located within the parameters of Māori health frameworks such as Te Whare Tapa Whā (Durie, 1994) and Te Wheke (Pere, 1984). Participants frequently drew on tikanga and whakaaro Māori *[concepts and beliefs]* as a way of describing their peer role. They described Māori health as holistic in which spiritual, mental and physical aspects were considered together as a whole and not treated as separate entities. However it is also important to note that Māori peer supporters talked in a similar vein as non-Māori peer supporters around a range of peer related issues.

Whakawhanaungatanga

The kaupapa Māori services described whakawhanaungatanga as central to the way that the peer support relationship was created. The ability to connect with tangata whai ora as whānau was beneficial.

> Well-being out in the community on the coast, it's being able to, if you can whakawhanaunga to the person you're dealing with, that's a big thing when you first meet them. You're able to connect and it's just so easy to work with them after that. (Ellen, peer supporter).

Whanaungatanga was generally described in two ways. One outlook was that it was the connections made by sharing common ground (Steve, peer supporter). This description caused some debate around the idea of support and connection. Some participants probed into whether whanaungatanga was making connection but that support was an extra element of the peer support relationship. Within that discussion the majority concluded that whanaungatanga was a benchmark of peer support.

> So, yeah, for me it's a natural progression from whakawhanaungatanga into doing the peer support. And if you've already got that knowledge and you're aware of the values around whakawhanaungatanga then it just enhances your mahi as a peer support worker, does that make sense? (Vanessa, manager).

The second aspect to describing whanaungatanga was from the literal sense of the term being genealogical ties and the relationship extended to others where a close familial, friendship or reciprocal relationship is formed. "The Māori holistic view is to look at the whakapapa first." (Janet, peer supporter).

One peer supporter spoke at length on how whanaungatanga was achieved. He stated that the physical act of the hongi *[physical greeting, pressing of noses]* was the beginning of the relationship. He also talked around how establishing whanaungatanga by finding genealogical connections helped built trust.

Trust starts with usually that whakapapa, that's what we do as Māori. It's making those connections. Once I can identify whakapapa I can take them on a journey of whakapapa and that's when they start feeling safe, because we're whanaunga *[relatives]* and if we're not then let's build at it. (Tane, peer supporter).

Within the ambit of whanaungatanga came the aspect that, within tikanga Māori, it created responsibilities. Koro noted how the literacy of understanding whanaungatanga was simple to achieve and re-label in peer support as connection, but it missed the subtle understanding of "intrinsic obligatory things that aren't spoken, that are told in our stories, that are told at our marae *[meeting grounds]*" that was gained from growing in the "intensiveness of whanaungatanga."

For me there is a difference between a peer and a friend and that is how I would see it if we were talking about whanaungatanga. There are many views but certainly there is a contemporary understanding of the name whanaungatanga and the more pure understanding for me, the purest view for me is having this conceptual and intrinsic understanding of all the obligatory things that were handed down in kōrero *[stories]*. We may be privy too but not every Māori that we work with may be. They may come from different thinking and that's what we have to ascertain, that relationship. But our culturalist told us that at that point as a Māori to Māori, we have this altercation. This is whanaungatanga; we just have to find out where it crosses and how to find that in the kōrero and the talking, its two ways. As a Māori, not only in Māori peer support, when I come as a whanaunga, I come with all those other respect mechanisms that are attached to it. (Koro, kaumatua).

Part of creating whanaungatanga with tangata whai ora was looking beyond the individual. Tane stated that the obligations could also be to the whānau of tangata whai ora.

The tauiwi *(non-Māori)* ways are different. They go in and wham *[claps hands together]*, it is very clinical, very clean cut, in and out, just tick the box. When I

go in there, there is no way I can do that. I have got to sit there and it may be a couple of hours before we even get around to "so tell me, what can I provide for you", because it is about that whanaungatanga making that contact and gaining that trust, gaining the trust of the whānau because at the end of the day it is the whānau that are dealing with the situation at that time. And they have a different perspective of what is going on that may not always line up with that tangata whai ora but I have to respect all perspectives so it's a challenge because you're dealing with different opinions for one reason. My purpose is being there for that tangata whai ora, well that is what the paper says, and my purpose is to actually be there for the whole whānau. (Tane, peer supporter).

Participants considered a kaupapa Māori approach to be a crucial concept in developing culturally appropriate services for Māori people. They also recognised the realities of dealing with Māori who did not outwardly identify as Māori or were less familiar in a kaupapa Māori environment, especially amongst younger people. Where this occurred, peer supporters were comfortable in matching the comfort level of the tangata whai ora (Tui, manager), and being able to conduct peer support in a more mainstream way (Tane, peer supporter). Other ways of resolving this was to build up whanaungatanga through rapport (Steve, peer supporter); and identifying why they had come to a kaupapa Māori service, such as whether they had self-referred themselves. Introducing them into a kaupapa Māori setting was also stated as being a part of the healing process itself.

And that's kudos to Shane because we've had a lot of non-Māori come into the men's group, and young Māori. Shane being Shane has taken them up to Hikurangi *[an ancestral mountain],* marae and we see them thrive, we see the change. And this is one of those young men who is now saying "yeah, I wanna learn waiata *[songs]*, I wanna learn reo *[language]*." He's very much embraced those aspects of tikanga and whakawhanaungatanga through being introduced to it. And that's part of his healing now. (Vanessa, manager).

Both organisations also dealt with non-Māori tangata whai ora. They noted that non-Māori enjoyed having access to their services. When participants were questioned on why consumers came back, they explicitly answered that it was whanaungatanga.

Tuakana-teina relationships

During the interview the idea of power and power imbalance was discussed. An intriguing point was raised around the possibility of the peer relationship being the equivalent of a tuakana and teina relationship. These familial terms refer to the relationship between an older (tuakana) person and a younger (teina) person of the same generation, and often within the same gender. They have been used within education frameworks specific to teaching and learning in the Māori context, where an older or more expert tuakana will help a younger or less expert teina.

The way Koro talked about using the tuakana – teina relationship within peer support was to describe the parameters of how the tuakana should work as a safeguard. He intimated that the role of tuakana has been misused as a control tool.

> There is this ownership to ensure that we have reflected the safetyness and not this having to be in control and at the same time tuakana teinatanga has its own mana *[prestige]* where it's like you look after your mana your way and I will try and help you look after it, but it's really up to you, the choices are really up to you. Tuakana teina, there are two views in that, there is the purest view, the traditional view and the contemporary view and in today's climate they are mixed. And for me there is this sense of power but in the traditional view it was just safety really and safety was not so much age but experience and life really. If you've been there, done that, then you can see it coming. You have a responsibility to put in a little flag and the teina will either say thanks or bugger off. "Oops you fell. Dust yourself off and try again," that kind of thing. That's the kind of tuakana I have been raised with. But today in the contemporary view the tuakana isn't, what I say goes and if you go against my word I turn and attack you. But it's not it, you turn and you go "alright then buddy" just to make sure then my role there is to watch, "any minute

1,2,3. Ok get up, get up and dust yourself off", not to take it personally you know. That's the tuakana, because that's their learning and you can't take responsibility for their learning, that's the tuakana. You can only flag it and then if they pick it up ka pai *[good]* and if they don't well ka pai too. (Koro, kaumatua).

He reiterated that this idea of peer support was to keep the mana of the tangata whai ora intact.

Yes, that's the hope I suppose. That your supporting them to a time when they are okay, standing, functioning in their own mana and their own thinking but know they have support there and don't expect that we are always going to be there and it's actually a false reality to think that it's always going to be there, there will come a time when they are going to have to do it alone. But if it is there then it is there and its care and meaningful peer support and especially for Māori from a Māori point of view you have to understand that sometimes they walk with us and sometimes they won't but the next time they come back to us how are we thinking? What are we thinking? We should be open because it's what they are going through, we're not (Koro, kaumatua).

To conclude his train of thought, the question was put to Koro whether the tuakana – teina roles were static. He suggested that the role could be fluid, in noting that the peer supporter and consumer could switch roles when sharing their own story.

But that's another concept of tuakana teina that people don't understand in today's world, is that if you're the learner then you're the teina So there's that level of teina, but not many people know that type of teina. They only see teina – tuakana as an age thing… And the ticks really for us, shouldn't involve much conflict and/or drama during the process. The ticks aren't that we've got this paper and that paper. The ticks are its flowing, whatever has happened is flowing. (*Koro; kaumatua*)

The description of the tuakana – teina relationship is close to an ideal peer relationship that Mead and MacNeil (2006) depict, which is more mutual and reciprocal. In this relationship both peer supporter and tangata whai ora take on the roles of helpee and helper within the relationship. They aspire that the peer relationship be shared:

> It is this level of mutuality that most resembles community type relationships
> and allows us to move towards full citizenship rather than feeling simply like
> the integrated mental patient in the community (Mead and MacNeil 2006).

Kaupapa Māori approaches to peer support offer us new ways of understanding the richness and depth of the peer relationship.

2.7 Effectiveness of peer support

This study did not set out to measure the effectiveness of peer support, and did not engage directly with service users. Our participants were peer supporters and peer support managers who talked primarily about the practice of peer support, although some of these participants also talked about their experiences of receiving peer support. In addition, our study was qualitative, so we did not collect systematic or quantitative evidence of effectiveness. However, a relatively large amount of anecdotal evidence for the effectiveness of peer support was collected in the course of our interviews. These primarily took the form of stories of transformation experiences that were experienced by peers using the services. We have included some of these stories, where they can be suitably anonymised or where we have specific permission to use the story, and we have interwoven some discussion of the research literature on the effectiveness of peer support.

One of the key goals of peer support is empowerment. Therefore, it is surprising that the three year follow-up study that Nelson, et al, did (2007), didn't find evidence of significant differences on the empowerment scale with the comparison group (Nelson, et al 2007: 663). They suggest that this may be due to the self-esteem scale they used not being sensitive to the types of empowerment occurring in peer support settings. This points to the importance

of recovery-orientated evaluation scales being developed. However, in their study of the vet-to-vet peer support programme in the United States, Resnick and Rosenheck did find that peer support led to improvements in general empowerment (Resnick and Rosenheck 2008: 1312). Meanwhile, Bracke, et al (2008) found that, in relation to empowerment, giving peer support is more beneficial than receiving it.

Our research was full of stories, both sketchy and detailed, of people who had become empowered through the provision of peer support. Often this involved empowerment in relation to the small details of everyday life, rather than larger and more obvious changes:

> I do have one client... he's been under the thumb of everyone for so long, written off as useless and not able to do anything for himself, that I give him little tasks to do. He wanted a clothing allowance from WINZ. No one had ever let him go and get a quote for clothing. By saying, all you have to do is write down the steps he had to take to get it, him going in and doing it, he went and did it. He did it fine. He said I didn't even need to use your little list, but thanks for that. Confidence in him just grew. And that's giving him back his power (Craig, peer supporter).

Thus, in relation to empowerment, the jury must be considered to be out, until such time as more accurate ways of measuring consumer empowerment, such as are made possible by the new measure: *Taku Reo, Taku Mauri Ora: My voice, my life* (Gordon 2009), have come into evaluative use.

There is a growing amount of quantitative evidence that peer support makes a significant difference to the quality of life of people receiving it. Doughty and Tse's systematic-review of recent high quality studies found that a majority of the studies they reviewed reported a reduction in hospitalisations (Doughty and Tse 2010: 12) amongst people participating in peer support. There were also consistently greater improvements reported in practical outcomes, such as employment, education, finances and living arrangements (Doughty and Tse 2010: 12). At their three year follow-up of a longitudinal comparative study, Nelson, et al. found that people who remained active in consumer survivor programmes over a period of three years had significantly better scores on a quality of life scale. They also reported enhanced community integration and reduced symptom distress (Nelson, et al 2007: 662).

This relatively long account of a peer who is happy for her story to be told, gives a flavour of the way that peer support can enhance quality of life, alleviate anxiety and depression, and lead to improved practical outcomes.

When we met she was sleeping all day and was up all night, and sort of had her day night cycle back to front. We sat and talked for about an hour the first time I met her, and she just didn't have any sense of herself having any value in the world. There was no reason to get up in the morning. There was nothing about her that was important enough to have the things that she wanted. She had some ideas about what she wanted for her life, but she didn't think they were going to happen, because, for all sorts of reasons, she didn't think that she deserved them, essentially. I think that was what was underneath it. We were talking about some of the peer employment work, the training that we'd done around recovery pathways, and she just got so excited. I mean, it was three or four years ago now, and I still remember it. The idea of hope, having hope, being the essence of everything. And also empowerment, and having choices. And, "Well, what does empowerment mean? What do you mean by that?" And so, really challenging me to talk about what those things mean (Zoe, manager).

And we've talked about it since.... She was really interested in that first meeting, but then didn't really believe that any of that was going to happen for her, so she started avoiding meeting with me. She would be somewhere else when we'd agreed on a time. Or she would be asleep, even though she knew that was the time that I was going to be there. And I didn't give up. I just kept turning up at the times that we had agreed. And when I said I would be there, I was there. And just turned up, week after week. And she said she reluctantly started to talk a little bit more about the things that we'd talked about in that first meeting. And something shifted for her. Something in that time just really changed. She started to believe in herself and to believe what was possible. She decided to do the peer employment training herself. And I had the great privilege of supporting her through that training with transport.

Because the training venue was quite a long way from where she lived, and she physically couldn't get there. So we made arrangements for me to pick her up and take her there. And the great privilege and joy was that every day I got to hear for her what was happening. And her shifting and changing in her thinking about herself and what was possible. She was living at home at the time. She's since moved out of home; found her own place. She set up a really nice place for herself, and has since found meaningful employment that she enjoys. She has a young child who she was concerned about. She got her child settled successfully at school. And most of all that happened because she was able to find some hope for herself (Zoe, manager).

In this story, we see an account of what reduced symptom distress, enhanced quality of life, and good outcomes in relation to employment and education actually *mean* in practice.

Greater community integration was found to be a benefit of peer support by Nelson, et al (2007), although Doughty and Tse (2010) found that there is some evidence that involvement with consumer staff may restrict the evolution of natural community and family supports (2010: 12). It is likely that the way the peer support is offered will have an impact on whether greater community integration results from it. One effective way of building greater community involvement is through running peer support groups:

We have a woman who started coming to [our peer support group] early last year. At Christmastime this year, she made a hundred Christmas cards. She burst into tears at the last meeting of the year, and said, "Last year, I didn't send any Christmas cards." This year, she made a hundred, and she sent out about eighty something Christmas cards. The only thing that had changed in that year is that she started coming... she was referred to [us]. And from that referral, she's met and got to know people in old people's homes where she does volunteer work now, the people at [our group] that she goes and, she goes and visits people in hospital now. She's got a little telephone community that she rings up, just to say "How're you going?" Now all of this started just because when she was in a mess, and we started one on one, and it went from there. So out of *that* relationship has grown all these others. And to me, that's just a magic thing (Deborah, peer supporter).

Studies focusing on peer support groups have found that they are effective in improving consumers' social networks (Castelein et al 2008: 70). Other studies have found mixed evidence that mutual help groups can be effective across a wider spectrum of outcomes (Pistrang, et al 2008).

One of our peer support managers was pleased to report that twelve of their peers had found employment in the previous year, and twelve the year before that (Vanessa, manager). These sort of 'hard' outcomes have been well reported in the literature. (Kaufmann 1995; Nelson et al 2006; Ochocka 2006; Doughty and Tse 2010). However, it's harder to put a finger on the subjective life changes that arise as one is learning how to see oneself differently, to reframe one's experiences and to develop in self-awareness. Our interviews were full of such stories.

> As a context to my recovery, peer support has been about getting other people to understand that sense of transformationalness about what mental illness is. It's actually, for me it's been a journey of becoming more embedded myself, and leaving behind the things of restriction and confusion, and inability, that were a part of my earlier life and resulted from other people exerting power over me, or dumping on me in some way or making me feel inferior, leading me to a place where I made myself feel that way. And so peer support I saw as a natural fit. It was kind of the answer that I'd been looking for (Simon, manager).

This manager saw peer support as being about spiritual transformation. He had been on a spiritual journey and his mental illness and eventual discovery of peer support was part of that process of crisis as learning opportunity (Mead and Hilton 2003).

In the section on 'benefits of peer support to peer supporters', we will look in more detail at the way that peer support can lead to enhanced life outcomes for the current and former service users who are providing this service.

3. Practice Issues

3.1 Risk

How to handle risk – the risk of suicide, self-harm or harm to others – is a key issue for peer supporters, as it is in community mental health more generally (Sawyer 2008; Sawyer 2005). This is a matter of good practice, but also of health and safety, since some peer supporters discussed ways in which they keep themselves safe. In the research interviews, we talked to all our participants about risk, and this section addresses some part of the complex answers they provided. We start by talking about the degree to which 'risk' is a problem in peer support, and then move on to look at some of the policies and practices by which it is addressed. We then explore whether peer supporters handle risk differently from other mental health workers, in particular by working through relationship and by treating crisis states as a learning opportunity (Mead and Hilton 2003). In the section on health and safety at work, later in this report, we talk about the ways in which peer supporters keep themselves safe; what are the health and safety practices used to address risk?

First, about half of our participants indicated that 'risk' was perhaps over-emphasised as a problem in peer support. Crisis situations are not often encountered in peer support services. One manager expressed this succinctly:

> "We are incredibly lucky. We very very seldom have any kind of conflicts like that. We've had people show up here who say that they have swallowed pills. We have people say they are going to leave and do something to themselves right away; that's pretty regular. But there haven't been – I'm very superstitious and I really want to knock on the table right now – there haven't been incidents that were beyond our ability to manage them, in either programme, so far. And a big part of that is because consumers really act, self-harm, much less often than they want to. It might be a driving voice all the time, but they succumb to that driving voice much less frequently than the media think, or people think" (Brigid, manager)

Mental health legislation and practice in most Western countries is pervaded by risk thinking (Godin 2004; Sawyer 2008; Rose 1998). A shift has taken place from a therapeutic consciousness to a risk consciousness – centred on assessing and managing 'risk factors'—in community mental health. According to some mental health providers, this has involved a narrowing of the services provided, a shift to the use of technical checklists, and the possible loss of capacity to listen to service users' own accounts of their experiences (Sawyer 2005). So challenging this risk consciousness by de-emphasising risk is an important step.

In addition to stating that they don't often face 'risk' situations of any kind, a peer supporter working in two services emphasised the differences between suicide and self-harm. Most of the people who self-harm are not trying to commit suicide, but simply want to express distress. This view can be reinforced by Mark Cresswell's research into the movement for survivors of self-harm in the UK (Cresswell 2005). Self-harming might provide some relief, and even reduce people's need to suicide. With understanding, self-harm can be addressed well by peer supporters.

> Some of the young ladies are very good at, you know, damaging themselves quite intensely which can actually be quite dangerous, life threatening. But 99% of the time that's not what it's about. So self-harm in itself can be managed by distraction and just [by contacting us] sometimes. Or one guy that made me laugh one day, he says, "You know when I feel like self-harming I just go and find something else to do." You know. And that's it in a nutshell quite often (Melody, peer supporter).

However, the risk of suicide is seen very differently to self-harm by peer supporters and peer support managers. One participant said that suicide was a choice that should be open to people "A person is entitled to have this last form of control" (Velda, manager). However, that view was not shared by anybody else we spoke to, and in every single service, great thought had gone into ways to keep people safe in suicidal situations. Most people emphasised the need to do whatever was necessary to keep people safe from attempted suicide. That involves two primary strategies: dealing with the situation through conversation and relationship, and contacting clinical services.

Our [area's] stats were through the roof a few years ago with one of the highest suicide rates in [large region of New Zealand]. So I'd rather err on the side of caution when we're dealing with our whānau like that, and they understand. We don't make it sound clinical. It's more about, "we really care about your well-being and how can we help you keep safe and how can we keep ourselves safe." And again, the relationships we've already built, they're happy for us to do that (Vanessa, manager).

Almost everybody we spoke to said that they would ring the crisis service, or the peer's key worker, if a genuinely dangerous situation arose. Only within one service did the workers fail to mention this as a policy for dealing with very risky situations. In this service, extensive support was provided by the peer supporters to people at risk of suicide. In all the other services, there was a clear policy that, in situations where there was a risk of suicide or harm to others, clinical services would be alerted, and confidentiality would be broken.

There were variations, however, in how this policy was put in place. One service had a very structured process for determining if a person was at risk. This involved asking three set questions and, depending on the answers, then moving on to contacting clinical services. A peer supporter in this service said that the process **had** to be highly structured. "It's about their life" (Caitlin, peer supporter). Other services leave it up to the discretion of individual peer supporters. "The approach is if you feel really worried you can ring the crisis team on your own behalf because you can't go home feeling worried. You take the action you need to take to put your mind at rest" (Velda, manager). There was also a difference in the level of concern that needed to be felt before clinical services were contacted. One peer supporter emphasised that he went to the clinical services as soon as he had any concerns at all.

I am very clear with my tangata whai ora that I'm working with at that time that this is what is going to happen. If I see or I hear at any time that there is any reason for me to feel that there is a safety issue here for you, me or anybody else then I am going to go to the appropriate agencies to keep you safe, and I won't hesitate. The moment you even say one word

like I feel suicidal, I feel like cutting, anything, I will call the crisis team or whoever. Whoever I need to call, I will bring in (Tane, peer supporter).

This quick recourse to clinical services was somewhat unusual, however. Most participants emphasised that they spent time dealing with the problem through relationship, and that in practice they called the clinical services rarely, if ever. One service described the process they went through before calling the crisis services as emphasising a relational attempt to work through the problem. As a result, they rarely needed to call for clinical assistance. "And [the crisis team] take us very seriously. If we ring they know there's something really bad. You know. We won't ring otherwise so they're there immediately" (Ross, peer supporter).

One key aspect regarding the policy on calling in clinical services is the transparency with which this occurs. The overwhelming majority of our participants emphasised that they always told their peer that they were going to contact clinical services, and even that they asked them to make the call themselves. They told their peers, as they engaged with the service, that they would be prepared to break confidentiality over a safety issue, and they then informed them again at the time that they actually contacted the services. This was to ensure that trust was maintained between peer supporter and peer, and that no betrayal would be felt. In practice, sometimes peers did feel betrayed, however, as was indicated strongly in a story told by one peer supporter (Rose) about a time she had to contact clinical services in regards to a peer. To prevent that sense of betrayal, one peer support service said that they were not always honest with their peers about having contacted services.

> I was just saying how those relationships are so valuable as peer support
> that we don't want to do anything to jeopardise it. And it's not often we've
> had to do it, but often our whānau are unwell and they'll come straight
> here to us before anyone else, or we'll see the signs and we're not going to
> let it go. We know we've got to act to get them in as soon as possible to
> get them well again. So it's always about, Ok, we might meet the key
> worker at the door. 'Just pretend you've just popped in…' (Vanessa,
> manager).

This was the only service that didn't have a policy of being as transparent as possible when contacting clinical services, and even here, this approach was adopted to sustain their relationships with tangata whai ora. This relates to the general approach to risky situations adopted by peer supporters in Aotearoa New Zealand; working with the risky situation through the building of relationships is central to how peer support is practiced.

When asked how they deal with risk situations, participants repeatedly said they did this through relationships:

> "Conversations. … So if you go back to the peer support model: 'what's happening at the moment, you know, what has happened yesterday that's brought this feeling?' So you just have those conversations. Organisationally we've not had to deal with a major, major risk scenario. I think because a peer support relationship actually is such that people have those honest conversations in a way that makes, that the peer feels that they can have, they don't have to go with a message of: 'I feel suicidal.' I know that peer support workers deal with that and that they have those conversations with people, but it's a conversation that they have, rather than jump on the phone to the clinicians and say, 'so and so is suicidal' (Lydia, manager).

So offering peer support can be a way to avoid medicalising distress. The peer is encouraged to take responsibility for their own feelings through an upfront discussion of what is going on, and what they are feeling. One peer supporter described the peer support approach as being quite different to some other ways of dealing with distress:

> And where I think a big difference is that we see the person and whatever their illness is, is part of them, but it's not who they are. And I think that's a big difference. And I think, because of that we don't feel fear to actually talk to people about things. If someone's sitting with me, telling me that they want to overdose and stuff, it doesn't freak me out, I'll talk to them about it. I think other people would want to medicate to stop them wanting to feel like that. (Stephanie, peer supporter)

Nurturing care is a big part of what peer support can offer. However, as discussed earlier in this report, this care need not be undermining of independence, when it is provided by peer supporters within a logic of self-determination and self-responsibility. One peer supporter working in a crisis house described the difference between peer support and other forms of support as follows:

> We work on relationship, I think that's the thing that we do really well. And when those relationships are working well we're checking in with the people all the time and we're seeing whether they're eating, drinking, doing all the normal things or not. And you know, if the person stops eating and drinking and stuff like that you might think what's going on with them, and you can check it out and see if they're ok. It's that relationship and we put a lot of intense hours into just chatting with people…. And it's really great to get people reporting for themselves and taking responsibility for themselves to say, "hey, I'm feeling a bit unsafe", you know, recognising it first themselves before they do anything" (Maya, peer supporter).

Finding the right balance between keeping people safe and encouraging them to take responsibility for their own lives is a delicate matter, with high stakes attached. Much depends on building rapport, maintaining relationships, and then recognising the power of trust. One peer supporter told this story:

> I had someone say that they were coming to the office, but they might stop on the bridge and jump over. And I met them on the bridge. I said, 'when you get to the bridge, just stay, because I'll meet you there.' And I ran from here downstairs and met them on the bridge. And we talked about jumping over, and we talked about the consequences of that for her family. And we talked about the things that she wouldn't be able to do in the future that she might want to be able to do. Then I left her. I said, "I'm going to walk up to [peer support service] now. And I'm going to put the jug on, and hopefully you'll be up for a cup of tea not long after I get there" (Deborah, peer supporter).

The peer did come up to the office for a cup of tea, but the profound and uncertain effects of such experiences go deep. As Deborah said, "I don't know what I would have done if she hadn't."

This raises the question of whether there is a 'peer support' way of dealing with risk. Of the 21 participants who answered this question directly, fourteen said that peer support did involve a different way of being with risk, while four participants said it didn't; all good mental health workers would address risk in similar ways. Three participants were in two minds about this, but felt that there might be some differences. One participant felt very strongly that 'deep peer support' did offer a contrast to mainstream ways of dealing with risk. This approach builds a culture of engagement, or a recovery culture, but one has to live with some degree of risk, in order to create and sustain relationships that work with mutual respect and understanding.

> I guess we come from this thing that actually, yeah, sure people get in a very acute state, but there's still reason to trust them. And some people have been, you know, survived many a – I guess, yeah, the ability of people with mental illness is, you know, fundamentally anyone who's got this experience is a survivor against the odds because there's a hell of a lot of them that don't survive. So there's trust in people, they've got resilience in there, they've got strength in there. You've got big concerns but also got strengths. And trust in the relationship as well (Geoff, manager).

Part of the difference between different answers to this question related to the type of training peer supporters had received. Peer supporters and peer support managers trained in the Intentional Peer Support (IPS) model, and in in-house models drawing substantially from IPS, were more likely to say that there was a specifically 'peer support' way of dealing with risk.

So a problem arises when peer supporters working with this approach must work with mainstream services looking at risk through the eyes of a risk culture. In talking about interaction between peer support services and mainstream clinical services, Geoff said:

One team's coming from a very risk averse medical model approach. And we're coming from an opportunity, risk is opportunity and if you don't take any risk you don't learn anything, sort of approach. And, but the safety's in, I guess, safety's not quite the right word. The **container** is the relationship, really, the peer relationship (Geoff, manager).

This brings us back to the importance of the peer support relationship, not just in protecting against risk, but also in every aspect of the process of recovery. How that relationship is maintained in a sustainable way is the subject of our next section.

3.2 Boundaries

Boundaries were discussed extensively in these interviews; every interview included talk about this issue. While there are a huge diversity of ways that 'boundaries' are handled by peer supporters in Aotearoa New Zealand, certain common themes emerged. First is the nature of peer support as a practice, and the empathy, disclosure and connection that goes along with it. This leads into discussions of the tension felt between maintaining that intimate connection and maintaining a requisite professionalism. How are boundaries handled in the 'profession' of peer support? The similarities and differences between peer support and friendship were extensively discussed, as was the need for time to refresh and rejuvenate oneself. Finally, the fact that peer support relationships have a mutuality that is not present in other types of mental health support work were seen as an important boundary issue.

Peer support was seen by most of our participants, although not by all, as being very different in nature from other kinds of mental health work. A major part of those differences lie in the empathy and understanding which is part of peer support, and the disclosure of one's own experiences that sometimes accompanies peer support relationships.

I think, probably the two main [differences from clinical work] is the disclosure, the willing to go into disclosure and be mutual in that relationship. That the relationship is just as much about my stuff as their stuff, really. And

the other thing is around flexible boundaries. Oh yes the other thing is, too, that yeah, my story can be a story of hope for people. So I've got to be careful how I, and mindful about how I craft my story. Cause I don't see a peer support relationship as a place to vent. Yeah I think it's very important as a peer support worker that we need to know that it's not a place to vent really, vent against, rage against the machine. Or the weather. Or anything else. It's a place to really be able to be mindful of the power and importance of our language and the power and importance of our stories and craft those stories quite intentionally, to be stories of hope really. (Rick, manager).

This theme, that one must be mindful about how we craft our stories, is something that emerged again and again in the interviews. This whole question about when to disclose personal stories, or personal issues, and when to keep them to ourselves, seems to be rather fraught for many peer supporters. There is a purpose in telling our stories, and that purpose is to effect a change for the peer that is being supported, to instil hope and to bring about a different way of framing experience. This framing of one's personal experience to effect change for others is a very particular sort of *work*.

The concept of 'emotional management' as a particular kind of emotion work was developed by Arlie Hochschild (Hochschild 1983), and has been further discussed in the sociological and health studies literature. Emotional management is the inducing or suppressing of a feeling, in order to create a bodily display that produces a particular state of mind for another person within personal relationships (Wharton 2009: 149). Emotional management is certainly part of peer support. But to disclose such intimate personal details, as part of a paid job, makes peer support quite different from other types of work involving emotional management, such as being an airline flight attendant, a fast food worker, an insurance agent (Leidner 1993) or even a nurse (Theodosius 2008). Peer supporters are putting some of the deepest parts of themselves 'out there' as part of their general working life (Mancini and Lawson 2009).

So the hardest part I think is when it's a job. I think it's not that easy to step out when you need a break. Yeah, because it is, you know, no amount of money can pay for that part of yourself that you give. And of your own story

that you give when you're working. There will never be enough money to pay back a person for that part of themselves that they give. I don't know of any other job actually, that a person has to give something that intimate and that important to that person, than peer support (Alexandra, manager).

One important boundary, then, is around whether and when to disclose one's own personal story. While a number of participants said that disclosure was an important part of peer support, an almost equal number said they rarely, or in one case never, disclosed information about their personal lives. Some peer supporters drew a distinction between disclosure that was helpful in moving a peer forward, and had a direct relevance and purpose, and disclosure that was just for its own sake. Like in other mental health fields, it was seen as important that peers shouldn't be unnecessarily burdened with their peer supporter's difficult experiences.

> There are times that I share and there are times that I don't, and it's about me identifying when I feel safe enough to do so and whether it's appropriate for me to do that. Because a lot of the times doing the peer support is not about me, it's not about me, it's about the tangata whai ora I'm dealing with at that time. It's about their kaupapa *[philosophy]*, their māngai *[telling their own story]*, their take *[issues]* or whatever. And for me, it's about me allowing them to tell me about their journey. If there is a time when I can share that or I can assist that and bringing that out, then ka pai*,* I'll do it. But sometimes it's about safety, safety for me, because at the end of the day I'm sensitive to where I'm at in my journey as well. There's stuff in there that I don't need to share and don't want to share. That's my private stuff (Tane, peer supporter).

This question of disclosure relates to a broader question. Is paid peer support a health profession, with the boundaries that go along with such professions, or is it something more akin to friendship? This was discussed in one of the group sessions we held:

> But I think it depends on the individual. How responsive you are to people and how you are in yourself, how open you are to others (Vanessa, manager).

> So that's like the personal versus the professional (Selena, peer supporter).

It's a real tricky one, that one. Because there is a degree of professionalism

needed but at the same time, too, we're peer support. There can at times be

that conflict (Vanessa, manager).

This tension between the two divergent ways of viewing boundaries emerged in the answers participants gave to questions around this issue. A substantial minority of our participants said directly that peer supporters have looser and more flexible boundaries than other sorts of health workers, while others implied, similarly, that this is the case. However, everybody said it was important to have firm boundaries in place. More than half our participants directly stated that peer support relationships are not friendships, while about half emphasised that peer support is a *professional* relationship.

It's like we're friends, but [a difficult situation] taught me a lot about actually

we're not friends. This is not about friendship. It can be, when it's informal

peer support, when you're making friends with people that are doing the same

thing or you've met them in hospital. But when you're actually working with

that person in a paid capacity in an organisation, you can't, the friendship or

the boundaries around the relationship have to be really clear (Cathy, peer

supporter).

Only in one service did the peer supporter and peer support manager say they were happy to be contacted by peers outside of their working hours. Everybody else asked about this said that they don't socialise with peers outside of working hours, *while* they are still providing a peer support service. If a friendship should happen to develop with a peer, there is a change of peer supporter or advocate, in many cases. In other cases, that friendship would not be allowed to develop until the peer had exited the service. Three services said further that they don't encourage, or allow, friendships between peer supporters and peers for a set time – such as a year – after the peer has exited the service, while other services would allow a friendship to develop immediately after a peer has left the service.

There are also boundaries put around the type of relationship that develops while the peer is still with the service. One advocacy service emphasised that they don't get into a joking relationship with peers; they maintain a professional demeanour (Rose, peer supporter). A peer supporter in a crisis house pointed out that they would draw firm boundaries around

behaviour such as interrupting conversations or following the peer supporter around. Modelling good boundaries is actually helpful to the peer, she noted. "It's just working it all through within relationship and the context of relationship. Because, yeah, relationship is the thing that makes the place work" (Maya, peer supporter).

This raises the question of how one maintains these boundaries while still protecting the connection and rapport which is central to a peer support relationship. Peer support involves giving of oneself in a way which does not happen within most other helping professions.

> But if we had a policy that said you're not allowed to continue the friendship, then going into peer support with someone new, I would not be giving of my full self. If I knew that in a year's time I was going to have to back off. Whereas now I will go into it not knowing if it's going to develop into a friendship or not (Stephanie, peer supporter).

In the above service, there has been discussion about putting a policy in place that prevents peer supporters continuing friendships with their peers for a year after the peer supporter has left the service. This peer supporter spoke eloquently about how that would make it impossible for her to practice peer support in its full sense, which involves a whole hearted relationship that is open as to where it might go.

> What makes peer support work really well is actually the, the true connection and that connecting and talking and stuff that's sort of giving of yourself. And the best work's done in those grey areas of, am I transcending a boundary, or not? Those sort of areas (Geoff, manager).

This need to 'give of yourself' brings us back to the question of emotional management and what we mean by 'professionalism' within peer support. The concern of the participants quoted above is that if boundaries are used 'as a wall' (Geoff, manager), then it will be impossible to genuinely feel the connection, care and joy in the peer support relationship that brings the peer supporter his or her deepest feelings of passion and accomplishment. To step past some of the stricter boundaries might be a way in which to actually sustain well-being within the intimacy of the peer support relationship.

Laurie Curtis and Martha Hodge have discussed the boundary issue in some detail (Curtis and Hodge 1995). They point out that boundaries exist in all relationships, and may be understood as the highly personal translation of moral codes into our relationships with others (Curtis and Hodge 1995: 49). A key issue in the mental health sector is the degree to which worker and client, or peer, interact only within their assigned roles. 'Professionalism' has traditionally been about remaining within defined roles, but peer support challenges traditional understandings of professionalism, because its notion of mutuality challenges 'defined roles', as such. Even so, peer support in a paid context is similar to other mental health occupations, in that it requires sustaining the capacity to provide empathetic support.

> There's aspects of friendliness in it and there's aspects of some sort of connection which is quite a deep one. And often, we don't really have that many words for it, but actually it's also: this is my job and I might feel that with you but I'll feel it with the next person that comes through and the next person and the next person and the next person (Geoff, manager).

In this way, peer support is quite a special and unusual occupation, in which boundaries become tied up, not just with professionalism, and protecting time for rejuvenation and self-care, but also with the recovery model and the mutuality of peer support relationships. The boundaries issue thus becomes less about creating barriers and more about developing honesty and mutual respect. It becomes another question: How do we sustain our peer support relationships? (Geoff, manager).

3.3 Honesty, mutuality and avoiding burnout

Burn out is endemic within professions and workplaces involving helping work. Peer support also has some people talking about the possibility of burn out, although to a strikingly smaller degree than in some other health occupations.

> You can walk away from it at the end of the day and leave it behind. Which you don't do with a friendship, that stays with you all the time. And it's necessary to do that because I mean this is very difficult territory and God help you if your only friends in the world are constantly mentally unwell

because you're going to have a very difficult time if that's the only friends that you've got. Of course not everyone is like that. And people do go through phases of being more and less well. But when you're in this kind of work you're going to be fairly constantly dealing with people who are significantly less than their best in terms of wellness. And so you've got to have that ability to kind of step away from it (Simon, manager).

However, the key to preventing burn out was said by Simon to be applying the principles of peer support in a more comprehensive way, rather than stepping back from them.

I'm here to try to be as thoroughgoing as possible throughout the organisation in applying the principles of peer support, and the way that that worldview works.   Because that's, to me that's a framework for professionalism that's actually got a heart as well. And so you can do it out of love without putting yourself in that place of risk (Simon, manager).

Being true to the principles of peer support involves keeping close contact with the principle of mutuality. Within 'Intentional Peer Pupport', "What I feel, what I see, what I need" (Mead and MacNeil 2004: 14) is a key principle. What's going on for the peer supporter is just as important as what's going on for the peer. One peer supporter noted that it was quite all right within her service for a peer supporter to tell her co-workers that a particular peer "really tries my patience" and to have that key relationship made by somebody else (Maya, peer supporter). It's also fine for a peer supporter to step back, and say that he or she just isn't up to doing something today.

But I think with the relationship, I think it's the authenticity. You know how they talk in the IPS *[Intentional Peer Support]* about authenticity. It is *so* that. It's so that. It's *so* being honest. And having the courage to, if someone's doing something that's upsetting you, own it. Say, 'look I don't know why but what you're doing is actually really upsetting me'. Like with me I sometimes will say, 'when I see you next time I will probably be able to tell you why, but I don't know why. All I'm telling you is that I'm feeling really uncomfortable at the moment.' It's owning it, and having the courage to own it, you know (Stephanie, peer supporter).

This isn't a one-way 'helping relationship' then, but a relationship that is, at least to some extent, mutual. This allows for an honesty within the peer support relationship that protects the capacity of the peer supporter to be genuine in his or her feelings of care and support.

However, this principle wasn't always carried out in practice and therein lies the potential for burn out and emotional exhaustion.

> If you're having a crap day, that's your stuff. You don't go to your peer person and say "I feel like crap". But that person already feels that way. They don't want to know what's wrong with you. They want to tell you what's wrong with them. You're their peer so you're going there to support them (Selena, peer supporter).

> It's our responsibility to look after ourselves, as I was saying before. Like if someone is coming in like if they were suicidal or something, and they said "oh yeah, I cut myself." I'm not going to turn around and say "that's what I do all the time as well, mate (Eli, peer supporter).

The dangers of burn out are discussed again in the section on health and safety at work, but within peer support, boundaries are as much about an embedding of mutuality as they are about distancing the peer supporter from his or her peers. This mutuality, when it works, allow the peer supporter to sustain the authenticity which makes peer support such a rewarding profession.

Mancini and Lawson suggest that the most committed, professional and engaged peer supporters – the ones most likely to 'go beyond the call of duty' for peers – are the most vulnerable to burnout and vicarious re-traumatisation (Mancini and Lawson 2009: 11). However, in our study of peer supporters and peer support managers in Aotearoa New Zealand, we didn't find evidence of such burnout, vicarious trauma, emotional numbing or loss of self. Indeed, peer supporters consistently said they were passionate about their work, enjoyed it greatly, and found that it helped them with their own well-being. One peer supporter said: "I'm very passionate about [peer support], because I know it works. Every single person that I work with teaches me something. Every single person helps me with my recovery" (Deborah, peer supporter). Many peer supporters echoed these sentiments: "And

just being passionate about what I do; I don't think I could ever walk away from it now" (Brenda, peer supporter). While some peer supporters had left their work due to burnout, many peer supporters had stayed in these relatively low-paid positions for a long time. For example, in one organisation that had been offering intensive peer support for eight years, two thirds of the original workers were still with the service.

> And that's how I very much saw it in the beginning, that it would be a place for people who had gone through this whole distressing mental health episode to find their feet, to gain their confidence, to work in an understanding environment and then, get their qualifications or whatever, find the direction they wanted to go in and move out, go away, that was the whole idea. Now some people haven't managed to go away yet [Laughter]. But they're also a magnificent team. By now they're so sturdy. You know, there are situations which are, they can take on many things. And hold their own. And they don't burn out and they don't run away and we don't have a large turnover. And I wanted a large turnover but it's not happening. You know, how mental health organisations are complaining about the staff turnover? Well I actually set it up with the idea in mind that this was one of the goals, to have large staff turnover. And it doesn't happen (Velda, manager).

How is such intimate work in such demanding circumstances sustained over time? This is a question faced in many mental health occupations, and it is often addressed through 'professional boundaries' (Curtis and Hodge 1995). Shery Mead, the founder of Intentional Peer Support, notes that mutuality is not often a characteristic of mental health workers' relationships with their clients. "Everything we have learned about help in the mental health system pushes us to think of it as a one-way process" (Mead and MacNeil 2004: 10). This is a characteristic of most forms of 'professionalism' and it leads to the need for emotional management, distanced relationships and emotional labour. By contrast, as we have seen, peer support is imbued with the value of emotional honesty.

Bolton and Boyd (2003) describe four types of emotional management at work. Two key ones are prescriptive emotional management, where emotions are managed according to

professional rules of conduct, and philanthropic emotional management, where workers offer rapport, supportiveness, nurturance and empathy as 'a gift' (Bolton and Boyd 2003; Lewis 2005: 568). Bolton and Boyd sharply distinguished these types, while Lewis found that for neonatal nurses these types of emotional management are actually in tension with each other. By contrast, for peer supporters they merge into the same thing. As a professional practice, peer supporters are expected to offer their peers emotional engagement 'above and beyond' that provided by health workers in general, emotional engagement characterised by genuine feeling and by authenticity.

Being expected to offer authenticity as part of paid employment can be characterised as a very particular form of work. We suggest calling it by the rather strange name of 'authenticity work', to indicate that achieving authenticity in the peer support relationship actually requires active and skilled effort. This is directed at clearing the obstacles to the development of genuinely caring relationships. These obstacles can be found in myriad emotional responses to others' behaviour, and must be addressed by a very thorough practice of honesty and mutuality, as well as a willingness to sit with emotional discomfort. One manager told this story:

> We had a staff member here who, someone selected to work alongside her, and she decided that she, you know, she could do that. Started, you know, having a relationship with the peer, and started working, they started working together, alongside one another. But every time I had a conversation with her there was, it was quite clear that things were coming up for her which remained unresolved. And that she did not feel that she could actually have the conversation with that individual because it was her stuff that was being raised. The other individual was completely unaware of what was going on for her. So to me it was a matter of that she was not honest with this individual, and did not feel that she could be honest with this individual because she was scared of what that might create and cause, and that it would hurt that other person's feelings. So the reason it didn't work was not about this person and the relationship, it was around the peer support worker not following what a peer support relationship is about. Not being honest, you know, wanting to take responsibility for that person's emotions that

might come up without actually taking responsibility for her own. And not giving that person the opportunity to make a decision around whether this is working or not working. So it was around taking some of that control away from that person in the end. And that didn't work. The person eventually said, 'oh, this is no different to what I get from my CSW' *[Community Support Worker]* (Lydia, manager).

In this relationship, an understanding of 'professionalism' in which one doesn't raise one's own feelings or perceptions was operating. The result was a peer support relationship which failed. The peer eventually decided not to access the service any longer, because of a perception that it wasn't different to what other mental health workers could provide. But the peer supporter's manager was clear that this is not what a peer support relationship should be about. A deep honesty was required in the peer relationship; supervision and training should help the peer supporter achieve the ability to do that.

In order to create authenticity, peer supporters have to engage in "authenticity work", a form of emotion work in which spaces for authentic relationship are created and shaped by active and deliberate processes. Mutual behavioural rules are established with peers. One's own feelings and needs are expressed. The peer supporter's behaviour and appearance are shaped in such a way that emotional safety is created for both parties.

Peer support provides organised emotional care to people suffering mental distress, and one core of that care is to be found in honesty.

What people really need is interaction with real people. Real, true interactions. Because there's two things about mental illness. It's that, A): it's not necessarily politically correct and B): it's basically an honest experience, you know. Basically all the bullshit's ripped away and this is how it is. And for here when you need that, you need honesty and openness. And that's, I would hate to see that getting taken away for that. Why would they be doing it? They'd be doing it for risk reasons. But I think it actually, it could well be creating as many risks as what it's taking away. So it's about being very careful about that (Geoff, manager).

This leaves peer support with the conundrum of 'authenticity work'. How does one organise, train and supervise peer supporters so they are able to be as fully authentic in their relationships as possible, even while they contain the work within the boundaries of a paid job which has to be repeated on an ongoing basis? How does one 'work' at being genuine and spontaneous? We would suggest that the answer is to be found in clearing the decks emotionally, and letting the relationship emerge as and when it will.

> ...let the moment create itself, the relationship create itself. Yeah, so that we're not trying to force it or push it anywhere. We're just letting space and sometimes silence and laughter create the connection (Rick, manager).

What is required is self-awareness, emotional honesty and institutional support for workers as they unlearn the relational patterns which characterise most social relationships in the Western world. In order to achieve this, a type of professionalism is required, but it is a different understanding of professionalism than the emotional detachment and affective neutrality which is most commonly associated with that word. Instead it is training and support in a set of competencies around taking responsibility for oneself, but not for the other (Mead 2004: 14); it is around 'being real', and around having the difficult and challenging conversations when that is required for the worker's own emotional wellbeing.

3.4 Benefits to peer supporters

Peer support has been supported by mental health funding agencies, in part through consumer development monies, due to the benefits that it has for peer supporters. It is seen to help in overcoming stigma, creating jobs for people experiencing mental distress, and assisting with recovery. This research study suggests these benefits are very real. A number of managers talked about seeing peer supporters with little confidence or hope of finding work come into the service, and build their confidence, obtain experience and qualifications, and in some cases move on to other employment. Similarly, a number of peer supporters talked movingly about the way peer support had led them into work they found satisfying. One peer supporter found that her mental illness experiences, and consequent experiences

with the family court and benefit system, had qualified her to become a highly skilled advocate:

> I mean two years ago on the DPB *[Domestic Purposes Benefit]*, three children still at home, no training, no qualifications, you know, been through the family courts, had to be observed by court appointed psychologist with how all my children interacted with me, and things like that, wave around the whole mental health card is why I shouldn't have my children when I left my husband. And you know, from where I was then, I never thought that I would be the person that I am now. And a big part of that is this job, I believe (Rose, peer supporter).

This advocate found that her levels of confidence have grown tremendously while she has been in the advocate role, and doesn't see any possibility that she would want to ever leave the job.

Much of what makes this movement into peer support jobs possible is the confidence that peer support provides, both to recipients and to those providing support. This partially comes from the strengths-based model that most peer supporters are working within.

> If I look at it from my family's perspective, from having me go from doing absolutely nothing all day to getting a job and going to work and studying and doing volunteer work. If I hadn't had peer support, I don't know. Maybe it would have happened; maybe it wouldn't have. But I've got to credit the work my peer supporter did with me. I think just having the belief, having somebody else believe in you, makes all that, you know makes a difference. Especially if you don't believe in yourself (Roberta, peer supporter).

As one manager noted, "people who have gone through the mental health system have often lost confidence in their abilities" (Velda, manager). Peer support services can create a supportive environment in which tangata whai ora can learn new skills, take risks, and occasionally make mistakes. The result is a situation in which new levels of recovery are possible. One peer supporter described how he had lacked the confidence after his illness even to go into a supermarket. Then a job at a peer drop-in centre had eventuated.

And since I've been working at [the drop-in centre], I've gained so much confidence. I've gained a heck of a lot of training. I've gained a lot out of supervision; my confidence levels have just absolutely soared. Every morning that I work is a buzz…. So the mornings that I work at [the drop-in centre], those are the mornings my alarm clock goes off. The alarm goes off and it's out of bed, and it's like: *yes!* You know, because I know that I'm hopefully going to have a really good day (Jack, peer supporter).

Bracke *et al* (2008) found in their study that peer support empowers peer supporters more than it does those receiving peer support. This effect will be partially due to the increase in confidence levels that working in peer support creates.

Another area of benefit for peer supporters is in relation to their own recovery from past mental distress. One peer supporter talked about having become more open since she had been doing peer support; she was more willing to talk about the past trauma and abuse she had suffered (Jennifer, peer supporter). A manager described his mental illness as having been his "deepest, darkest secret" (Rick, manager). He didn't think about it or talk about it. Then, when he was ready to face that part of his life, he connected with peers. Another peer supporter talked about the role peer support played in her recovery from suicidal thinking:

It certainly has got me involved in thinking about my recovery on a daily basis. And when you get unwell to the point where you want to die, which is *so* unlike who I am, so polar opposite of who I feel like I am… For my mind to be so unwell that I was ready to give it all away has taught me that the steps leading up to that feeling or those emotions, which, you know, lasted for nearly a year, were quite obvious when you look back at them…. So peer support has changed my life in the way that I've realised that building quality relationships, regardless of their setting or their boundaries, is incredibly important to me. Having that feeling of connectedness and being connected to my society and my community and to my organisation and my personal and private relationships is incredibly important to me. Peer support has taught me that (Melody, peer supporter).

One of the concerns clinicians often raise about peer support is that the stress of doing the work will lead to peer supporters becoming unwell. Our data suggests, however, that the causality may well run in the other direction. Peer support, by creating recovery orientated and supportive working environments, and facilitating meaningful work, may in fact be keeping people well. One peer supporter said that his role in peer support had been invaluable in keeping him well most of the time (Ross, peer supporter). When asked how, he articulated what Sally Clay has called "the helper's principle"(Clay 2005). Needing to be there for other people was also very helpful to him.

A third area in which peer support is beneficial to peer supporters is in self-development – learning new skills and new self-awareness.

> I think I've become much more aware of the struggles, some people's journeys, some people's experience. I think I've developed my own strengths if you like, my own ways of coping. I've drawn on other people's experiences to adjust my own life and my ways of dealing with stuff to keep myself safe and well. So it has been a two way thing in that way (Matthew, peer supporter).

As one manager put it, "you teach best what you need to learn most" (Alexandra, manager). She feels that her peer supporters learn a lot about themselves from the conversations they have with other people. Another manager talked about the value of learning to reframe a mental illness experience as a resource, rather than a deficit. "It actually is something that equips people to do really powerful work" (Elisabeth, manager).

This reframing of experience contributes to a real capacity to challenge the self stigmatisation which often accompanies experiences of mental illness.

> There's a great freedom, and it's actually a lovely thing to watch, when you hire a new person and they are, perhaps for the first time in their lives, working in an environment where they don't have to shield their history, where they aren't thinking: "how much can I say?"… So that freedom to just say, "well, you know, back before I had good counselling and stable meds, when I was self-medicating", or whatever. The freedom to say something like

that, and to be accepted, is a major thing. And you can really see a blossoming of self-acceptance (Brigid, manager).

The development of new capacities takes many forms. Several people talked about a new assertiveness that they had discovered in themselves. Others talked about a growing capacity to build good relationships. A number of people talked about their improved self-image, and better feelings about themselves. One participant talked about her values having changed for the better.

A final area in which peer support has value for peer supporters is in the new sense of purpose that many peer supporters find. They really feel they are making a difference in people's lives.

Ah, look, it is just **such** a privilege and an honour to be invited into a person's life, and to do part of their journey with them. You know, and it never ceases to amaze me, the courage that people bring. The resilience, the courage, the passion, and, yeah! It just blows my mind. It's such a privilege and an honour, you know? (Caitlin, peer supporter).

To truly make a difference in somebody's life is an experience that has great emotional and personal value. This leads in a virtuous circle to greater confidence and a better self-image.

And on a personal level I found that really rewarding, and started to see that it's about that meaning and purpose in our own world. I had found a purpose, and it seemed to be working well for me and for the people that I was supporting. I enjoyed it, and wanted to keep doing it. On a personal level, you know, that notion of having value in the world was one that I found personally quite challenging. So working in a way that is reinforced by the relationships that you develop with people, I found that actually a lot of what I thought about myself has changed over these last five years (Zoe, manager).

Peer support has value for the peer supporters, as well as for the recipients of that support. It is simultaneously consumer development, leadership training and the provision of mental health services.

4. Peer Support and the Health System

4.1 Peer support and the medical model

Participants in this study had quite a bit to say about clinical practice, and how peer support differs from what is often on offer within biomedically orientated services. We say what is **often** on offer, because a number of our participants emphasised that clinicians vary a great deal in the way they work. Some clinicians work within a recovery model and are extremely effective at building relationships with their clients. So what we are exploring in this section is an 'ideal type' of clinical service, summed up in what is often known as the biomedical model (Nettleton 2006; Bentall 2009; Stevens and Price 1996) and the ways that peer support might offer something different and complementary to that. Exploring this also makes it possible to see what, specifically, peer supporters feel that they contribute to mental health provision in Aotearoa New Zealand.

The mental health system of Aotearoa New Zealand is officially recovery focused. (MoH 2005; MoH 2006; MHC 1998] However, this focus on recovery is unevenly implemented in the mental health system as a whole. Peer supporters, by contrast, tend to place 'recovery' at the centre of their beliefs and actions.

> It means we believe if people want to change and move on they can. And we do come across people that have been in the system for so long that they've taken on the beliefs of their carers, that this is how it is going to be until they die. And we don't believe that ... it's just because, I think we come from the strength of the point of view that because we've been through it and we've recovered, we know it's possible. So we have that. Nobody can shake that belief in us. Whereas what I find through my own experience with a few really well meaning clinical people and not all of them, but some of them that are purely book taught and have the experience of people they've worked with. They work with you but they're not really convinced you're going to get better (Stephanie, peer supporter).

This belief in recovery is accompanied by other differences from much mainstream clinical practice that naturally accompany it. Peer support is said to be strengths-based, rather than

based on diagnoses, symptoms and pathology (Caitlin, peer supporter). In it, the purpose of the relationship is directed by the peer, rather than the peer supporter (Rachel, manager). Peer supporters are not directive; they don't give advice or tell the peer what to do (Jennifer, peer supporter). Conversations are never held about peers unless they are present, or have given their express permission to talk about a particular issue with clinicians. "Nothing about us without us" (Lydia, manager). Peer supporters work in a calming manner, because they are able to be understanding and empathetic from their own experience (Craig, peer supporter). Connection, and building relationships, is key to what peer supporters do (Steve, peer supporter).[5]

While it is possible for clinicians to also work within a recovery model, and to focus on building effective relationships, some peer supporters felt that many do not.

> The whole mental health sector is supposed to be working under this recovery model. That is how we are supposed to be working. The recovery model is based on empowerment not disempowerment, and yet the majority of it is disempowering activity, behaviour and treatment. So if we are role-modelling empowerment from the beginning then consumers are actually able to say "you can't do that to me. You need to treat me like a human-being". So you work from the bottom up, as opposed to trying to break away the top of the roof (Craig, peer supporter).

Part of the problem with clinical practice is that it starts from a scientific methodology with an emphasis on diagnosing problems, having measurable criteria for making those diagnoses, and creating treatment plans based on clinical formulations. Evidence-based treatments play a central role. Even for mental health clinicians who are not psychiatrists, there is still "quite a lot of prepared material and prescribed ways of doing things" (Simon, manager).

> I think [peer support is] a living example of how you can take philosophical principles and work with them in order to get a really positive mental health

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[5] It is also key to what community support workers do (Curtis and Hodge 1995). So although this may not be a point of difference, it is nevertheless central to peer support.

outcome without necessarily being highly technical about it. I think that's an important balance to bring to the fore, if you like, of the way that mental health services work. I think there has been a very deterministic kind of approach from, you know, because that's the way that the scientific community operates (Simon manager).

This raises a problem for peer support in that keeping its integrity *as* peer support involves finding a way to sidestep that "very sophisticated language around pathology and symptomatology" (Geoff, manager) which characterises the medical model. "But peer support which is talking about recovery, recovery and the whole person, what's the sophisticated language around that? We're still trying to make it, you know" (Geoff, manager).

Managing a peer support service in an environment which is orientated around the way clinical services operate can be a challenge. When asked what made her job difficult, the manager of one crisis house replied:

> Peer support not being recognised, the philosophy of peer support not being recognised. Being audited on things we don't do and we can't do because they're not part of our philosophy. They're part of the medical model. We're not a medical, all those, you know, the amount of paperwork generated by medical requirements, by audit requirements, by PRIMHD requirements[6], by, and actually we don't fit in. There is no room for our way of practicing and all that, and that makes it hellishly complicated (Velda, manager).

She went on to describe being asked for assessment reports, for statistics regarding how many people with particular diagnoses they worked with, and for HoNOS reports[7]. None of that is possible to produce within a peer support model that doesn't assess, doesn't work

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[6] PRIMHD is the Programme for the Integration of Mental Health Data, and is a data collection process for tracking the movement of service users through mental health services. See the section on 'dealing with information' for further details on PRIMHD within peer support services.

[7] HoNOS is 'Health of the Nation Outcome Scales'. It is a 12 item assessment of the service user, measuring behaviour, impairment, symptoms and social functioning. They are completed after clinical assessments.

through diagnoses, and evaluates outcomes of the basis of goals that peers have set for themselves.

Thus, as peer support becomes more embedded in the mental health system, some measure of challenge to clinical practice is becoming evident.

> It's an emerging practice, so I think it contributes a considerable challenge to some of the people at the reins of things, really. Because it is about the recovery model, and service user leadership in action. And that causes some discomfort... that comes back to the question of power, really, where power sits. So some of it is a direct challenge to clinical power, and clinical ascendency. Because I believe most of the recovery stuff comes from the hearts and minds of peers. Not from clinicians (Rick, manager).

How that will play out over the next ten years is unknown; there were differing views on this question. On the one hand, one manager working in a clinical context enthused about the change in systems she was seeing, a change to a recovery consciousness amongst clinicians. On the other hand, some participants felt that we are seeing the pendulum swing back towards the medical model (Deborah, peer supporter).

> And I think we've had a bit of a cyclical change, where I think New Zealand was seen to lead the way in recognising that mental health is both inside the mind and outside the mind. Then you'll find people who really believe in the biomedical model will quietly listen, until there's an opportunity to assert that worldview again. And then they do. And they have done, in the last eighteen months, I think. I notice a lot of the language in some key documents has been more diagnostic and pathological (Rick, manager).

This leads to a key question for peer supporters and peer support managers. What is the attitude of clinicians towards peer support?

4.2 Clinicians' attitudes towards peer support

Two of the most salient issues for peer supporters are the relationship they have with clinicians, and the attitude of clinicians towards peer support. In spite of the fact that this was not on the original list of questions to be asked in the interviews, early participants all brought up the question of clinicians' and funders' attitudes spontaneously. Later, we added it to our list of questions and it was discussed fairly extensively in every interview. When asked what were the main issues facing peer support, or how peer support's contribution to mental health in New Zealand could be improved, almost two thirds of our participants mentioned the need for more recognition of peer support from clinicians and funders.

> Definitely, we need more respect for our knowledge. We need more respect for the support that we can give. We're not utilised as fully as we should be. It's not only to the detriment to that whai ora but we're here to help, hello.... They actually need to acknowledge that we're a taonga *[treasure]*. We're a diamond in the rough, peer support services. We're here because we love doing what we do. Sadly, and my staff will attest to it, the money ain't the greatest. So we're here because we're passionate about it. We want to help people (Vanessa, manager)

A very large number of participants mentioned that negative attitudes of clinicians towards peer support had been a constraint in their work. In fact, fifteen people described various ways in which clinicians had made it more difficult for them to do their work. When asked if there were any overarching things about peer support she wanted to add, one peer supporter told this story:

> The other one that I forgot to mention was when you're going to see clients in hospital. And some of the constraints are the staff and their attitudes.... Yeah, that's definitely a constraint. Yeah, you know, you try and see a client and you ring up and say that you've come to see the client and they haven't got any kind of interview room for you. And you're sometimes put in unsafe positions. [Like having to be in their bedroom]... or in the arts and craft room, you know, where they then threaten you with a pair of scissors. It's like the

perception that as an advocate you're out to get them, the staff I'm talking

about, you know (Rose, peer supporter).

These problems were seen to stem, in part, from clinicians' lack of knowledge about peer support; this was mentioned by eight people. "If you talk to the majority of clinicians or managers, they couldn't tell you what a peer supporter does. I've heard the kōrero *[conversations]* many times. They have misconceived conceptions of what we do" (Tane, peer supporter). As such, this was seen as something that can be addressed through education, role modelling and giving presentations to clinicians. One manager felt that peer supporters should change their conception of their role to include actually making those connections with clinicians and educating them about peer support (Lydia, manager).

When presenting to clinicians at a community mental health centre or something, I'd think, well there's really two purposes, or two, I hope, outcomes of this. One that we have some people thinking, having an understanding of our service and referring peers. But also that clinicians see people who have these experiences, or have the experiences of their clients, standing here being functioning members of society. And doing that, I hope, some kind of shift happens there as well (Elizabeth, manager).

This desired shift in attitudes towards mental health consumers points to a second major reason why clinicians' attitudes towards peer support might be problematic. Eleven people pointed to discrimination and stigma as part of the problem: "There's so much stigma within mental health services against people that use mental health services" (Cathy, peer supporter). Seven people added to that the idea that some clinicians might feel fearful or threatened.

I know a few years ago that [a mainstream organisation] were definitely anti all the peer-run systems. And I think that is a fear-based thing, because as I said I've come from a counselling background, and I think they think without all those really tight boundaries everything goes to custard (Maya, peer supporter).

Indeed, fear in general, and concerns about risk in particular, seemed to be driving an initial lack of referrals to some services, such as the crisis houses.

> ...for quite some time no one wanted to refer anyone to them because they just thought mad people leading mad people is just not going to work. It's just going to be chaos, there's too much risk involved, what if all the staff get unwell on the same day, blah blah blah, it goes on and on and on (Melody, peer supporter).

In this context, the need to demonstrate the worth of peer support was mentioned by almost half of our participants. One manager mentioned that it was necessary to do the work really well, to go beyond people's expectations, and thus to make people think about their attitudes. "Because it's pretty hard to discriminate against someone who can do things better than you can" (Rick, manager). Another participant described the way relationships with clinicians had improved as his peer support initiative demonstrated its effectiveness:

> I think a lot of staff in the unit initially thought it wasn't going to work. Mainly because we are consumers and we were watched very very closely. I think we were considered, you know, were going to fall over in the first six months or so.... So, it's been really really great that we can prove them wrong (Ross, peer supporter).

This leads to a major theme in relation to clinicians' attitudes towards peer support. While there have been problems with this in the past, and in some instances problems are ongoing, these relationships are improving dramatically.

> And the acceptance of it is growing, and the understanding of it is growing as well. And I think there are some people in the traditional clinical professions who will never get it because they don't want to. And they are quite scathing about; how can you do that kind of work, you don't have training. That's fine. But there are others equally who have seen what a difference it's made in people's lives who now advocate it and those are the people that need to spread it further (Stephanie, peer supporter).

Eleven participants talked about how their relationships with clinicians had improved during the time they had been involved in peer support. One manager was glowing about the support she had received from clinicians: "the clinicians were really excited because I think that they saw that people with experience of mental illness could give something that they couldn't give. They knew it, they knew it. They absolutely knew it and they believed that it was a critical part of recovery" (Alexandra, manager).

Much of what is making these relationships work better is the effort peer supporters have put into relationship building with clinicians and funders. This involves being careful to work collaboratively, and not to place clinicians in defensive positions by criticising the way they are with their clients (Zoe, manager). This can be difficult, particularly when working in a clinical setting:

> I think just within our team, obviously it's all I can speak of, I feel that the clinicians are getting recovery more. They are more conscious of when we are here, and language, and thinking recovery. And I think that's just a presence that has come about since we've probably been here. There are some people that don't get it, you know, and that's fine. But it can be hard to hear too sometimes when a clinician might be talking about somebody, and you think, well, you know: that is somebody's husband or wife or daughter or son, and those struggles are very real for that person. And it's being joked about or something like that. But I think we are, we are starting to make a difference, and have the team see us as an integral part of the team (Brenda, peer supporter).

Where it is practiced within clinical settings, peer support has started making a difference to the way that clinicians think about not just peer support, but about tangata whai ora in general, and about recovery.

> But I think what shifted things for some of our clinical colleagues, was when they could see the shifts that were happening for people that they provided care to. That was what engaged people, when they could hear people talking about how valuable they found it talking with peer support specialists. Some changes that people were making for themselves out of having a renewed

sense of hope, that things were possible. And that's when some of the transformation stuff started to happen (Zoe, manager).

These changes have been slow, but have led to definite changes to the culture of the wider organisations where peer support is embedded or involved. So overall, with mutual respect and attention to doing peer support well, the negative attitudes that some clinicians have can be turned around. "But if you're respectful it comes back the other way. So it's not about jumping up and down, going 'oh, you've got it all wrong'. You know, it's actually working in a partnership" (Rachel, manager). This leads us into the question of how peer support can work in partnership with clinical services. How can we integrate peer support more effectively into the wider health system?

4.3 Working in conjunction with clinical services

Whether peer support should be offered in conjunction with clinical services has been a point of contention in the consumer/survivor community over the past decade or so. Whether close integration with clinical services is a good idea has been debated at great length, and strong opinions have developed on both sides. On the basis of this study, however, we would like to suggest that this debate has moved on in Aotearoa New Zealand's peer support community – from **whether** peer support should work in conjunction with clinical services – to **how** this integration should be accomplished. There are already a variety of ways in which peer supporters work cooperatively with their clinically based colleagues, and there is enthusiasm among peer supporters and peer support managers for still closer collaboration, as long as the integrity of the peer support approach can be maintained.

The perhaps older view, that peer support should work as separately as possible from clinical services, was expressed by only one participant in this study.

> I did notice in some of the talks I went to at the [Building Bridges] conference, people's ideas of peer support. They'll say, 'Oh, and this is our clinical staff and this is our...'. You know, hang on guys, that's not peer support. You know, never the twain should meet, really (Ross, peer supporter).

Even this participant, however, talked about the two types of service as being complementary, and creating a good balance. All of the participants in this study expressed respect for the clinical services and the work they do.

The view that peer support should be entirely separate from clinical services is being superseded on the ground. A number of peer support services are already working in close relationship with clinical services. The ways they are doing this vary. They include teaching Wellness Recovery Action Planning (WRAP) – a self-management programme developed by and for consumers (Copeland 1997) – to clinical workers and families as well as to tangata whai ora. It also involves meeting with patients in acute hospital units, holding joint meetings with peers and their clinicians, accepting referrals from clinicians, working closely with multi-disciplinary teams within crisis houses, and working within the provider arm of a District Health Board.

> In our WRAP trainings, we used to have just all consumers, but of late, and just by slippage more than any deliberate change, we have support workers and supporters, even family, coming to them now. And my personal observation, it's been really helpful in breaking down a them and us type culture. And understanding from support workers, and hearing tangata whai ora and their whānau in the same room, discussing stuff, it's really helped with communication and empathy (Rick, manager).

This observation that the 'them and us' culture is being changed is one that was made by a number of participants who are working with clinical staff in one way or another. It relates to a general change in the attitudes of clinical staff towards peer support, which was discussed in the previous section.

A number of peer support services have worked out agreements with the District Health Board, and now go into hospitals to meet with patients, and ease their transition into discharge. These arrangements are being further developed on an ongoing basis. This is particularly beneficial, as peer support can be at its most valuable at times of transition (Geoff, manager).

Eventually we'll be working with multi-disciplinary teams in the acute unit prior to patient's discharge, and planning with the patient and the team packages of support and care so that they will have that pre-discharge, during discharge and after discharge. That isn't completely in place yet but I do go into the acute unit and talk to people. But that will then happen on a more formal basis (Deborah, peer supporter).

This collaborative work with clinical services allows peer support services to build relationships with patients prior to discharge, and then work with them to ease the transition back into the community. Another service takes referrals from clinicians around peers needing intensive support, as they transition from residential care, or from the hospital's acute unit, into the community. They then provide an intensive version of their peer support model to this group of peers. In this programme, they sometimes, with the peer's agreement, have collaborative meetings with the referring clinician. This has worked really well. "It meant that the clinician had the sort of insight into the work that we were doing, a sense of the goals the person was working on, the value of the service to them, that they never would have had otherwise" (Elisabeth, manager).

One District Health Board in Aotearoa New Zealand offers peer support as a service within their provider arm. Consumers within the specialist mental health services can self refer to the peer support service. Alternatively, this option might be suggested to them by their doctor or key worker. In some cases, peer supporters will approach somebody that they feel can benefit from the service (Brenda, peer supporter). As a peer support manager in this DHB said, "...being located in a DHB mental health service means that we are accessible to a wider group of people in the population" (Zoe, manager). They are able to work with people across the age range, from very young people to older people, and also work with people across a broad socio-economic spectrum. In this context, peer supporters and clinicians work closely together, which has a number of implications. On the one hand, maintaining the integrity of the peer support role is a constant concern. By the nature of the environment there may be subtle pressure to shift into a more clinical way of being with people. This is more often experienced as perception rather than an expection of managers and funders. On the other hand, offering peer support through the provider arm has created a cultural change throughout the wider organisation.

What shifted things for some of our clinical colleagues was when they could see the changes that were happening for people that they provided care to. That was what engaged our colleagues, when they could hear people talking about how valuable they found it talking with peer support specialists. Some changes that people were making for themselves, from having a renewed sense of hope, things were possible. And that's when some of the transformation started to happen. ...The staff at [a community-based mental health centre] have said that the culture has changed there. That peer support specialists brought them hope. That they started to see that recovery was possible for people. And it just reminded them that people can change, that things are possible, that sometimes when we're kind of ground down by our work, we might see people in a particular frame that doesn't honour what the possibilities are for them (Zoe, manager).

In achieving this cultural transformation, the issue of role integrity, or 'staying peer', is central. There are substantial challenges that need to be overcome in order to make it possible to work in a health services context, and still maintain a peer support philosophy. Brenda, a peer supporter working in a district health board provider arm, suggested that the "peer support worker will be almost the go-between, the first point of contact" with clinicians (Brenda, peer supporter). She told a story about being caught in a very problematic situation while playing this 'go-between' role. The mutuality and reciprocity which is central to peer support can be undermined when peer supporters start acting as liaisons with clinicians. Another peer supporter, who works in a crisis house, noted that what they offered wasn't "a true peer model". It's "watered down" because the clinicians actually control length of stay, whether people can go out, and other facets of the situation, while the peer supporters implemented those decisions (Cathy, peer supporter).

Even when working at arm's length from clinical services, close collaboration with health services can bring in ways of working that don't fit well with a peer support philosophy. When asked what, if anything, made her job difficult, one manager pointed to the philosophy of peer support not being recognised. She detailed issues raised by PRIMHD data collection, by audit, and by other medical requirements.

Just to always try to find ways to have to fit into that, otherwise you lose your funding, so you have to fit in, to find ways of doing it that still come within our philosophy. Which creates work that is only done for that purpose, it doesn't contribute anything to our work, it only contributes to rules, regulations. And it's not so much that those rules and regulations are there, the problem is they don't fit. And that makes my role really difficult (Velda, manager).

This issue of the compatibility of a peer support way of working with a risk averse medical model came up as problematic in a number of different ways during this research project. One difference between a peer support approach and a clinical approach relates to information. Many peer support services are adamant regarding the slogan "nothing about us without us" (Lydia, manager). They will not provide information about a peer to anybody else, including a key worker or case manager, without the peer's express permission and, preferably, their active involvement. This can generate problems when collaborating with clinical staff, because the relationship between peer supporter and clinician does not seem to be reciprocal.

And it's really difficult because it's a relationship based on not sharing, it's really hard. Because we won't talk to the key worker without the peer person with us, unless we've got their permission, other than getting the risk and safety assessment. And often when the key worker wants something they'll phone us. We can't talk to them because we're not prepared to talk about the peer without the peer being present. So it's kind of like a double standard. We need them in one sense but they can't understand that it's a two-way relationship between us and the peer, and they're sitting on the outside (Roberta, peer supporter).

One concern raised by a manager is that peer support might become part of a new type of 'community institutionalisation', in which services become 'clinicalised' (Rachel, manager). In this way the deinstitutionalisation movement might be reversed in practice, if not in structure. To avoid this, it is important to 'stay peer', and to be quite deliberate about sustaining a peer support philosophy as closer collaboration with clinical services are achieved. In fact, she would like to see "community mental health services paid for by

something other than health boards. Because while they're paid for by health boards, there are reporting requirements that are very much tied into the clinical kind of model (Rachel, manager). When asked who might fund such services, she suggested that even the Ministry of 'Culture and Heritage' might be appropriate.

If these problems can be solved, however, there is enthusiasm in the peer support community for closer relationships to be built with clinical health services, and even for peer support to be 'mainstreamed' within the wider health system.

> I was inspired by the conference recently. In particular, the Counties Manukau project in involving peer support workers in the multi-disciplinary team [MDT] forum, and I thought we could have that down here. I happened to run into the DHB cultural advisor and asked what do you think about peer support workers in MDT, supporting the MDT, not being clinicians but supporting? She didn't like the idea because she thought it compromised the essence of peer support work, the definition of peer support. Clients may have access to notes and it may compromise the relationship. We went to the Māori MDT and they were much more open to the idea because it was about everyone working together and that holistic point of view. So my point is peer support just depends on who you are talking to as to what it means. I think that is the same for whānau and whai ora too (Tui, manager).

Some participants have been thinking quite laterally about new possibilities. Simon talked enthusiastically about a proposal at one DHB to open a crisis service run on peer support lines, but with a resident psychiatrist and some nursing staff on hand to administer medication and clinical treatments. After "a changing of the guard" in that DHB's funding and planning department, the proposal was modified, leaning more towards the clinical side. He felt, however, that the original model would have been quite workable, partly because some clinicians really "get it". They "...understand that this is about one human being communicating with another" (Simon, manager). Another peer supporter talked about the value of peer workers joining a wide variety of health occupations, bringing a recovery philosophy with them.

I don't see it as something as distinct as occupational therapy or social work or nursing. I don't think there is a thing, peer support work, like that. Personally I don't. I see it as more qualities and attributes of all of those other workers... Yeah, I think it's more about valuing people's experience of recovery in all those other roles (Matthew, peer supporter).

The ultimate aim, as Maya said, is that mental illness won't be thought of so separately, as something that happens to those people over there, rather than to any of us here (Maya, peer supporter). Achieving this in conjunction with the clinical services will depend on finding a way to achieve mutual respect with clinicians and funding agencies.

Because as peer support people, we can model our side of the relationship. And I think by modelling that, if they have issues around ability to be effective in their relationships coming back the other way, I think they can learn a lot from us, really. If we can model effective relationships, and an effective way of being in the world, in spite of all the things that have happened to us, I think people will... and if we're willing to disclose that, and have our lives an open book, I think people can learn a lot. If you hide your light under a bushel, nothing much gets seen, really (Rick, manager).

Applying a peer support model to relationships with clinical colleagues is a way to achieve respectful and constructive, but honest, working relationships that will allow for the development of closer collaboration.

4.4 Contracts and funding

The New Zealand government's mental health plan for 2006-2015, *Te Kokiri*, makes a commitment to expand the range of effective and integrated services to include, among other things, serviceuser-led services within mainstream services, and also to expand independent peer-led services, which provide support, recovery education and advocacy (MoH 2006: 20). This is part of a high level strategy within New Zealand's mental health system to provide recovery-orientated mental health services that provide choice and promote independence (MoH 2005: 5) and to build a service user workforce (MoH 2005: 11). Excellent progress seems to have been made on these goals. When we began this

project by surveying DHB funded peer support services within Aotearoa New Zealand, we found that every District Health Board in the country now has some form of peer support provision.

While in some cases these services are offered through the provider arm of the District Health Board, in most cases independent agencies are funded through the Planning and Funding arm of the relevant DHB. In many cases, Planning and Funding arms have been positively enabling for peer-led providers, through the structuring of Requests for Proposals (RfPs), and by providing support for agencies to put proposals together. One DHB provided a small peer-led organisation with funding for the development of a proposal.

> So they said we want you to have a proposal, that's what they'd said up front. We want your proposal, you need to build. And because of the size of our organization and the size of the city and things, I was quite unsure what to ask for. So we asked for 2 FTEs. And so we negotiated that. And after several meetings and a lot of clarification... They wanted us to be quite specific in how we were going to service the rural areas in particular, and older people, and what we were going to do with youth and what peer support looks like. So we built on our expression of interest and built a proposal around and talked about the rationale. And we talked about the rationale, we defined peer support and advocacy. We talked about our history, our philosophy, vision, key values, our relationship with tangata whenua *[indigenous people]* our mission, our governance, operations. And we talked a lot about linkages and relationships we developed (Rick, manager).

Once relationships have developed, contracts in New Zealand are often quite loosely defined, allowing peer support services a great deal of leeway to offer services within their own values and philosophy.

> The contract I guess is very broad, I don't know if it's the same contract the other areas have but in terms of the specifications it's fairly broad so it does give you a bit of flexibility.... What I find simply more restrictive are the standards, the health and disability sector standards. It can be a little bit more restrictive at times (Tui, manager).

Generally, managers asked about contracts had few complaints with the ways that either the service provision guideline documents, or the contracts themselves, were written. "What they expect me to do is exactly what I want to do. So I'm quite lucky" (Brigid, manager).

However, there were a few areas where contractual issues were problematic for peer providers. It thus may be valuable to revisit particular restrictions in certain DHB regions. These included services where the contract restricted peer support provision to people who were receiving community-based mental health services, excluding people who are patients in the primary sector. This is an issue in almost half of the organisations participating in this study.

> We go to community meetings, anywhere we can. The horrible thing about that is you'll get people coming up asking if they can access, and we have to say 'are you under the public mental health?' And when they say no the last thing you want to do is say: well, you'll have to go there to – I'd never say that to anyone, it's like taking ten steps backward to take one step forward. So that's why, it's in one of my things here, is really if we can access GPs. That would just be huge (Stephanie, peer supporter).

A number of providers emphasised that people located in the primary health sector are the very people for whom peer support could be *most* beneficial. They have not yet reached the stage where they've 'fallen off the cliff', and can really benefit from short term, skills-based, peer support (Stephanie, peer supporter). Moreover, with current mental health policy placing an emphasis on keeping more people in the primary sector, this is going to be a growing issue (MoH 2006; MoH 2010).

A second area in which contracts can sometimes be restrictive is in terms of age. Adult mental health services are for people aged 18-65. Younger people are covered by youth services and older people by older adult services. However, there is often no specific peer support available to these age groups. One Māori service said they often had to step outside their contract, and provide services informally, to cater to people aged late 60s who needed peer support. "You know, Māori health is holistic, so maybe the structures we have in place to support that should be more holistic" (Tui, manager). This service also wanted to

provide services to the entire whānau, while only being funded to provide services to individuals (Tane, peer supporter).

A third area in which current contracts can be detrimental to the practice of peer support is in putting limits on the length of time that a peer support relationship can last. One Māori service had a particular problem with the expectation that service users would move on, because the practice of whanaungatanga entails the creation of a whānau-like atmosphere. Ending the relationship, and exiting people from the service, is incompatible with this Māori-focused approach.

> Cause we take some of our whānau here that have been here, well I've known them for eight years since before coming, that they've followed us here to [our service]. And yeah, we're being questioned as to why these people are still with your service; they should've been moved on; they should've exited. And we're trying to explain a lot of our whānau we don't exit because no matter what, we might help them and get them a whare *[house]* and we help them with employment and we might help them with this crisis or with this issue, but then they will always keep engaging because for some of them we're it. We're their whānau *(family)*; there's no one else (Vanessa, manager).

At the other end of the scale, one service operates with a contractual obligation to exit peers after providing only one year of peer support. The peer supporters within this service find this obligation extremely disruptive in some circumstances. A peer supporter here, for example, described somebody who took eleven months to settle down and begin trusting her peer support worker; then her time was almost at an end (Stephanie, peer supporter). There are possible benefits to a short time-line, in that it means the service remains recovery-focused. However, severe tensions can be created.

> Your peer has made a really strong connection, and to actually terminate that can be quite traumatic. You know, and there's that tension of: I really want to continue with this because I'm getting so much out of it as well. And why does the contract then stipulate that you can't? So to me there's that tension in it being really timeline-focused, you know, recovery-orientated getting people, you know, on a track that's going to take them to the life that they

want. Versus a relationship that's really meaningful, really creating something for that individual that's core and key and could probably move them further than it would otherwise if you cut it. And yet you have to (Lydia, manager).

These issues can flow on directly to the types of peer support relationships that are created and sustained.

Much of the contractual requirements relate to reporting, and there was a great deal of discussion of this issue, taken up in more detail in the section on information. All services funded through Planning and Funding arms of DHBs provided their DHB with regular narrative reports on their progress. They also had to provide various statistics to the Health Board. Some services were also reporting under PRIMHD, which will be discussed in more detail in the section on information. One service instituted a service user recovery review, which takes place every three months, because of a contractual requirement from their DHB. They adapted a clinical review, to make it relate more closely to a peer support philosophy, asking different questions. This was quite a significant change to their service (Elisabeth, manager).

One concern some services had was that the reporting they did for the DHB didn't provide a good picture of the benefits of a peer support service.

> It's quite basic reporting. There's no room for reporting phone calls. And we receive quite a lot of phone calls, probably quite a lot of our work's done on the phone. There's no room for reporting the peripheral extent of the service, by that I mean working with CYFs or WINZ. So it doesn't really give a good picture of like what the service is doing, if you like. You might put like one face-to-face contact, but that may have taken four hours. So I mean that doesn't tell them what we're doing at all (Rachel, manager).

This problem affected a number of services. For instance, a peer supporter in a more rural service mentioned that he might spend several hours, each way, travelling to see a peer, which would be reported as only a half hour meeting that day (Craig, peer supporter). Another participant mentioned that they might spend many hours with one peer, attending meetings with them and providing support (Rachel, manager). Some participants expressed

the concern that their funding might be at risk due to having reporting requirements that did not adequately reflect the kind of work that peer supporters actually do.

This leads to the question of funding, an issue that was up front for almost all of our participants. We asked all participants some global questions, such as: "What are the main issues affecting peer support in Aotearoa New Zealand?" Almost all of our participants mentioned funding in relation to this question. Securing adequate and continuing funding was seen to be *the* key issue facing peer support in New Zealand. One peer supporter repeatedly said that funding was the biggest issue they faced.

> It's just people not being able to have enough time to do their job properly. You know there's a lot of people that work with [our service] do throw in extra time for nothing. But you can't expect people to throw in, I mean I know I do it and I'm paid for less than half the work I do. But it seems as if it's your choice, you know, and you can't expect people to work for nothing. … I think, I honestly believe the only thing that's really stopping us is the funding issues (Ross, peer supporter).

Lack of adequate funding had a number of flow on effects. One was a lack of workers to cover the potential workload. Three services said that they couldn't advertise, simply because they wouldn't be able to handle the resulting workload on their current funding. As a result, some people were not receiving peer support who could benefit from it.

> I think we could support a whole lot more people if we had the time to do it properly and to spend the time with people. We don't go out and advertise ourselves as vigorously as we could because I know we would get inundated with people. So in some ways we wait for, wait for word to spread by word of mouth, in some ways. So lack of time to actually do as much peer support as we would like (Matthew, peer supporter).

One manager said the result of this was that peer support was seen as a rather exclusive "boutique service" when it could be a mainstay of the mental health system were adequate resources in place (Lydia, manager).

Another problem was that peer supporters are underpaid for their skills and experience, and are working far too hard.

> We are *so* under-funded. It is just heart-breaking. Which means that, as so often happens, the willing horses get flogged to death, until they're just worn out, burnt out and can't do it anymore. Because there is a cost to doing this sort of work. It's really easy to go too hard, too far, and put yourself out there too much (Deborah, peer supporter).

Some team leaders and managers emphasised that they actively managed workloads, placing peers on a waiting list, if necessary, in order to keep workloads to a manageable level (Roberta, peer supporter). However, it isn't always easy to judge the work involved with a particular situation at the outset, and so this can be difficult to do (Rose, peer supporter).

Finally, worries that their funding might be cut were a constant reminder that peer support has not been long on the mental health scene in New Zealand, and has a rather tentative place here.

> I think [our service's] funding is under threat anyway because of lack of mental health money. It's the easiest thing to chop off, isn't it? You know, I mean they could chop it off and say, That's not making any difference to mainline services (Geoff, manager).

This anxiety relates back to the peripheral role that peer support plays in the New Zealand mental health system. Designated service user roles make up only a small part of the total mental health and addiction workforce, less than 1% of the DHB workforce, and around 4% of the NGO workforce (Swanson and Jury 2010; O'Hagan 2011). This includes both peer supporters and consumer advisors. Around 8% of NGO services in Aotearoa New Zealand are led by service users, or are peer support services (Swanson and Jury 2010: 10). While peer support has been growing quickly, it's place in the mental health system is only starting to be assured and embedded.

5. Organisational Issues

5.1 The professionalisation debate

There is relative support amongst the peer support community for some sort of professionalisation of peer support. Of the people who directly addressed this question, 13 were broadly in favour, 6 were in two minds about it, and four were strongly opposed.

Many of the reasons that participants were in favour of professionalising peer support were the greater credibility it might bring peer support, with associated increased referrals and funding. This was expressed in a fairly typical way by Roberta, a peer supporter in a fairly large peer support service. When asked if she thought peer support should become more of a profession, she responded:

> I guess it would give us more credentials, more validation. We'd probably be taken a lot more seriously. But it would need to be done in such a way that it didn't take away the meaning of what peer support really is (Roberta, peer supporter).

Her linking of professionalisation to greater funding and credibility, as well as her reservations regarding the nature of peer support, were quite widely shared.

A reason intrinsic to the practice of peer support was provided by Geoff, a manager in a large organisation. He used the analogy of a fire fighter. Anybody passing by a fire might try to put it out, and save the people inside, but a fire fighter does this for a job; they have to keep doing it and keep doing it and keep doing it. This is very different to just doing it once.

> "So I do think there needs to be some education, some self-awareness, some of your own journey and your own triggers. And you need to know that stuff because it's how do you sustain your role…. So I suppose, with a caution, yes, I think there does need to be some sort of professionalisation." (Geoff, manager)

In spite of his support for professionalisation, Geoff made the point that this isn't

> "…true peer support, because true peer support is two people with an experience and one day this person might be supporting him, and the other day

it might be the other way around. Whereas if you're in a role you can't do that."

(Geoff, manager)

So professionalisation is necessary in the context of services offered within the health system, but this steps outside the true meaning of peer support. This point was also made by Simon, another manager of a peer support service, who felt that although professionalisation is necessary in the context of offering a service, this misses some of the greater potential of peer support, which can be found only when peer support is embedded in the community.

These views were fairly typical of the tone adopted by participants, who generally expressed support for greater professionalisation, along with some reservations. The reservations generally fell into three areas: First, professionalisation might exclude excellent peer supporters who weren't academically inclined or able to study. Secondly, potential peers might be less comfortable accessing peer support if they felt that peer supporters were putting themselves up as experts. Finally and most importantly, something of the essence of peer support might be lost.

One manager who was a strong opponent of professionalisation told the story of a person who completed the peer support training and made a lovely peer support worker even though she couldn't read and write. Conversely, another person did well on the course because she was academically inclined, but would have made a poor peer support worker.

Yeah, and if you start making it a profession, you need to create standards by which a person becomes part of that profession. Where you lose the ability to actually get people with natural abilities doing a really good job. And they're going to be weeded out in favour of people who say all the right things, write all the right things but are lousy at, as, you know, they don't have it. Some people just have it, are naturals. (Velda, manager)

This view was expressed by a number of people, whether they generally supported professionalisation, were in two minds about it, or were opposed. One person noted that she had been unable to finish her qualification, but she had "a PhD from the university of life." (Vanessa, manager)

A second reason for opposing professionalisation was a fear that this would change the way peer supporters were perceived by potential peers, or clients.

> "We're just, we're just us. You know, [potential clients] feel they can come in. They see the sign and they think: 'Oh, I'll give it a try… Now if you suddenly get this professional sign put up, that would scare a lot of them off… So no, I don't really like this idea of becoming professional." (Jennifer, peer supporter)

This view was expressed by only two or three people, but it fed into a much more widely held view that professionalisation had the potential to change the nature of peer support in quite fundamental ways. A peer supporter said, "You know the great thing is it's not about 'them' and 'us'. We're in it together. Once we become professionals doing it to 'them', what's the difference between any other way of doing it?" (Cathy, peer supporter) This concern about becoming like clinical workers was also expressed by a peer supporter in a fairly large organisation who was generally supportive of professionalisation. She said,

> "One of our big philosophies that we come with is you're the expert on your own life. How can I help you access that? We're not the expert. We can't tell them, you know. And I would just be scared that that would get lost." (Stephanie, peer supporter).

While this danger of becoming like clinicians was expressed by a large number of people, Stephanie also noted that professionalisation could be a way of keeping more of the essence of peer support. "hey, actually this is a profession. We actually have our ethics, our morals, our policies, procedures… we work from the same philosophy, and we offer the same tools and techniques. We've all been taught the same skills." This idea that professionalisation might make peer supporters more distinctive and better at what they do was expressed most eloquently by Maya, a peer supporter in an intensive role. Noting that the more you work at relationships, the less you need to invoke hierarchy, Maya said,

> "So then as we become more professional, the main thing that's developed for me in this has been relationship. I've got better at conducting lots of different relationships. If I was to become a professional peer support worker… would we

fall into the medical model or would we learn to just be better peer supporters?" (Maya, peer supporter)

Maya then noted that as she had become more professional as a peer supporter, the distance between her and the medical model had grown. This points to something very interesting, in that within peer support a new understanding of what professionalism means is developing. The concept is coming to denote less about expertise and objectivity, and more about skill in building and maintaining empathetic relationships, as well as self-awareness.

Regardless of their reactions to the notion of professionalisation, there was widespread support for the creation of a national body of peer supporters that could protect the essence of the peer support approach, and possibly develop some common training approaches. "I'd like to see us develop a more active, national network of peer supporters, somehow, so that we can have these discussions more openly, before we make any decisions about [training models]." (Zoe, manager). This points to the possibility that a type of "professionalisation" could actually protect what is special about peer support, if it is handled with due sensitivity to the need to embrace diversity, be inclusive of less academically inclined peer supporters, and focus on self-awareness and building relationships.

5.2 Training and qualifications

The ten organisations we visited have very different approaches to training their peer support workers. One organisation, Mind & Body, run their own NZQA qualification in peer support. This requires several months of training in theory, with "screeds of reading" (Stephanie, peer supporter) and assessments, followed by 520 hours of practical experience providing peer support (Roberta, peer supporter). The course covers philosophy and ethics, culture and ethnicity, legal context, teamwork, Mind & Body's tools, and safety/ supervision (Mind & Body 2010). Mind & Body is the only organisation in New Zealand offering an NZQA qualification in peer support, which is also offered to people in other organisations.

However, few other organisations seem to have taken this possibility up, with participants in our study citing cost and distance as reasons.

Three of the organisations we visited use Intentional Peer Support (IPS) training, while a fourth organisation with no organisation-wide training package of its own has sent some of its staff members on IPS training workshops. One of these three organisations combines the IPS approach with some tools drawn from Mind & Body's training system, while another combines it with Wellness Recovery Action Planning (WRAP) facilitator training, and the third combines IPS with their own organisation's training. The IPS training focuses on the building of mutual relationships which can lead to a multi-faceted recovery. The four keys of IPS are connection, understanding each other's worldviews, mutuality and moving forwards (Mead 2005). IPS can be initially learned in a five-day course, but can also be learned over a series of mini-workshops lasting up to twelve weeks. Advanced workshops are available to train the trainer.

One organisation draws on training from Recovery Innovations, formerly Meta Services, from Arizona in the USA. This training package is particularly noted for training peer specialists to work alongside clinical colleagues, and for its skill in leading participants to reframe their experience in hopeful ways (Zoe, manager). A sixth organisation has developed their own training package, which draws on tools from IPS, from HIV/AIDs peer support programmes and a variety of other sources. "We do what works for us, and if we find something that doesn't work we scout around: is there anyone else in the world who has had some similar thing we could borrow, use?" (Velda, manager). So six of the ten organisations we visited drew on specific 'peer support' training, with a seventh organisation employing some IPS trained staff members.

The other four organisations tended to rely on peer support workers who had completed the Mental Health Support Worker's Certificate, which is not geared specifically to peer support. However, in three of these organisations, workers had not always completed this certificate. This was generally attributed to time constraints, financing difficulties and a feeling that their in-house training was sufficient. A variety of training was offered in these organisations, drawing on seminars and workshops offered by the local DHB and other mental health organisations, as well as in-house training. These included first aid training,

de-escalation training, workshops on specific disorders, suicide prevention and intervention training, seminars on Asian mental health, health and safety training, and so forth. So overall, we might conclude that there is a substantial minority of peer support workers in Aotearoa New Zealand who do not receive specific training in peer support, and a different minority who do not have specific, NZQA level, qualifications in mental health work. One issue addressed by these organisations is whether peer support needs a specific training programme at all.

> I remember getting a pānui *[notice]* about peer support training and I sort of thought "we're doing it." It might have been a bit arrogant of me but I thought, "do my staff need training around peer support?" I mean I would probably put it to them and if they put their hands up and said yes, I really want to go do the training, I'd support that. But I remember the first time I ever got a pānui and I can't remember what organisation it was from that was running the peer support stuff; I kind of thought "do we need that training?" (Vanessa, manager).

In partial response to this question, we found notable differences in the way people with different training talked about peer support. Those whose training was not in a specific peer support approach tended to have a less complex understanding of peer support, seeing its essence as being in empathy and the shared journey of peer supporter and peer. People who had been trained in peer support, by contrast, tended to talk also about recovery principles, mutuality, understanding different world-views and crisis as a learning opportunity. Those trained in the Mind & Body approach had a more structured way of talking about peer support than those trained in IPS, Recovery Innovations, or the in-house peer support models. Mind & Body trained peer supporters put a greater emphasis on choice, goal setting and self-determination than other peer supporters, while putting less focus on the mutuality of the relationship. These differences are just indicative; our sample wasn't large enough to draw firm conclusions on this question. However, it would seem that peer support training does add value to the way that peer support is practiced, bringing peer supporters to see their work in a deeper and more philosophical manner.

A number of participants talked about their peer support training as having been a transformative experience.

> I turned up to the training thinking "Oh, well, it's about communication and I know about that stuff." And it's about this and that, and I know about those things. And perhaps was on the first morning a little bit arrogant in my own thinking about what it was going to be. And was completely unprepared for what it actually was, and what it meant to me and how it changed my life. The training significantly changed my own understanding of my experiences, and really valuing what I'd experienced, and my own process of recovery. Which is an ongoing process for many of us. And I was quite unprepared for that, and found it quite shocking on some levels, and incredibly life changing on other levels... That those really really difficult experiences that I'd had could be of value to me and perhaps to somebody else.... The training holds a mirror up to you to have a look at who you are, and what you're about, and what you bring to the world, and what you have to offer. Because at that time I didn't think that I had anything to offer (Zoe, manager).

It was emphasised that peer support training is different from counsellor training, and leads to a different way of working (Elisabeth, manager). It provides access to a unique way of being in relationships.

> The peer support training specifically has done a huge amount for me in terms of how I deal with relationships. Not just at work, not just in my relationship with somebody that I'm working alongside, but with my colleagues, with my husband, with my children, with family, with my sister. So it's really spread out quite widely in terms of how I view relationships and how I conduct myself within some relationships. And I don't think I could have done that had I not gone to that training and started implementing it in some, practicing it in some other relationships and gradually it's grown into how I actually deal with things (Lydia, manager).

If peer support training is seen to add value, it might need some sort of formalisation. One of the issues discussed by some participants is whether a nationwide training programme in

peer support should be created. One of the issues involved is whether the differing models of peer support can be made coherent enough to support a single approach. This problem was raised by five participants. A second issue is whether another NZQA qualification should be created, and whether that would become an entry requirement that would in some way detract from the nature of peer support.

> I'm a bit torn about this Intentional Peer Support training being necessary. I've got a lass who comes to [our organisation], and I was her one-to-one supporter, and still am. And she's just learned so much that she's started doing it with other people who come [here]. And she's great! She's absolutely great! She's just soaked it up by osmosis. Now knowing her academic background, or lack of it, there's no way she could do an Intentional Peer Support course as presented by the Copeland Centre. She wouldn't understand half the words. So do we deny her the opportunity to be a peer supporter, simply because she can't do the training? Or do we leave her as she is, and because of her natural abilities, offer a lot of other people the benefit of who she is and what she can do, simply because of who she is, and what she can do? There are a lot of people who come to our service who are not well educated, who are not vociferous, they can't put their feelings into words and things. And this lass just has this ability to make them feel good, to make them feel accepted, to make them feel they're just like her and that's ok. At the same time, I don't think I could do some of the work that I'm doing if I hadn't had the training that I've had (Deborah, peer supporter).

In a contrasting view, another participant emphasised the danger that peer support as an occupation faces if some people set themselves up as peer supporters without understanding its basic principles, self-care, and so forth. You might have a thousand positive outcomes, but it is the one badly handled situation that will be remembered and commented on (Ross, peer supporter). This could have consequences for the wider acceptability of peer support.

> I think everybody should, has got to have a minimum training, whatever that minimum level is. And again at the moment I think that, in a lot of places

around New Zealand there is no training for peer support that I can see. So it would be really good to be able to have nationwide training in as many centres as possible… You know, peer support is a happening thing now, so support them. Support the peer support and get on with it. Especially for places that don't have any training but they want to start up peer support services anyway. I think it's quite a dangerous thing to do (Ross, peer supporter).

On the question of whether some form of training was needed, participants were united in agreement. However, there were widely differing views on whether this should be specific to peer support or just in application to mental health in general. There were also widely differing views on whether peer supporters needed an actual qualification. Participants divided evenly, with about a third supporting some form of qualification for peer supporters, a third being quite opposed to a qualification becoming necessary, and a third taking a more mixed view. Many of these supported good workforce development, but were less sure that this needed to be in the form of credentialisation. "So I think it's really important that we deliberately focus on workforce development or qualifications. But they don't necessarily have to be NZQA or credentials" (Rick, manager).

In relation to the Mental Health Support Worker's Certificate, views were also mixed. Some people had found this course very valuable, either as their sole training or as an adjunct to peer support training. Some peer supporters – particularly those without other training – felt that it had assisted them in learning boundaries, engaging in reflective practice and understanding a diversity of worldviews (Jack, peer supporter). A manager mentioned that its primary value to people who had specific peer support training was in facilitating an understanding of the wider mental health sector (Geoff, manager). By contrast, some peer supporters felt this training could actually be counterproductive to peer supporters. One peer supporter who works in a crisis house mentioned that a colleague who had graduated from the support worker's certificate had less confidence dealing with certain situations than anybody else, and wondered if this was because on the Mental Health Support Worker's Certificate "they talk a lot about risk" (Cathy, peer supporter).

Overall, this was a rich debate, with a wide diversity of differing views and perspectives. Generally, there was a consensus amongst people who had done peer support training that it had been valuable to them. Peer support training was seen to provide a way of being in relationship that had value beyond the purely work orientated relationship with peers. In fact, one organisation had started offering IPS training to non-peer supporters, and even to non-service users. "As a matter of fact I think all people that work with people should do a similar sort of training. Because it's more than a peer support approach" (Geoff, manager).

5.3 Health and safety at work

The question of how to maintain health and safety at work is a major one for peer support services. Mental health work can be stressful; peers are sometimes unwell and volatile, and the work can be emotionally demanding. In addition, all peer supporters and most peer support managers have their own history of mental health problems. In some cases, peer support work has the potential to trigger renewed difficulties. In spite of these concerns, most peer support services have been successful in evolving means of ensuring the safety and wellbeing of their peer supporters and peer support managers. This is done through three major threads: policies for maintaining safe meetings, providing excellent workplace support, including ongoing supervision, and strategies that peer supporters use for maintaining their own wellness. In this section, we will look at each of these in turn.

Maintaining safety when meeting peers

While safety can be maintained through good relationships, there is an element of risk in meeting new peers, particularly before that relationship has had time to develop. Felicity, a peer supporter in a small service, expressed this quite well when describing the indecision she felt as to whether to take a new peer in her car.

> That's the thing about this job. People are unwell; that's what they're there
> for. And you meet people who are really, really manic and high, and then the
> good thing about the job too is once you see them when they're well and

more stable, how much better they are. But yeah, there is a risk. We're at risk.

(Felicity, peer supporter)

Felicity pointed out that although she had never been physically abused in many years of mental health practice, she had been verbally abused numerous times by unwell peers, and this was hard to deal with.

Services tend to deal with this risk in varying ways, depending on the type of service they are. In a peer-run drop-in centre, staff members will gently but firmly ask a very unwell member to leave the premises, and to come back another day. They do this in a way that upholds the dignity of the member, but that also is insistent. On the very rare occasion that this personal approach doesn't work, they will call the police (Jack, peer supporter).

Some services operating with one-on-one meetings with peers have a policy of taking two people to greet new peers, on the first meeting, particularly if the meeting is in the peer's home.

On our first visit and that's around that safety stuff so that you don't walk into a place that's maybe unsafe. Now if there is a wahine *[woman]* we are going to see, then I'll take a wahine along with me. If it is another male and there are issues that have popped up on that referral, then it's someone else and I make sure that one of us is safe at all times, and then we are able to come back to [our manager] with the information we have got and if there is a safety issue there, then we plant it there later to look at and revisit it. (Tane, peer supporter)

Some advocacy and peer support services also use safety measures in the office, such as making sure there are always two people in the office, or placing panic buttons in meeting rooms.

Going out to meet peers is seen as significantly more risky than meeting them in the office, however. When meeting peers, some services ensure that their peer supporters sit near the door, have their mobile phones with them, and have the crisis team's number in their phone. "Self-care always comes first with us. You know, and you never go into a situation that you feel there's going to be any danger" (Stephanie, peer supporter). Some services

have a policy of never going to visit peers in their own homes, unless a second peer supporter is able to go along with them. This raises difficulties of its own, however. If the peer is unable to come into the office, or is uncomfortable there, the peer and peer supporter must meet at a cafe, coffee bar, or public library. Most of these public locations are unhappy with meetings taking place that don't involve purchase of a coffee, so this is another item of expenditure that must be covered from limited budgets (Rose, peer supporter).

Services that engage with a peer and meet with them one-on-one over an extended period of time often have a policy of requiring a risk assessment to be provided by clinical services before that peer can ride in a peer supporter's car or be met in their own home. This is dealt with in varying ways, but generally an attempt is made to ensure that this risk assessment doesn't interfere with the development of a fresh relationship between peer supporter and peer. The problems raised for relationship by relying too heavily on risk assessments are very real. In one service, which does its own risk assessments, peer supporters said that the relationship could indeed be affected:

> You're switching back to that oppressor role, that clinician sort of thing. All of
> a sudden you're turning into a psychiatrist that's telling them, "Oh well, we're
> quite concerned that you're going to harm yourself or someone else so we'll
> be chucking you over here for now" (Craig, peer supporter).

To deal with this difficulty, many services which use risk assessments build a gap between the risk assessment and the peer supporter. In one service the risk assessment is read by the manager, who alerts the peer supporters only if extra safety procedures need to be put in place. The risk assessments are not kept in the peer's file, and are not accessible for peer supporters to read.

One service makes particularly extensive use of risk assessments to ensure safety of their peer supporters, but is frustrated by the failure of the clinical services to take their needs for such assessments seriously. One team leader described the difficulties this can cause:

> And everybody engaged with the secondary mental health services has a risk
> and safety assessment. They're supposed to, they are supposed to update it

every six months. I know for a fact we've had ones that are years old that have never been updated. And we keep requesting, because I get my peer support workers to get new ones every year, and I keep getting the same ones, *if* I get them, **when** I get them. So that's a bit of a difficulty (Roberta, peer supporter).

This lack of cooperation on the part of clinical services in the provision of timely risk assessments was mentioned by various participants. The issues it raises are picked up in the section on relationships between peer support and clinical services.

Workplace support

When asked how people were supported by their workplace in maintaining their wellbeing, six participants – representing five different services – emphasised that each person has responsibility to maintain their own wellness. Having said that, peer support workplaces that do an enormous amount to support the well-being of their staff, given their limited resources. Of the fourteen services involved in the research, at only one of these services did participants mention major problems regarding the support they had received from management and other team members. The other participants were striking for the degree of unanimity they expressed on this subject; they were happy with the support provided by their workplaces.

And the huge support from my colleagues and the management here, I think has been, it's really turned my life around from a personal – a very personal journey it has been as well. In a very short space of time. I feel a lot more confident, a lot more able to carry on helping others, thanks to the support I get (Brenda, peer supporter).

There is a great diversity of types of support offered by the different workplaces. At four of the fourteen services, participants mentioned being offered 'Mental Health Days', in addition to normal sick leave and holiday leave. This provision for an occasional 'duvet day' was greatly appreciated by participants, and seen as an important part of self-care. Five

participants, at four different services, also mentioned having access to flexitime as a great benefit in reducing stress levels.

The need for peer supporters to maintain their wellness was mentioned by a number of participants, some of whom described the potential consequences of peer supporters trying to work when unwell. One service said the manager had the right to ask peer supporters to go home if he felt they were not well enough to work. As a way of building self-awareness of their wellbeing, four services mentioned using WRAP plans – or something similar – with their peer supporters, and a manager at one large organisation said this had been so useful with peer supporters that it was being rolled out to other members of staff. If people did become unwell when working, four services mentioned trying to hold the job open as long as possible, while the staff member recovered. However, as one manager noted, this had to be weighed up against the need for business sustainability and having the ongoing capacity to operate a service (Rick, manager).

Supervision was offered formally by every service except one small service, which provided it informally. This supervision took a variety of forms. When critical incidents occurred, there was a debriefing offered by managers, team leaders and/or team members, and sometimes by all three. The use of this form of debriefing was mentioned directly by participants at eight of the fourteen services, but is probably a feature of all of the services. Group supervision was offered at seven services, and one-one-one supervision was offered to peer supporters at eight services. Some services offer both group and one-on-one supervision. This direct supervision can be offered either internally, by managers and team leaders, or externally, by experts in mental health who are sympathetic to peer support, although they are not usually consumers themselves. This supervision was emphatically distinguished from counselling by one participant:

> The reason that I think it's important is that that's where people can address
> the challenges in the work that may be getting in the way of developing good
> peer support relationships. Good relationships in the team. And having a very
> focused way, and an individual way to do that, so that they have a place to
> take some of the more challenging aspects of the work, and explore that. And
> develop and grow professionally outside of that. And the reason that's

important that it's done really well is that it's really important the supervisor doesn't get into a therapeutic relationship, and want to go there, to the place of therapy (Zoe, manager).

One of the Kaupapa Māori services involved in this study also provides cultural supervision, led by their kaumatua, while in the other Māori-orientated service the kaumatua provides a supervisory type relationship with the manager.

There were a variety of forms of specific support provided to staff, ranging from access to counselling services, to four day weeks, to provision of training, to careful monitoring of caseloads by team leaders, to the supervision mentioned above. However, what was striking in the interviews was the importance participants attached to the *informal* support they were provided, both by managers and team leaders, and by their team members. The value of the informal support provided by managers and team leaders was directly mentioned by almost every participant.

> And it's like another family, you know. So, yeah, I think that's a huge thing for why it makes it easy to do the job when you've got someone backing you up and supporting you all the time, and that as well. I think that, yeah, a good boss, a really good boss I think makes a good difference, and good colleagues, good supervision (Rose, peer supporter).

Participants at twelve of the fourteen services mentioned the support provided by team members to each other, and the huge value of that, in debriefing, maintaining wellness, improving practice and providing social support. A peer supporter at a drop-in centre described the value of group supervision for the peer support team as such:

> Picture a chain, a very, very strong chain. But every so often one link may start to open a little and that link may just need a wee bit of tweaking up.... we're our own best teachers. We teach each other from our own mistakes. So yeah, that's what I mean. We're like a very strong chain. Every so often a link starts to open a little bit; tweak it up and that chain is even tighter (Jack, peer supporter).

All of this comes down to the creation of a good environment for staff to work in:

It works. And I think part of that is, you know, to create the right environment. It's the same as my ideas around mental health. If you create the right environment for a person to operate effectively, they will. So if you have the training and supervision and support when needed, and encouragement and no support when people are striking out on their own.... And give people leave to make mistakes and not be judged on it but just take it as a learning experience for themselves and if they're willing to share it with others, for everybody. And create an environment where people find their confidence and that worked really well. And just taking the importance away from being well, or being not so well or sitting in judgement of each other of how well everybody is, and how stressed or not stressed. It's immaterial. It really doesn't matter. You know, that's what people are. Sometimes they're having a good day and sometimes they're having a bad day. That's life. [Laughter]. Get on with life, and have your bad day, allow yourself your bad day (Velda, manager).

Overall, there did seem to be a good environment in these workplaces, as attested to by low levels of staff turnover, positive reports from participants, and good evaluations received by services. Getting the environment right for staff is something that peer support services in New Zealand seem to be doing very effectively.

Managing one's own wellness

Peer support organisations do a good job supporting their workers, but they do so with very limited resources; this really limits what they find possible. Some peer support workers said they regularly go above and beyond their contracts, doing unpaid work simply because of the great need they find.These pressures are intensified for peer supporters who are working in a kaupapa Māori context.

Sometimes I have to give them part of me to be able to go in there and I don't think the contract boundaries can ever capture that or understand that when you're dealing with Māori. You actually do give a part of you away because

that is what is required of you in Māoridom. Sometimes I get drained (Tane, peer supporter).

In this context, some people find they can't continue working as peer supporters. They become burned out and leave, or very occasionally, become unwell. Others have "learned so much, and they've grown so much through the job, and they've come to terms with so much, and their resilience has increased significantly" (Lydia, manager). Given the stresses they face, participants consistently emphasised the need to develop awareness of their own states, and to maintain good self-care.

To do this work you need to be paying attention to your own wellbeing, in a very robust and consistent kind of way, and its forced me to do that in ways that I didn't used to before. To really pay attention to what's happening for me, and to be mindful of changes that I notice in myself, and taking some action on that, taking care of that so that it doesn't get in the way of me contributing in my role as a peer support specialist. So having developed my own wellness plans, and really taking charge of that, in a way that I hadn't before (Zoe, manager).

Self-awareness of your own triggers and means of staying well is thus a crucial strategy for wellness. One peer supporter used this self-awareness to realise the importance of building in regular holidays for herself, and doing things she enjoys and benefits from in her off time. Maintaining strong boundaries between work and home life has become central to her strategy for self-care (Stephanie, peer supporter).

That work-life balance can be hard to achieve when doing work about which one feels such passion and responsibility.

Learning of your work life balance is one of the really big things I think I learned. And I think that happens for most people that work here. It's kind of a gradual progression where you're so keen when you first start, or you turn yourself inside out trying to do a really good job and it's not that you don't want to continue doing a good job, it's actually finding what's sustainable. And initially I think everybody that starts, goes the extra mile for everyone

and you realise after a while you need to find something a little more centred and it is reciprocal and that it is ok to come when you're a bit tired and say, 'oh well I'm not up to doing that today, can we do that, you know, the next day when we're on?' Or 'can I do that a wee bit later on, I just need to take some time out.' (Maya, peer supporter).

Key to achieving this degree of reciprocity is being completely honest, and honouring the reciprocity and mutuality of peer support work. It's remembering and honouring the peer support model, as Maya put it.

A number of peer supporters talked about their work as playing a key role in keeping them well. This is because they were so passionate about doing the job, and meeting their responsibilities, that it kept them getting out of bed in the mornings and coming into work, even during difficult times in their lives (Ross, peer supporter). "Consumer/survivors believe that working for the recovery of others, especially one's peers, facilitates personal recovery for both" (Clay 2005: 11). Experiences consistent with the helper's principle were mentioned by a number of participants in a wide variety of different types of peer support service. These included the passion for the work, but they also included specific learning. One participant mentioned learning the value of medication from peers that both did and didn't take their meds (Cathy, peer supporter). Others find that their work with peers brings home strategies for maintaining wellness that they then can use themselves.

So I feel that having had the experience, and having been there myself, now I know a lot of the tricks on how to get yourself out of it. And I feel that because I, myself, have been there that I can actually - and I hear myself telling them things, and I think: god, that sounds so wise, why didn't I listen to it when I was, you know? So, yeah, it does, it helps, very much (Jennifer, peer supporter).

The final word on this subject goes to a peer supporter who discussed at length the way she maintained her boundaries, engaged in self-care and built in time to re-energise herself. She emphasised the intentional and active nature of self-care and the maintenance of wellness:

"I believe that recovery is a mission. Being well is hard work. It's actually hard work. And it doesn't matter what side of the peer relationship that you feel that you're on at any particular stage, the intent is doing the work" (Melody, peer supporter).

5.4 Dealing with information

Collating, maintaining and using information is a major part of the structure of contemporary societies. In fact, Michel Foucault suggested that the transition to modernity occurred when power began to be exercised through the surveillance and management of populations, rather than through direct, violent control. He calls this disciplinary power, or the government of conduct through setting up systems of control in which people are brought to *want to* behave in particular ways. The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm (Lupton 1997: 99). Mark Poster observed that:

> the principle of one-way, total surveillance of the subject was extended to the keeping of files... For the Panoptical machine[8] to have its effect the individual must become a case with a meticulously kept dossier that reflects the history of his deviation from the norm (Poster 1990: 91, quoted in Elliott 2009: 73).

So individuals are increasingly caught up in systems of power in which their behaviour is controlled by making knowledge about them visible to authorities and technical experts (Elliott 2009: 74). At the same time, this information about them is left *invisible* to the subjects of the information themselves. The people who are most subject to this form of disciplinary power are people who are in some way different from the norm, including mental health consumers.

The mental health services have been particularly focused on collecting information about service users, through regular clinical reviews, risk assessments, and other forms of note-taking. When talking about PRIMHD, one manager identified the way this information is

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[8] The Panoptican was a prison designed so that prisoners faced by constant possibility of surveillance by guards they couldn't see. It was used by Michel Foucault as a metaphor for systems of control in modern society (Foucault 1979).

collected in relation to a group not treated as a full part of the community: "I think to a degree it's a little bit stigmatising. What other sector of the population is, you know, getting all this data collected about them? How can you really map recovery?" (Rachel, manager).

On the whole, peer support services challenge this way of using information to manage and control the behaviour of service users.

> I mean just imagine yourself, yeah. You are really distressed and the whole world could go poof as far as you're concerned. And someone is talking to you about all that, you know, what's the phone number of your sister and that sort of stuff. And then you hear someone else ringing her and going blah blah blah blah behind your back. I mean it's just, a lot of people are very familiar with paranoia. And how uncomfortable it feels. And most paranoia's actually well founded. It's not paranoia about something that isn't happening, it's paranoia about something that *is* happening. So we try to minimise. It's part of providing a good environment. There's no things happening behind your back, no decisions being made, no gossip going on. You know, all that sort of stuff. No conferences between your doctor, without you being present, or your sister or your mother, or your case worker or whoever might have an interest in you (Velda, manager).

A number of participants emphasised that mental health consumers are often concerned, with good reason, that information about them should stay confidential. They are thus more confident about receiving services from an organisation that doesn't collect this information in the first place. Because of this, a few of the services we visited keep minimal information about their meetings or phone conversations with peers.

> What we have to do is by initials, there's no full names, they're just initials. Just when you saw them and what was the aim or the outcome from the meeting. That's it. But other than that, it's all in here. *[indicates head]*. And that's a good thing for them because they know that we don't keep files on people, nobody can break into the place and go through the files and think, oh yes. And that's a big thing for people coming here. Because they realise that it is free and open, there's no secrecy, there's no hidden files, we don't get,

you know, ooh ooh, get all the files out and talk about people. And they know

that. And I think that's what makes them feel easy about coming in here

(Jennifer, peer supporter).

This desire to keep minimal information, for philosophical reasons, comes aground on a need to maintain larger amounts of information for audit purposes, for demonstration of outcomes, for reporting to funders, for quality assurance, and for purposes of providing a coherent and continuing service. These, of course, are all ways in which 'disciplinary power' and governmentality, or the governing of conduct, is enacted in contemporary societies (Elliott 2009). So a tension is created for peer support services around information, which has been addressed in creative and novel ways.

A number of the services we visited maintain notes regarding each meeting they have with a peer. These tend to be services doing one-on-one peer support over a period of time, or services providing crisis houses. These notes are designed to be very different from clinical notes, in that they are written with a recovery focus, are strengths-based and, most importantly, are written in a collaborative manner.

But what's recorded in that note from peer support specialists is supposed to

be about – written with a recovery focus – written about what strengths the

person is using, what the peer support specialist is supporting them with,

what they might be working on together. They're not supposed to be

recorded using clinical language or any language that describes a person's

behaviour using a clinical type jargon. And it's supposed to be discussed with

the person, with the peer that they're supporting. "What do you want

recorded in your notes today?" So people are supposed to know that notes

are being recorded, and asked to participate in that process... I say to our

teams that you need to be thinking about what you write, all the time, from

the person's point of view (Zoe, manager).

 This manager went on to say that it was important that unnecessary information was ***not*** included in the notes. While clinicians often did this, it was important that peer supporters only wrote about what the peer wanted recorded. Moreover, the peer supporters were expected to write in a hopeful, rather than critical or judgemental, manner. In the notes, the

peer is not to become a 'subject' with deficits and deviance recorded as per disciplinary power, but a full participant in the process of recording his or her recovery journey. This seemingly small innovation in notes keeping actually has quite large social and philosophical implications.

Every service that uses collaborative notes, except one which is based in a DHB's clinical service, said that the notes are not seen by clinicians, and are entirely confidential. Moreover, a number of services emphasised that they do not even speak to clinicians about their peers unless they are given express permission to do so by the peer concerned.

> I know community support workers have conversations with clinicians, without the peers, without the service user/ client alongside them. Peer support workers would never ever do that. There's an absolute, within our service, an absolute rule: nothing about us without us. That's it. You do not have a conversation about this person unless they are actually there or have given you absolute instruction to do, have a conversation. And then that conversation has got to be about this, you can speak to them about that, and nothing else (Lydia, manager).

Moreover, what is on those notes is transparent. It is made available to the peer, to do with as they wish.

> They can write their own notes. You know? They can have copies of all their own notes. It's up to them what they write on a piece of paper, or have written on a piece of paper, on the notes templates and things. It's **their** information (Caitlin, peer supporter).

This principle of transparency, once again, applies to meetings as well as to notes. One peer supporter/ advocate told a story about being invited into multi-disciplinary team (MDT) meetings, while the peer was instructed to wait outside. At first, he insisted that, if the peer had to sit out the meeting, he would also wait outside.

> They would force the person out and they would go and sit on the floor outside the door while they were being discussed. At first we used to say, 'ok,

if they're not allowed, you know, we can't be here either.' So we would go

out with them (Matthew, peer supporter).

However, on some occasions they would be asked by the peer to attend the MDT, and feed back what was said. In addition to telling the peer what had been discussed, the peer supporters also challenged some of what went on in these meetings. They would say they didn't feel it was appropriate to have a conversation about where a peer should live, or what they should eat, without the peer being present. Over time, this has led to some changes in practice by the clinical team, who now often invite service users to be present at MDT meetings (Matthew, peer supporter).

So peer support services tend to operate with a number of principles in relation to information. First, information which is not needed is not collected. Secondly, information is kept strictly confidential. Thirdly, information is not kept and used in a way which is not transparent and visible to the peer. Finally, notes are kept in a collaborative way. All of this can be summed up by what Caitlin said about peers owning their own information. Information is used to empower peers rather than to control them, in keeping with the broader principles of empowerment and trust which are central to peer support.

With these principles in operation, the arrival of PRIMHD (Programme for the Integration of Mental Health Data) has been a challenge for many peer support services. PRIMHD is a Ministry of Health project to create a single collection of national mental health information. This includes service activity and outcomes data from across New Zealand's mental health sector. PRIMHD was identified in 2005 as one of four priority areas in the Implementation Plan of the National Mental Health Information Strategy. The information includes details of referrals into and discharges from services, outcomes, as well as all service activity, provider teams, legal status, diagnosis and issues classifications, and also demographic information (such as sex, date of birth, ethnicity). (MoH 2010b). PRIMHD is being implemented in stages, with DHBs participating in it first, followed by the larger NGOs, and with smaller NGOs expected to participate in the near future. Some peer support services are already participating in PRIMHD, while it is a live issue in many of the smaller NGOs. What it means in practice is that peer support services have to record each

interaction, meeting and activity performed against the name and the National Health Index (NHI) number of the peer or peers involved.

For participants from one organisation, PRIMHD did not raise ethical issues.:

> I kind of understand where it's coming from. I think it's a reasonable request. I guess it all depends what they're going to do with the information, you know, what do they want it for. But, yeah, it's pretty reasonable. I mean you go to hospital, they want your NHI numbers (Roberta, peer supporter).

Interestingly, this is an organisation which sees itself as 'a health service' and already collects relatively large amounts of information from peers, such as service user reviews, evaluations, goals plans, collaborative notes, strengths profiles, and WHO Quality of life surveys. In this organisation, the primary concern of participants was that PRIMHD might not be a fair measure of their workload and way of working. However, they expressed no ethical concerns with the government collecting outcomes and service activity data.

However, at other organisations, PRIMHD was raising great concerns. One of the major issues raised related to confidentiality, and people's right to control their own information.

> [This] organisation, survives, well it flourishes and does good work, because people feel safe coming to us, because they perceived us as being outside the state mental health scheme. Which meant they could come to us and be totally honest about their experiences there. There'd be no payback, no comeback. People felt safe because they didn't even have to give us their name... But of course, that individual line of data will be tracing all the mental health activities outside the state system, you know, for *years*. Even if they go for a walk round [a local] lake as part of a group of people who have mental health issues, *that* is going to be recorded. You know? Now where does this sit with this '[clinicians should be] on tap, not on top' idea? Where does this sit with the recovery model? It doesn't! (Deborah, peer supporter).

This peer supporter spoke eloquently about the stigma and discrimination that mental health service users face, and their consequent desire to protect their confidentiality. She spoke about the government not having a good record in relation to its previous treatment

of mental health consumers, and the resulting mistrust of government by some tangata whai ora. She was implicitly referring to the role that control of people's information has played in wider systems of disciplinary power and social control. Thus, she referred to confidentiality as a principle of peer support.

Another member of this service took a different view. He argued that confidentiality is not a principle of peer support, but trust and understanding the world-view of others *are* important principles. Understanding the world-view of the policy makers who have developed PRIMHD leads us to understand their need for more extensive quantitative data with which to plan mental health services.

> How much are people willing to trust the government, if the government hasn't been very nice to them in the past?... Should the system be organised for the people who don't trust anyone? Or should it be organised for the people who do trust people, and their ability to get along? And use the information they have in an honourable and ethical way... yeah, now we're talking about the cost of these systems. And really about shifting our culture from a blaming one to a learning one. Well, in a learning culture you do have trust and in a blaming one you don't (Rick, manager).

It seems that in relation to this data collection programme, the principles of peer support are in some conflict. This relates specifically to what it means to be doing peer support within a health system that is based on a medical model, and the control and management of information that has come to accompany it within 'surveillance medicine' (Armstrong 1995).

Members of six smaller services were having problems in relation to PRIMHD, while participants from larger NGOs had already started complying with it or were pragmatic about it. For one telephone-based service, PRIMHD was an existential issue. Anonymity was absolutely central to the service that was provided, and all three participants from this service said that if PRIMHD was imposed on it, they would rather lose funding and shut the line down, then comply.

A major concern with PRIMHD, as with all the required data collection for Performance Monitoring Reviews with the DHB, was in regards to the way it might affect relationships with peers. This was a particular concern for the Kaupapa Māori services.

> It's usually quite off putting for Māori to be confronted with paperwork as the first thing. So we have had to be quite flexible about it ... (Tui, manager).

> One of the other issues for us on that topic, we have another part where I'll be engaged by whānau *[family members]* to go in to assist. If I wanted to they could become a statistic and I would use their NHI number but for various reasons I don't go there because of the issues that are involved with the whānau of that time and its more about what I do with them and how I assist them, doesn't get documented and it's never captured because it stays there (Tane, peer supporter).

> We're finding that Tane is receiving formal referrals and then paperwork is an issue, when does it happen? And then he's also receiving informal referrals from whānau, people we know and they will ring him up sometimes at home or whatever and he will go and spend a couple of hours and you feel like you can't ask them to come and be assessed, a statistic basically (Tui, manager)

> It's an insult. (Tane, peer supporter)

> And so he doesn't ask and there is some time that he spends that isn't captured for that reason. So we're kind of seeing informal support provided and formal support provided and then we have the statistics at the end of the quarter that is not able to capture the full picture (Tui, manager).

This issue with Performance Monitoring Reviews (PMR) not capturing the full picture was mentioned by a number of participants in this study. Some participants mentioned that they don't ask for ethnicity until a relationship has developed over time. Thus, the ethnicity statistics for short-term relationships are essentially meaningless (Matthew, peer supporter). A number of participants mentioned that performance monitoring statistics do not capture work done on the phone, where much time is spent, and much is accomplished (Rose, peer supporter). Finally, several services mentioned the extensive paperwork that

both Performance Monitoring and PRIMHD are generating, the way that this is essentially an unfunded reduction in service provision, which takes time away from relationship building. As a result, it is not possible to keep excellent, up-to-date statistics. All of this points to the special difficulties that exist in relation to evaluation of peer support services, and the measuring of outcomes.

6. Implications and Conclusions:

6.1 Reflections on this study, and possible future research

This study has some real strengths, which have enabled us to add considerably to new knowledge:

1. It is 'insider' research. Two of the primary researchers, Dr. Anne Scott and Dr. Carolyn Doughty, have practical experience in peer support. Robyn Priest, who helped us set up this study, is also a peer support practitioner. Tamehana Consultants, who did our data collection in the two Māori services, are Māori, and mental health 'insiders', as well. Hamuera Kahi is not active in the mental health sector, but is deeply immersed in Te Ao Māori. There are real benefits to research on peer support being done by people who have lived experience of mental distress, of Te Ao Māori, and of peer support:

   a. Our collective experience of peer support has enabled us to recruit services to participate more easily. All ten of the organisations we approached about this research agreed to participate in the study. This involved a substantial commitment of time and enthusiasm on their part, and it meant that our sample was as diverse and comprehensive as was possible within the limits of our time and funding.

   b. It gave us some insight into useful questions to ask, and some contextual experience with which to interpret the rich responses our participants gave. It enabled the interviewers to more easily build rapport with participants.

   c. It has allowed us to model what peer support is about, by carrying out peer-led and peer-controlled research, based in and answerable to the communities concerned.

2. This research has been conducted within a 'decolonising methodology' for which we owe the traditions forged in feminist, participatory and Kaupapa Māori research. It is

rooted in questions being asked by the peer support community, and is responsive to the peer support community. We have followed ethical processes that involve 'taking back' the results to the community. This report is part of that process.

3. Māori orientated services have been engaged with on their own terms, with a Māori analyst, and with the use of tikanga-based data collection processes, rather than being forced to work within an approach designed for mainstream services. The mixed methodology we have employed is a response to Treaty principles.

4. The process of conducting two in-depth interviews with most participants means that participants had sufficient time to expand on their ideas, and to think through what they wanted to say. Participants often thought about the first interview, and came to the second interview with a clearer idea of what they wanted to communicate. Because interviews can only be a partial insight into the thoughts, ideas and practice of peer supporters, it is important to create space for reflection within the interview process.

5. Peer supporters are specialists in communication and relationship, and this led to our participants being extraordinarily adept at articulating their ideas within the interviews. We have been humbled and enthused by the rich qualities and generous nature of the talk that was shared in this interview-based study.

In spite of its strengths, there are some limitations to this study. Some of these are:

1. This study doesn't look systematically at the effectiveness of peer support. Some anecdotal evidence for peer support's effectiveness did emerge in the interviews, but we didn't go looking for such evidence, and thus doesn't add to the effectiveness literature.

2. This study engaged with peer supporters and peer support managers. A major gap is that it didn't look at the experiences of peers, or service users, except insofar as our

participants have also been service users, and this came up naturally in the interviews.

3. Peer support relating to addictions is not addressed in this study.

4. The mixed methodology meant that data collection with Māori services and mainstream services was at times different. In the Māori services, we had group interviews, while in the mainstream services we had individual interviews. These produced very different kinds of talk. In the Māori services, somewhat different questions were asked, in a different way, and in a generally different order. This means that the data we produced wasn't always commensurable between the Māori and mainstream services. This was an issue when we wanted to look at proportions of people answering a particular question in a particular way. Due to the fact that questions were not asked in the same way, this wasn't usually possible.

5. This study excluded Pacifica and Asian perspectives on peer support. This exclusion occurred in three ways. First, no specific Pacifica or Asian peer support services were included in the study. Secondly, as it happens, none of our interview participants were of Pacific or Asian ethnicity. Finally and as a result of the first two exclusions, we were not able to ask specific questions about the role of culture in peer support (outside of the Māori services where this was discussed extensively). This is a major gap in the report, and would be a good focus for future research.

6. There was no quantitative dimension to this research, and as a result we are not able to provide measurable results. For example, we didn't measure the strength of people's feelings about professionalisation, or about national peer support training.

7. This study has been conducted on minimal funding, which paid for interviewer travel expenses, our Māori consultants, and transcription. There was no researcher 'time' element in our funding.

8. Ethical constraints mean that some of what people have said can't be directly reported, due to concerns about confidentiality for peers.

9. Interviews do not provide unbiased access to what people actually do, in practice. Instead, they provide a social situation in which talk can emerge which constructs, and sheds light on, ideas, insights, beliefs and practices. The nature of the occasion has a big impact on the type of talk which occurs. Thus, this research can only provide an exploratory introduction to some of the issues being addressed by peer supporters.

Possibilities for future research:

This study raises some questions that might be answered by future research. Some possibilities are:

1. An in-depth study looking at either Pacifica or Asian peer support, done with culturally appropriate researchers and methodologies. This could focus quite closely on the question of culture in peer support practice. A qualitative study would probably be most appropriate.

2. A quantitative study looking at the effectiveness of peer support in Aotearoa New Zealand. We believe it would be useful to incorporate consumer-assessed measures of outcomes, for example *Taku Reo, Taku Mauri Ora, My Voice, My Life* (Gordon *et al* 2009), as this has been developed with consumer input and from a consumer perspective. This would enable us to do a rigorous study of outcomes in peer support that focuses on the outcomes that consumers themselves feel are important.

3. A mixed methods – qualitative and quantitative – study looking at the ethical and practical effects of the implementation of PRIMHD (Programme for the Integration of Mental Health Data) across the peer support sector, and the issues that this type of data collection raises. Such a study could be done on minimal funding, through telephone interviews and an email questionnaire.

4. Cross-national comparative research looking at the way that 'recovery' is being implemented in different national context and the experiences of service users. Culture could be a major element of such research which, once again, would ideally mix quantitative and qualitative methods. Such research would require an international research team and external funding.

5. An in-depth analysis of differing peer support training programmes across New Zealand, with an action research component looking at ways to create peer support training which is accessible, New Zealand focused and responsive to differing ways of doing peer support.

6. A study of New Zealand clinicians' knowledge of, beliefs about, and concerns regarding peer support. Such a study could be accomplished through questionnaires.

6.2 Implications for practice:

This research project has thrown up a number of areas where implications for the funding and practice of peer support are evident. Because of the limitations of this study, these can't be considered definitive. They are suggestions made on the basis of this research study, both this report and related journal articles which are currently in preparation. We have divided our recommendations into three sections: implications for people with lived experience of mental distress, implications for peer support services, and implications for funders and planners.

Implications for people with lived experience of mental distress:

- Peer support is incredibly variable in Aotearoa New Zealand. There are different types of services, operating within different understandings of peer support, with different training for peer supporters, and in different organisational contexts. Thus, do not assume that peer support is defined by what you have met in one context. Look around at the differing possibilities.

- Within peer support, self-determination is a key concept. The process of receiving support should be directed by you, as the peer.

Implications for peer support services and peer supporters:

- Training which is specific to peer support does make a difference. We found, in a paper we wrote on risk management in peer support, that the type of training a peer supporter had made a difference to their ways of handling risks of suicide, self-harm and violence to others (Scott, Doughty and Kahi, forthcoming). We also found in this study as a whole that people tend to have richer understandings of peer support philosophies and values if they have engaged in peer support training. We would recommend that some form of peer support training be made easily available, affordable and accessible to all peer supporters in New Zealand.

- The type of training people received in peer support also made a difference to the way they thought about peer support. This diversity is extremely valuable to peers. Thus, we would not recommend that only one model of peer support be adopted for national training. Instead, a variety of differing peer support training models should be made accessible and affordable, so peer support services can choose the approach which best fits with their own culture and kaupapa.

- Due to the fact that peer supporters have varying levels of time, resources and academic inclination, we do not recommend that an NZQA qualification become compulsory for peer supporters. However, shorter peer support training programmes which are accessible to people at varying levels of academic ability, should become the norm within the sector.

- Peer support needs to be defined more holistically, particularly so that Māori orientated services can incorporate their practice of whanaungatanga into the wider peer support community.

- New ways of integrating peer support with mainstream services would be valuable to develop. This involves building relationships with clinicians, funders and planners, and developing ideas ranging from shared newsletters to shared services. When integrating with mainstream services, role integrity for peer supporters, or 'staying

peer' needs to be a focus of attention, and built in structurally through role supervision, training and other means.

- Peer supporters and peer support managers might want to make use of the new interactive peer support website www.peersupport.net.nz being constructed by Balance New Zealand with funding from Te Pou – the National Centre of Mental Health Research, Information and Workforce Development, and from Frozen Funds.

Implications for policy-makers, and funders of mental health services:

- Funding for peer support by District Health Boards needs to include adequate funding for peer support training and supervision. Another possibility would be channelling funds for national peer support workforce development through Te Pou or through District Health Boards. Scholarships for peer support training could be provided to individuals, or training grants to services.[9]

- Peer support services are generally operating on insecure and inadequate funding, which leads to stress for workers and to limitations on services that can be offered. This was an issue raised by almost every participant. Secure and adequate funding for peer support services is needed.

- Contracts for peer support services are generally flexible and enabling. However, certain limitation on some contracts emerged as problematic. Contracts should not place short time limits (e.g. less than three years) on the length of a service user's engagement with the peer support service. Short time limits interfere with the ability to build trusting relationships with some peers. Kaupapa Māori services may need time limits to be removed entirely, due to their process of whanaungatanga.

- A funding mechanism that finances peer support for those accessing only primary care needs to be found. There is a general move towards treating people within the primary sector, and some of our participants suggest that it is at these non-crisis stages that peer support can often be most effective. Peer support should be available to primary sector service users.

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[9] District Health Boards have provided such scholarships in the past. For example, they have provided scholarships for Intentional Peer Support and Copeland Centre training at times during the past ten years.

- Specific training in peer support needs to be offered to clinicians. This could take the form of a short, two hour workshop designed to answer questions and alleviate concerns relating to peer support services in clinicians' specialist areas, and to provide information on peer support services operating in the locality.

- A national discussion on the applicability of PRIMHD (Programme for the Integration of Mental Health Data) to peer support services needs to be facilitated. PRIMHD is raising major issues for some peer support services, including capacity to comply with its requirements, confidentiality, and consistency with a peer support philosophy. Further research and discussion in this area is indicated.

- New ways of integrating peer support into mainstream services would be valuable to develop. This might involve the engagement of peer supporters with inpatients moving towards discharge, the development of shared crisis services, or other ways of working together.

6.3 Conclusions

It has been a privilege to learn about the practice of peer support in Aotearoa New Zealand and we hope this report has assisted you in understanding the wealth of ideas and rich practice peer supporters are bringing to their work. Trying to reduce such a varied and rich set of interviews into a short summary is near impossible, but we will nevertheless attempt to draw out some overall conclusions here.

1. Peer support is more than a change of personnel. It goes beyond simply offering the same mental health services, but this time by present and former consumers. It has a philosophy of practice which is extremely rich and is challenging for the community mental health services in New Zealand as a whole. When operating at its best, peer support facilitates self-determination within the space made by caring and mutual relationships. It involves an engaged practice which reformulates the way 'risk' is understood. It involves the creation of learning environments in which experiences of mental distress can be reframed as resources for living. It inspires hope that recovery is possible. It thus brings the abstract concept of 'recovery' to life, and puts it into practice.

In this way, peer support is setting a challenge for all mental health services to look towards, and to use as a basis for reflection on their own practice.

2. Peer support involves unique challenges for practitioners. Because of peer support's philosophy of practice, it must address challenges such as risk, the maintenance of boundaries, integration with clinical services, and practices of information gathering, in a new way. In this way, the community mental health sector as a whole may be stimulated towards innovative ways of practicing and thinking.

3. Achieving security and adequacy of funding is thought by the peer support community to be the most important issue facing peer support in contemporary Aotearoa New Zealand. A second and related issue considered extremely important by participants in this study is the need to receive greater respect and understanding from clinicians and funders.

Peer support is in good heart in Aotearoa New Zealand. The peer support community tend to be happy in their jobs, and passionately committed to what they do. There has been good growth of services in the past few years, leading to services with a variety of approaches and offerings. Peer support training is becoming increasingly available, and a cohesive peer support community is developing. However, there are concerns about our ability to maintain these gains, and even to advance on them, in the future.

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7.1 Glossary of acronyms and Māori terms

Acronyms

CSW – Community support worker

CYF – Child Youth and Family Service

DHB – District Health Board (Statutory boards for New Zealand's public health system)

DPB – Domestic Purposes Benefit (Welfare benefit for single parents)

HoNOS – Health of the Nation Outcome Scales (for assessing mental health service users)

MHC – Mental Health Commission (of New Zealand)

MoH – Ministry of Health (of New Zealand)

NGO – Non-governmental organisation

NHI – National Health Index (NHI numbers identify individuals receiving health and disability services)

NZQA – New Zealand Qualifications Authority (Certifying authority for secondary and tertiary level qualifications)

PRIMHD – Programme for the Integration of Mental Health Data

WINZ – former acronym for Work and Income New Zealand

WRAP – Wellness Recovery Action Planning. A self-management programme for people with mental illnesses

Māori terms

Aroha – Love, feel compassion

Awhi – To embrace, aid, help

Hongi – Physical greeting, rubbing of noses

Ka pai – Good

Kaumatua – An elder, either man or woman

Kaupapa – Philosophy, foundation, platform, policy

Kaupapa Māori – Māori philosophy

Kōrero – Stories, speak, conversation, narrative

Mahi – Work, employment

Mana – Prestige, inherited status and standing. Mana is the spiritual power or supernatural force. It is closely related to tapu (sacred)

Manaakitanga – Hospitality

Māngai – Mouthpiece, spokesperson

Marae – Traditional meeting ground.The courtyard or open area in front of the wharenui (meeting house)

Maunga – Mountain

Mihi – Greet, introduction, thank, pay tribute

Pānui – Notice, advertise, read

Pono – Truth, honesty

Rangatahi – Youth, young person

Reo – Language

Take – Issue, cause, concern

Tangata whai ora – Consumer, peer

Tangata whenua – People of the land, indigenous peoplse

Taonga – Treasure, property, something prized

Tautoko – Support

Te Ao Māori – The Māori world

Teina – Younger sibling

Te Wheke – Octopus. Health model developed by Rangimarie Rose Pere

Tikanga – Correct procedure and custom, code of conduct, method, plan, meaning

Tuakana – Elder sibling

Wahine – Women

Waiata – Songs

Whai ora – shorthand for tangata whai ora, or peers. Pursuit of health

Whakapapa – Genealogy, genealogical table, lineage, family tree

Whakatau – A welcome or welcome speeches often considered to be less formal in nature

Whakawhanaungatanga – Process of establishing relationships and connections

Whānau – Family

Whanaunga – Relative, kin

Whanaungatanga – Relationship, connection, kinship

Whare – House, building

Whare Tapa Whā – House with four walls, where each house represents a different dimension of health. Health model developed by Mason Durie