

Service user, consumer and peer workforce

A guide for managers
and employers



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Background

The service user, consumer and peer workforce is a diverse and rapidly growing workforce in today's mental health and addiction services in New Zealand. It includes all roles that require lived experience for example consumer advisors and peer support workers.

This guide has been written for mental health and addiction services that employ workers in identified lived experience roles. It is designed to be used in conjunction with the **Competencies for the mental health and addiction consumer, service user and peer workforce**, available from www.tepou.co.nz.

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

Definitions

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

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

The national context

National policy and frameworks

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

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

- **Consumer leadership, consultancy and liaison** for mental health and addiction services.
- **Consumer advocacy services** for advocacy with individuals.

- **Consumer resource and information service** for information, education and networking.
- **Peer support service for adults** for support and community involvement.
- **Peer support service for children adolescents and youth** for age appropriate peer support.
- **Community phone service** for peer support via phone lines.

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

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

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

The formal evidence in both mental health and addiction is growing and shows high satisfaction from services that use all kinds of peer support as well as positive outcomes for people who receive peer services. Outcomes from peer services are as good if not better than conventional services¹.

Indications for service users include:

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

Indications for people who provide peer services include:

- creating jobs, learning new skills, developing routines and increasing income
- assisting with recovery and staying well
- satisfaction of using challenging life experiences to make a positive difference.

Indications for organisations include:

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

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

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

The 'Competencies for the mental health and addiction service user, consumer and peer workforce' are an ideal resource to inform the service design or improvement process. These articulate the expectations for peer workforce roles, management and leadership.

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

It is important to understand what makes the peer workforce different from other workforces and consider what unique skills this workforce brings to your organisation, service or team.

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

Peer values

Peers can provide many types of services but peer work is not so much defined by what is done but by **who** does it and **how** it is done.

The '**who**' must be people with lived experience of mental distress or addiction and recovery.

The '**how**' is guided by peer values.

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

- **Mutuality** – the authentic two-way relationships between people through 'the kinship of common experience.'
- **Experiential knowledge** – the learning, knowledge and wisdom that comes from personal lived experience of mental distress or addiction and recovery.
- **Self-determination** – the right for people to make free choices about their life and to be free from coercion on the basis of their mental distress or addiction.
- **Participation** – the right for people to participate and lead in mental health and/or addiction services including in the development or running of services as well as in their own treatment and recovery.
- **Equity** – the right of people who experience mental distress and/or addiction to have fair and equal opportunities to other citizens and to be free of discrimination.
- **Recovery and hope** - the belief that there is always hope and that resiliency and meaningful recovery is possible for everyone.

These values provide a strong foundation for peer work. It is important to note that while peers may take part in projects to improve or eliminate compulsory interventions, such as putting

people into seclusion or restraints, taking part in the actual tasks does not fit with the values of the peer workforce.

An honest and transparent relationship with the people who use the service, which may include collaborative note taking is a requirement of their work. Where there are serious safety issues peer workers should take a 'risk sharing' approach and openly negotiate a process with the person to reduce their risk, including where appropriate, seeking clinical or emergency services support. Nevertheless, peer support workers should remain aware that as health workers they have a clear statutory obligation to ensure the safety of the people they work with and others.

Peer boundaries

Traditional professional boundaries in mental health most often include non-disclosure of personal information and emotions. Peer values include mutuality and the use of the knowledge gained from lived experience so the boundaries in peer relationships are broader and more flexible. This requires the peer workforce to be competent at explicitly negotiating boundaries on a person by person basis. This must be done with consideration to values, the rights and wellbeing of the other person, and their own wellbeing, along with a health workers legal obligations. It is important that managers understand and support peer workers in this area and that the organisation has clear policies and procedures around this.

Peer roles

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

- **Peer support workers** work alongside individuals and groups of people who experience addiction or mental distress to help restore hope and personal power and to inspire them to move forward with their lives. *Peer support worker* is used in this paper as an umbrella term for several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist.
- **Consumer advocates** work independently of the systems they advocate in with individuals to resolve their experiences of unfairness or injustice, or at a systemic level to resolve collective injustices.
- **Consumer advisors** work mainly within mental health and addiction organisations to provide operational and strategic advice based on peer values and recovery principles, and to ensure the voices of people who experience mental distress and addiction influences the direction of the service. Consumer advisor is used in this paper as an umbrella term for other roles and job titles with similar functions, such as consumer consultant, consumer leader and client engagement facilitator.
- **Consumer, peer and service user educators** provide education from a lived experience perspective for other peers, mental health and addiction workers or community members.
- **Consumer, peer and service user researchers and evaluators** do research and evaluation from a lived experience perspective in partnership with their peers.
- **Consumer and service user auditors** provide a service user perspective in teams that audit mental health and addiction services, amongst other areas they lead the audit of service user participation and leadership.

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

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

Types of peer services

There is a huge variety of peer work resources, responses and services around the world. Many of these are delivered by mainstream providers. The difference for the peer workforce lies in the values and the way peers work using their own experience.

Peer support services may include:

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

Other peer services provide:

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

Peer practices

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

Twelve step fellowships (AA, NA, Al-anon, GA, OA, SLAA)

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

Wellness Recovery Action Plan (WRAP)

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

Intentional Peer Support (IPS)

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

Peer education programmes

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

Other practice methodologies have been developed.

- The New Zealand Needle Programme's dedicated needle exchanges are recognised as a peer-based initiative driven by people who inject drugs.
- SMART Recovery – a non-spiritually based self-empowering addiction recovery support group, with tools for recovery based on the latest scientific research.

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

Workforce capacity and capability

In 2010 a workforce survey was done on the service user workforce and provided a snapshot of roles, tasks, and requirements.

www.tepou.co.nz/library/tepou/service-user-workforce-survey---where-are-we-at

The 2014 stock take of adult mental health and addiction services will also provide more current information about the peer workforce.

www.tepou.co.nz/supporting-workforce/workforce-planning/more-than-numbers

Organisational context and structures

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

- Informal grass roots networks run by volunteers with lived experience of addiction or mental distress such as twelve step fellowships and hearing voices groups.
- Funded independent peer run organisations staffed and governed by people with lived experience such as Mind and Body and Mental Health Advocacy and Peer Support (MHAPS).
- Mainstream service agencies with peer support workers, teams or initiatives within them such as the peer support teams in the Counties Manukau DHB mental health service, the Waitemata DHB community alcohol and drug service and Key We Way within Richmond New Zealand.

Mainstream organisations who employ a number of peer workers can consider structures and processes to preserve their identity and wellbeing. Some options include:

- creating semi-autonomous teams of peer workers
- employing peer managers or team leaders to line manage peer workers
- providing peer supervision for peer workers
- providing opportunities for peer workers to meet and share experiences.

Competencies for the mental health and addiction service user, consumer and peer workforce

‘Competencies for the mental health and addiction service user, consumer and peer workforce’ outlines the expectations of the peer workforce in New Zealand. Competencies are observable behaviours that demonstrate possession and use of the knowledge, values, skills and characteristics that distinguish levels of performance in the work environment. Competencies are required at some level by everyone in the workforce but the depth and level required to work effectively is dependent on their role and the time they have been in the role.

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

There are 13 competencies.

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

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

- **Essential** – people when they start work or after an agreed induction period needs to demonstrate this level of competency.
- **Peer practitioner** – people who have worked at least two years in their role need to demonstrate this level of competency.
- **Peer manager** – team leaders and other line managers need to demonstrate this level of competency.
- **Peer leader** – organisational leaders need to demonstrate this level of competency.

While the peer manager and peer leader competencies are designed for managers and leaders in identified lived experience roles they can also be used by mainstream managers and leaders who manage people in identified lived experience roles.

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

Organisational policies and procedures

Human resource policies are usually flexible enough to respond the diversity of the staff in any organisation. In employing peers the learning from challenging life experiences can be an asset in the workplace, but they may normally be excluded due to past experiences, for example people with interrupted education and employment or a criminal record may be valuable when working with others with similar life experiences. It may be helpful to develop human resource policies to reflect this.

Service policies need to be checked to see if they are consistent with peer values. Sometimes organisations may need to create a new policy, change an existing policy or make exclusions for peer workers in a policy. The most likely areas are those that deal with risk management, restraint, restrictions on freedom and documentation. New policies could include collaborative note taking, sharing risk and being alongside people in difficult situations while still fulfilling legal obligations around safety. This could become an opportunity for the organisation to review all their service policies to become more aligned with recovery ways of working.

Recruitment

Prerequisites

Lived experience on its own is not a sufficient criterion for the selection of a peer worker, it is simply a prerequisite.

Advertising for positions

People with experience of addiction or mental distress may anticipate employment discrimination and may have experienced this kind of discrimination in the past. It's important that all job advertisements give positive messages about the value of lived experience such as:

- job advertisements for all positions that include a note that applications are welcome from people with lived experience of mental distress or addiction
- a peer worker advert that states the applicant needs to have lived experience of mental distress and/or addiction and is willing to share this experience in their work
- both requirements and challenges around disclosure of criminal records and how this is managed.

Information on the organisation provided to all job applicants needs to highlight its peer work and peer services so that candidates with a positive attitude towards peers are motivated to apply.

Selection processes

Applicants for peer worker roles often feel relieved and positive about the value placed on their lived experience. The organisation can show positive regard for applicants by including people with openly identified lived experience on selection panels – both peer workers and people who use the service.

For peer workforce roles it is important to ascertain during the interview if the applicant:

- has learnt from their lived experience and can communicate this
- has personal resilience strategies
- can deal with self-stigma and is at ease with self-disclosure in the work context
- can share relevant aspects of their story for the benefit of others
- has empathy and listening skills
- is able and willing to fulfil the duties in the job description
- is able and willing to learn new skills.

The face-to-face selection process can include more than just interviews which on their own are not always reliable. It could include role plays, presentation of the applicant's story, and group exercises with all the applicants, or other processes to augment information gathered during a standard interview.

It is preferable that peer workers, like other workers, reflect the demographics of the population the organisation serves. Peer workers should also have had broadly similar life experience to

the people who use the service. For instance, a service that works with people with addiction would usually seek peer workers who have experienced recovery from an addiction themselves.

Job descriptions

Peer worker job descriptions need to be developed with reference to the 'Competencies for the mental health and addiction service user, consumer and peer workforce', which provides a framework for determining both the level of competency and the type of competencies required for a particular job role. Employers need to add more detail about the types of tasks required and the settings they are expected to work in as well as their qualifications and accountabilities.

The peer job descriptions may also need to clarify what is not expected of the role, especially if it varies from a similar non-peer role. For example, unwanted monitoring of medication compliance or participating in seclusion and restraint are not compatible with peer values.

Work conditions

Workplace adjustments

All new recruits, whether they are peer workers or not, need the opportunity to discuss any workplace adjustments they may need that are not routinely provided by the organisation. These negotiations may need ongoing adjustment. Under the Human Rights Act 1993, employers have to make 'reasonable accommodations' for employees with disabilities, including people who experience mental health or addiction problems unless it would be unreasonable for them to do so. Most workplace adjustments are the same that are used for any employee.

Types of workplace adjustments needed by people who have experience of mental distress or addiction can include:

- adjustment of work schedules such as starting and finish earlier or later in the day
- flexible sick leave such as long term unpaid leave and gradual return to work
- part time work or a reduction or increase in hours
- quiet workspace if a person hears voices and is sensitive to noise
- flexible personal and professional development opportunities
- additional supervision during difficult times.

Managing the transition from service user to peer worker

Some peer work applicants may still be using mental health and addiction services, including the service they are applying to work in. The usual practice is that employees do not use the mental health or addiction service they are employed by to avoid role confusion. There may be some flexibility around this if the organisation is large and the person is working in a different location or service unit. If the person works in a district health board the usual policy is to send them to an acute service in another district health board. However this may not be practical in a rural setting and the peer worker may prefer to use services in their own district health board. These issues should be negotiated on a case by case basis.

Self-disclosure at work

Peer workers by the nature of their roles identity disclose they have lived experience of mental distress or addiction. They must make their own judgements about what aspects or details of their lived experience they share with their colleagues or the people they work with. These judgements need to be based on the benefits self-disclosure will bring to others as well as the personal safety and wellbeing of the peer worker. Peer workers should always choose what they want to share and should not be pressured to disclose personal information to others. They may share different elements of their lived experience with different people. Any information shared with a manager or colleagues needs to be treated as confidential unless the peer worker says otherwise.

Wellbeing plans

It is recommended that organisations work with employees to develop wellbeing plans which enable them to practice self-care, good work life balance and to deal constructively with personal crises of any sort. These should be made available for **all** staff, not just peer workers.

Orientation and training

Peer workers will go through the standard orientation process for the organisation. This process could also include an introduction to peer work, its origins, values base and role in the organisation.

Ideally training should precede active duties or coincide with the start of employment. The 'Competencies for the mental health and addiction service user, consumer and peer workforce' provide guidance on the content of the training.

The New Zealand Qualification Agency (NZQA) recognises the Certificate in Peer Support (Mental Health) (Level 4) that is currently offered by Mind and Body Learning and Development Ltd – a training agency approved by NZQA. This qualification will eventually be superseded by a New Zealand qualification achieving similar learning outcomes and is likely to be provided by other tertiary training agencies as well as Mind and Body. The Mind and Body qualification will continue to be recognised.

It is expected that all peer support workers will be required to undertake this level of training in the same way that other workers are expected to complete a level 4 certificate.

Preparation and training for non-peer colleagues

Organisations that have not previously employed peer workers can prepare staff to work well together. This will maximise the opportunity for culture change and ensure staff understand peer roles as well as the benefits they bring to the organisation and the people who use the service. Ideally peer led training for staff should be offered. The training could include input from non-peer managers who are experienced at working with peers.

The content of the training for non-peer staff could include:

- definitions of peer work
- origins and development of peer work
- values of peer work
- the benefits and evidence base for peer work
- peer perspectives in boundaries
- viewing addiction, mental distress, services and interventions through a peer lens
- identifying and eliminating stigma and discrimination in the workplace
- providing space to 'unpack' any difficulties staff may have with peer colleagues.

There should be opportunities for ongoing dialogue following the training.

Some of the concerns staff may have about peer workers

Common concern	Response
Peer workers may be too fragile to handle the stress of the job.	Many have learnt resilience and robust self-care as part of their recovery and are mentally tougher than most people.
Peer workers often relapse and other workers have to take on their responsibilities.	People are less likely to relapse if they are employed and have jobs that satisfy them. Staff take sick leave for many kinds of conditions and organisations plan for this.
Peer workers won't always follow confidentiality and boundary rules.	Boundary rules are slightly different for peer workers due to using their personal stories in their work. All staff including peer staff work under confidentiality agreements set by legal and organisational policies.
Peer workers may not have to be as accountable as other staff.	Peer workers need to adhere to policy and procedures as much as other workers. If they are not expected to be as accountable as other staff this may be due to discrimination and low expectations on the part of the employing organisation and needs to be addressed.
Peer workers may replace other work roles and take away my job.	<i>Rising to the Challenge</i> outlines clear expectations regarding developing more service user, consumer and peer roles. There is enough room for all disciplines, roles and experience to be needed in mental health and addiction work. It's all about providing a continuum of choices and services that supports the best experience and outcomes for people using the services

Joint orientation

The organisation could consider joint training or dialogue sessions between peer and non-peer staff. This would work well after both groups have completed initial separate training to ensure there is a shared understanding of the values and nature of peer work and vice versa. Peer staff may also be able to share some of their peer practices to other staff for them to use, such as collaborative note taking and shared risk taking.

Line management and supervision

Line management

Ideally peer workers should be line managed by other peers but this may not be possible in many teams. If the line manager is not a peer, peer supervision for the peer worker is even more important.

The line management skills needed to manage peer workers are essentially no different to that of non-peer workers. Managers do, however, need to understand the values, practices and unique challenges of peer work. Using the Manager level of the 'Competencies for the mental health and addiction service user, consumer and peer workforce' will support managers and team leaders to work well with peer workers.

If a manager has concerns about any staff member's mental distress or addiction they need to relate to them as an employer and not as a mental health worker. Managers can encourage people to find and use their own natural supports, mental health and addiction services, counselling or supervision to address these issues.

Performance review

In performance review it may be useful to use the 'Competencies for the mental health and addiction service user, consumer and peer workforce' to:

- identify competency levels to be developed over the next year
- plan training to address competency development or gaps identified
- identify and prepare for career development opportunities.

Serious concerns about a staff member's performance may lead to performance management. Some line managers of peer workers may worry that their performance concerns are related to the person's mental distress or addiction or that the process of performance management may be too stressful for them. Peer workers need to be as accountable for their performance as other workers and be subjected to the same performance management thresholds and processes. Performance management for **all** staff needs to take into account what mitigating circumstances may be occurring in their lives and respond appropriately for the person, job and service.

Peer supervision for peer workers

Individual and group peer supervision is essential to give peer workers the space to share their concerns, reflect on peer values, their practice and to share ideas for improvement. Supervision can:

- support and educate to ensure safe, ethical and effective work practices
- identify and address areas for competency development
- understand the best ways to use own lived experience for the benefit of others
- prevent burnout and vicarious trauma.

Supervision should be regular. Group supervision can be particularly effective for peers working in isolation in different teams. Supervision could be facilitated by a trained peer staff member within the organisation or an external peer expert. The supervisor should have specific training, experience and knowledge of the area of work. Themes that emerge in peer supervision can be fed back to the organisation with the agreement of the peer workers.

Peer workers are sometimes offered external supervision from people with a clinical background. This may be a useful addition to peer supervision but should not replace it. Clinical supervisors need to understand peer values and peer work roles and avoid using a clinical or therapeutic lens when viewing peer work practices.

People with lived experience who work in non-peer roles may also want the option of peer supervision. Especially if they openly identify as having lived experience in the workplace or want to become a peer worker.

Peer supervision for managers

Non-peer managers of peer workers may benefit from access to an internal or external peer supervisor to address issues around peer values and any practice issues that arise. This may be through a formal supervision relationship or an informal arrangement with an internal or external peer leader.

Implement, monitor and evaluate

The effectiveness, relevance and feasibility of workforce development needs to be evaluated regularly and reported on for fine tuning of workforce strategy and service delivery.

It is important to evaluate the value and efficacy of the peer workforce in action as this is a relatively new area with, as yet, less evidence than other roles.

Peer workers such as consumer advisors, advocates and leaders are pivotal when evaluating services from the service user perspectives. They also facilitate service user engagement and involvement in quality improvement initiatives.

Service development and quality improvement

Organisations that provide services to people who experience mental distress and addiction can use advice or guidance from peer leaders. These may be external experts, consumer advisors or peer support workers in team leader or management roles.

Peer leaders need to contribute to:

- the strategic developments of all service work and particularly peer work within the organisation
- identifying and negotiating changes to any policies and practices to align with peer values
- liaising with human resources on adapting employment policy and processes for peer workers

- ensuring training for peer and other staff
- acting as a conduit for feedback from peer workers within the organisation and people who use the service.

Quality improvement

Ideally people who use the service and peer workers should be involved at all stages of the quality improvement process in an organisation. They bring the peer perspective to review and audits of policies and practices.

People who use the service and peer workers need to be viewed as two distinct groups whose interests may differ at times. Peer workers have the same obligation as other staff to listen and respond to the views of the people who use the service.

Feedback or qualitative evaluation of the peer service should be incorporated in the quality processes of the organisation. Feedback from a variety of direct and indirect sources can be used to develop and improve the peer service and performance of the peer staff.

Exit interviews

All peer workers and volunteers who resign should be given an exit interview. Focus could be applied to finding out if the organisation was 'peer worker friendly' for them and if not, what were the barriers and what potential solutions exist.

References and useful information

Major research papers

- Davidson, L., Bellamy, C., Kimberly, G. and Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of the evidence and experience. *World Psychiatry* 11, 123–128.
- Doughty, C., and Tse, S. (2011). 'Can Consumer-led Mental Health Services be Equally Effective? An integrative review of CLMH services in high income countries'. *Community Mental Health Journal* 47:3, 252–266.
- Janzen, R., Nelson, G., Trainor, J. & Ochocka, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part IV – Benefits beyond the self? A quantitative and qualitative study of system-level activities and impacts. *Journal of Community Psychology* 34, 285–303.
- Rogers, E., Teague, G., Lichenstein, C., Campbell, J., Lyass, A., Chen, R. and Banks, S. (2007). Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. *Journal of Rehabilitation Research and Development*, 44 (6), 785–800.
- White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evidence*. Chicago: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

Guidelines

- Ashcraft, L., Anthony, W. (2007) Adding peers to the workforce. *Tools for Transformation*, 27(11), 8-12.
- Basset, T., Faulkner, A., Repper, J., and Stamou E. (2010). *Lived Experience Leading the Way: Peer support in mental health*. London: Together.
- Centre for Excellence in Peer Support. (2013). *Considerations when operating a peer support service*. Victoria: ARAFEMI.
- Daniels, A., Fricks, L., Tunner, T. (Eds). (2011). *Pillars of Peer Support -2: Expanding the role of peer support services in mental health systems of care and recovery*. Available from www.pillarsofpeersupport.org
- Faulkner, A. and Kalathil, J. (2012). *The freedom to be, the chance to dream: Preserving user-led peer support in mental health*. London: Together.
- National Committee for Addiction Treatment and Matua Raki. (2013). *Consumers contribute to the addiction sector in more ways than one*. Author.
- Peer Work Project. (2009). *Employer tool-kit: Employing peer workers in your organisation*. South Australia: Baptist Care and Mental Illness Fellowship of SA.
- Repper, J. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health and Mental Health Network, NHS Confederation.
- Sunderland, K. and Mishkin, W. (2013). *Guidelines for the practice and training of peer support*. Calgary, AB: Mental Health Commission of Canada. Available from: <http://www.mentalhealthcommission.ca>