# PEER WORK IN MENTAL HEALTH AND ADDICTIONS

## Paper prepared for Capital and Coast District Health Board

## Phoenix Group

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## Purpose of this paper

Peer work is the fastest growing occupational group in the mental health and addictions workforce and offers considerable potential for all service providers to improve their services. As yet, this potential is very much in its infancy at CCDHB and understanding and definitions of peer work vary considerably.

The Capital and Coast DHB Commissioning Group has indicated a strong interest in developing peer work and this paper has been prepared to help the DHB define, the major types of peer work, its origins, policy context, its values, evidence-base and development needs. The paper recommends way forward for CCDHB to collaborate with the Phoenix Group to develop this workforce. It has been prepared on behalf of the Phoenix an informal local group of mental health service users that promotes our shared interests.

## Origins of peer work

Informal peer support has always existed among people with mental health and addiction problems. The first known reference to using peers to deliver mental health services came from one of Philippe Pinel's colleagues in 1793 when he wrote 'As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane' (Davidson et al, 2012). Since then we have seen the development of Alcoholics Anonymous and other Twelve Step groups from the 1930s on and a variety of mental health peer initiatives that arose from the international user survivor movement from the 1970s on. In the last twenty years in many Western countries mainstream mental health services have begun to employ peer workers in various roles. Peer support is the fastest growing occupational group in the mental health sector today.

## The policy context

The development of peer work is consistent with the development of the recovery approach and resilience as well as general trends in health towards self management of health conditions. Peer support is mentioned in Blueprint II and is likely to have a prominent place in the Ministry of Health's upcoming mental health and addiction service development plan. CCDHB has recently adopted the Three Wisdoms in its planning process that recognises the need for combined clinical, peer and community/whanau expertise in the delivery of services.

## Definitions

Services provided by peers may be:

- Funded or unfunded.
- Use volunteers or paid staff or both.
- Operate out of consumer run organisations OR other mental health and addiction agencies.

- Delivered by teams of peers or by an individual peer in a team of non-peer workers.

**Peer work, peer workers and peer workforce** – all workers in mental health and addiction services who are employed to openly identify and use their lived experience of mental distress and/or addiction as part of their work. As this workforce develops there is a greater need to create new roles and define the boundaries between them.

The peer workforce includes:

- **Peer support workers** provide support for personal and social recovery to people with mental health and or addiction problems. Peer support workers may provide support in many service contexts including acute mental health services, housing, supported employment, community support and so on.

- **Peer advocates** help individuals or groups of people with mental health and/or addiction problems to have their rights respected and needs and wishes addressed, on a range of issues in a variety of settings.

- **Peer educators** who provide education from a lived experience perspective for other peers, mental health workers or community members

- **Peer navigators** assist people using services to find, choose and gain access to a full ranges of community resources, networks and services

- **Peer advisors (consumer advisors)** work in partnership with mental health service providers to enact the Health and Disability Services Standard 2.5 Consumer Participation. They present consumer perspectives at all levels of planning, implementation and evaluation, and provide feedback to service users.

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

Peer workers can provide many of the same kinds of services non-peer workers and professional provide. The essence of peer work is not so much what kinds of service is provided but who provides it and how. The 'who' must be a person with lived experience. The 'how' must be built on the values of peer support.

People with lived experience who are employed in non-peer roles such as a community support worker do not fit the definition of peer support worker, even if they openly identify their lived experience and use it in their work.

## The values and fundamental concepts in peer support

Peer support is an explicitly values driven activity with values derived from the consumer movement and recovery. These values include:

Self determination – the right to direct our own lives

- Participation and equality – the right to direct our own services
- Reciprocity – a two way helping relationship
- Experiential knowledge – the use of lived experience as a knowledge base
- Recovery and hope – hope and belief in people's ability to recover

The values of reciprocity and experiential knowledge are unique to peer support and have many

implications for how peer workers do their work. One major implication is the differences in boundaries exercised by peer workers and traditional professionals. In terms of mutuality a peer worker sits between a friend relationship and a traditional professional relationship.

## The evidence base for peer support

The evidence in both mental health and addiction is growing and shows high satisfaction from people who use all kinds of peer support as well as some positive outcomes for people who receive peer services:

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

There are also proven benefits for people who provide peer services including:

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

(Davidson et al, 2012; Doughty and Tse, 2011; Janzen et al, 2006; Rogers et al, 2007; White, 2009)

## What needs to happen now

There is much work to be done in developing this workforce so that it becomes a unique and powerful player of the mental health and addiction sector. This work must be led by peers.

Development work that needs a more national focus includes:

- Defining the unique features of peer work.
- Peer ethics, boundaries and standards.
- A national qualification and career pathways.
- Career pathways.
- Peer practice tools.

Development work that needs a regional or district focus includes:

- Targets for increasing the workforce.
- Explicit contract requirements to employ peer workers.
- Tailored accountability requirements to suite the nature and values of peer services.
- Guidelines on the employment of peer workers.
- Programs for preparing non-peer colleagues for working with peers.

The Phoenix Group offers to meet with the CCDHB Commissioning Group to explore collaborative planning and implementation for the development of this workforce at the district and regional level, especially for the reshaped NGO sector.

## References


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