Models of care that reduce preventable hospital IPU admissions

What we have learnt from Piripono evaluation and research

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Introduction

Recurrent mental health IPU admissions (as well as the utilisation of Emergency Departments) is common among some people who live with significant or acute mental distress which negatively impact on their mental health, and co-occurring substance abuse or misuse. This results in high healthcare costs which are potentially preventable. Peer support services are increasingly recognised as part of an effective service delivery continuum in mental health and addiction services, both in NGOs and DHBs. There also appears to be wide support from tangata whaiora and whānau, lived experience leaders and policy-makers to grow and develop peer delivered services in the mental health and addiction sector.

In New Zealand, the funding and implementation of peer delivered services experienced significant slow-down over the past 5 years, although it has progressed to become a necessary and fundamental part of mental health, addiction, and other social support service delivery. The implementation of Piripono (2013) was the last new peer support initiatives funded within the WDHB and ADHB regions.

This report looks at the following aspects of peer delivered service options:

1. The approaches, models and practices that are used effectively to reduce preventable hospital admissions.
2. The extent to which these models, approaches and practices are used across the WDHB and ADHB regions.
3. The required structural supports required to support the implementation of such service options, including funding, training, and other requirements.

Key Definitions:

Peers: This term is used to refer to someone who are accessing support from peer support services

Peer Support Worker: This term is used to refer to individuals who are employed and trained to deliver support within a peer support service.

Peer Support: The term is used to describe the practice of shared interactions between peers and peer support workers, where people seek to use their lived experience to learn from each other, and where people offer knowledge, experience, emotional, social, or practical support to each other. For the sake of clarity, please note that Intentional Peer Support is a relational framework, developed by Shery Mead and is not a definition for peer support.

Peer Support Services: Many definitions exist of what constitutes a peer support service. For the sake of this report and considering the learning from the Piripono evaluation as theme, peer support services are defined as peer services that are managed and delivered by people who identify as having lived experience of mental distress and/or addiction and are trained to provide such a service.

Respite service: a service provided to people who ordinarily live in their own home in the community and need additional support to prevent distress from escalating to a point where acute options need to be considered or accessed.

Short term acute residential service: a service that provides an acute response to people who are experiencing high or acute levels of distress, mental anguish or emotional pain, or an emergency related to their mental health and wellbeing and who needs an urgent, intensive response with the goal of nurturing reduced levels of distress or emotional pain and reducing the need for hospital admissions.

Peer Support responses to crisis, health care experiences and outcomes

One important addition to trauma informed care has been the addition of peer run acute alternative treatment options. Such services are essentially grounded in the knowledge that crisis can be a transformational experience; those new contexts offer new ways of thinking about one's own experience; and that mutually supportive relationships provide important points for connection, learning and a relationship of trust, that supports creating new meaning or ways of thinking and doing.

We know that hospital-based care and treatment is expensive and that many people and their whanau experience it as unsettling and even traumatising. Preventing hospital admissions however requires the provision of alternative options and choices for people and their whanau. Short-term alternative residential and treatment options in home-like environments are one specific approach that has been used in New Zealand, with the likes of Key We Way (Wellington) Tupu Ake (Counties Manukau) and Piripono (Silverdale). Other approaches that have been found in America are the "living room crisis model" (situated within a Psychiatric Emergency Department), that is provided by both peer staff and consulting clinicians, peer bridger programs, as well as community-based peer support.

Evaluations of New Zealand Based Programs

Evaluations were conducted of each of the three acute alternative treatment service options, using different criteria, evaluation methodology and areas of focus. This report will explore the outcomes of these three reports, and consider the research conducted overseas and consider the overall learning from the reports and research.

1. ***Piri Pono Evaluation (2017)***

Piri Pono is a five-bedroom, short term peer-led acute residential service based in Silverdale. The service is staffed by peer support staff who work 24/7 rostered shifts and has a registered nurse on site for 12 hours per day. Intentional Peer Support (IPS) is the key framework for service delivery within Piri Pono and all staff are IPS trained.

The service offers an alternative treatment option and alternative to inpatient admission. Service criteria include that people who are referred to the service are experiencing an acute period of distress because of a serious mental illness and are vulnerable to the extent that they require 24-hour intensive support and treatment. The service offers a home-like environment, and the objectives of the service in the Waitemata DHB service specifications include:

- To rapidly enable service users/tangata whaiora to reduce stress levels, enhance wellness and strengthen their ability to maintain their safety with the community
- To provide a service and setting that is valued by service users/tangata whaiora who access it, and that is experienced as welcoming, safe, comfortable, and supportive.

The evaluation focused on how guests experienced the service, through both quantitative and qualitative data, collected over the first 18 months of Piri Pono's operation. The evaluation framework allowed data to be collected via four methods

- Guest satisfaction survey upon exiting the service
- Kessler 10/K10 self-rating and self-administered distress scale provided to guests to complete upon entry and exit
- Reflective survey sent out 4-6 weeks after guests left the service
- Staff focus groups for both Piri Pono and WDHB staff

Guest satisfaction of the service were overwhelmingly positive with a significant majority (80%+) indicating either agreement or high agreement with all but two of the statements, and 80% of respondents indicating high agreement with the statement "staff and service is inspiring and encouraging" and a further 17% choosing the option of "agree". The thematic analysis had a notable theme of thanks for staff input, the learning and positive impact of the service.

Kessler 10 (K10) psychological distress scale scores were collected for 62 guests who elected to use the tool. The overall distress level decreased by a mean of ten points. Overall, 84% of guests who completed the K10 had an improved score as well as a change in category (Low, moderate, or high), with 66% of those who were in the highest risk category for psychological distressed had moved out of this category.

The Reflective Survey indicated major themes around

- The importance of lived experience of mental distress amongst all staff
- The importance of connecting with others and being understood
- A theme of self-responsibility was evident, and many noted increased self-awareness.
- Significantly – not being judged.

Nursing staff in the service with lived experience of mental distress was also highlighted as having significant impact. Most respondents considered the collaborative recovery plan useful and spoke of using the plans to measure wellness and progress, identify early warning signs, maintain their wellbeing and to look back on when experiencing difficult times. The focus on self-directed goals is one that helped distinguish the service offered by Piri Pono where collaborative note-writing and recovery planning can encourage growth of awareness, holistic health, and a strengths focus, as laid out in the service objectives.

Staff focus groups brought a focus on building trusting relationships between WDHB and Piri Pono staff with an emphasis on commitment, negotiations, predictability, consistency, trust, collaboration, accessibility, and communications. Respect for the expertise each party brings to the partnership also emerged as a key theme, whilst including the guests as the experts in their own care. A shared understanding of the service model, and shared language used was also a key theme. Resources, and fully resourcing the service (and future similar services) emerged as another key theme, to ensure the service functions at optimal capacity and to include enough activities.

Clear strengths of the service included the staffing, and of note, the choice to employ Registered Nurses who themselves had lived experience of mental distress.

2. *Tupu Ake Evaluation (2017*)

Tupu Ake is a ten-bedroom, acute admission alternative service based in Papatoetoe. It also provides day support for an additional five people.

The purpose of the service is to provide brief support to people (called guests) requiring an acute level of care in a community setting. Guests would otherwise use the Counties Manukau Health inpatient mental health service during the time support is required. The service is set in a home like environment, and the Tupu Ake workforce consists of a team coach, peer support workers and a registered nurse.

The evaluation focused on utilising stories to understand and demonstrate how Tupu Ake functions and to gain the perspectives of key stakeholders of its value.

The analysis of stories demonstrated the value of the core peer values (Peer Competency Framework, 2014) namely

- Mutuality
- Experiential knowledge
- Self determination
- Participation
- Equity
- Recovery and hope

The report highlighted that all the guests' stories described experiences of acute mental distress when they accessed Tupu Ake. For many guests it was their first time receiving acute mental health services. The non-judgemental environment guests described encouraged them to talk openly and honestly about their experiences, often for the first time. The mutual relationship was emphasised as being a significant factor in increasing guest responsiveness to the support being offered. It also increased their ability to recover from the distress they were experiencing within a short period of time – this information was shared as narratives from guests rather than the utilisation of an outcome measurement scale. The narrative is however supportive of results seen from the Piri Pono evaluation.

Having clear goals with an identified time frame enables guests to focus on recovery without worrying about the negative impact lengthy admission may have on the rest of their lives, including employment, housing status, and caring for their loved ones. This too was echoed in the Piri Pono evaluation where goal planning was seen as valuable.

Guests shared experiences of feeling better able to cope when they returned home, because of the support and interventions Tupu Ake provided. The narratives presented demonstrated that the meaningful ways of sharing lived experience, the use of wellness plans and tools, and activities enables guests to recovery from their mental distress in a short period of time. Service user data from the evaluation shows the median length of stay is seven days, with the majority (93%) of people accessing the service only once during a 28-day period.

Overall, the evaluation demonstrated the positive effects of Tupu Ake as an acute admission alternative in the community.

3. Key We Way Evaluation (2009)

Key We Way is a four-bedroom peer delivered, short-term acute admission alternative service based in Paraparauma on the Kapiti Coast and was the first of its kind in New Zealand.

The purpose of the service is to provide residentially based support for people who experience acute mental distress, in the Capital and Coast DHB region. The service is set in a home like environment and staffed exclusively by peer support staff. There are no clinical staff on site and clinical support is accessed from DHB staff on a visitation and on-call basis.

The review focused on identifying the achievements, lessons and challenges faced by the service, and capturing the early history of a service, unique to New Zealand. It was further also seen as an important document to give funders and planners as a means of reflection and future planning.

The review further focused on best practice and quality indicators. This was done through a comprehensive literature review, staff interviews, demographic data and statistics collected by the service, and feedback from guests, whānau, and clinical stakeholders.

Some key themes came from the feedback gathered from stakeholders, and included the following positive factors:

- That it was run by "peers" and the lack of a power dynamic found in inpatient units, including an opportunity to talk without being judged, was a key part of people's recovery.
- The staff attitudes and ways of doing things, being caring, compassionate, and always available, particularly during difficult times.
- Prevention of acute distress, with people mentioning their stay at the service helped them to recover from their thoughts of suicide or self-harm.
- Personal planning processes and learning self-care skills alongside peer support workers, to identify things that helped build wellbeing and to look at wellbeing from a holistic perspective.
- Being nurtured, not only with high quality food, but also by being listened to and staff spending time with guests.

Many people had been in acute inpatient units, and without exception these were perceived as stressful in a time of mental crisis.

Suggested areas for improvement and future consideration included:

- The importance of strong support from management with the implementation of a peer support model of leadership.
- Exploring ways to provide supervision for staff
- Consideration for the location – both positives and negatives, e.g., being close to the beach, which some find healing, and being too far away from clinical services which made oversight more difficult.

"*The peer support model has earned the acclaim of guests, and despite the acknowledged areas for improvements, it is obvious that the model could be even stronger still once improvements have been made."*

Intentional Peer Support (IPS) is a key part of the Key We Way approach. IPS best practice is seen as trauma-informed, and works to maximise individual power, healing, hope, reinforce responsibility, create a supportive peer environment, and practice reciprocity between peer support workers and guests. (Shery Mead, 2006)

Other Research

Research reiterates what we have come to understanding, namely that being admitted into inpatient based hospital care is expensive and disruptive to both the person and their family. Having repeated admissions is common and preventing psychiatric admissions requires the provision of short-term alternatives for people who are not of significant risk of harm to self or others (Gaynes et al. 2015).

A report by the Kinnect Group, Peer Support Outcomes and Value for Money (Julian King 2011) noted significant evidence in their report that peer support can deliver outcomes at least as positive as those of other acute options, can reduce hospitalisation, crisis, and other service utilisation, and can be delivered at lower cost than acute inpatient options.

Peer delivered acute alternative service options are identified as treatments options in home-like environments, that will support people through crisis (Ostrow and Fisher 2011), in line with the approach taken in all three services in New Zealand.

Common principles include

- Safe environments
- Acceptance and non-judgement established through connection.
- Hope is held by others
- Everyday language is used to describe experiences
- Self-care and personal responsibility are a central focus
- Gaining a sense of mastery and power over one's life is encouraged

Of note is that the three service evaluations made mention of all, or most of these principles as those things that made a difference or added value.

The goal of peer run acute alternative treatment options are to encourage less dependence on the formal mental health system, and associated trauma that commonly occur in Emergency departments, and inpatient units.

One randomised control study of crisis respite care found that the average rate of reduction in presenting distress was greater in the crisis respite service than in the hospital comparison. People who accessed the crisis respite service expressed a higher level of satisfaction than those in the hospital comparison. The average savings for crisis respite care was more than US$450 per day. (Greenfield et al 2008). Whilst we do not have specific comparative data, it was noted in the evaluations for both Piri Pono and Tupu Ake that the median length of stay was 7 days or less.

The Living Room Crisis model in Pierce County, Washington contributed to a 32.3% reduction in hospital admissions and reduced readmissions by 26.5% over a period of three years. It has also reduced the average number of inpatient days from 19.6 in 2009 to 13.7 in 2013. (Optum, 2014a). This type of comparative data is not easily available in New Zealand yet and will require further research.

A study of the 2nd Story Peer Respite Program on the use of inpatient and emergency services, (Croft & Niluf, 2015) examined the relationship between access of peer crisis respite services and the use of inpatient or emergency services, amongst adults. The study found the odds of using any emergency services were approximately 70% lower amongst people who accessed the crisis respite service, compared to non-respite users, and concluded that peer respite services may increase meaningful choices for recovery and decrease the health system's reliance on less person-centred models of service delivery.

The New Zealand services is not specifically focus on decreasing dependence on IPU admissions as an outcome, however it could potentially be inferred that an increased level of self-responsibility (referred to in the Piri Pono evaluation) and the value of recovery and resilience planning (mentioned in all three evaluations) could ultimately result in this as an outcome.

Other models and approaches that have been tried to reduce preventable hospital admissions have included transitional services, designed to provide support to individuals who are involved in changes to their treatment, service provision, or life circumstances. A number of these programs have been developed in the USA and are called Peer Bridger programs. They were originally piloted to be used to support people with long term or repeated hospital admissions to make successful transitions back into their communities. A peer navigation model of intervention called The Bridge was tested against a treatment as usual group in a randomized trial (Kelly et al, 2013). The Bridge model of intervention is described as a comprehensive engagement and self-management model whereby participants are taught to access and manage their health care effectively. It is a manualized approach with four components:

- assessment and planning,
- coordinated linkages,
- consumer education, and
- cognitive-behavioral strategies to support health care utilization, behaviour change and maintenance.

Findings of the study supported changes in seeking care from a primary care provider rather than the ED and reduced physical health symptoms.

Another program was delivered in Wisconson by the Grassroots Empowerment Project, a peer-run organisation, and findings from this program included a 30% reduction in inpatient days utilised, and health costs savings of 24%. In New York the same program also resulted in a reduction of inpatient days by 63%. (Optum 2014a). These could be home based, program based or attached as a "day service" to an existing acute alternative service, as is the case at Tupu Ake.

Community based peer support services targeting a range of goals and promoting resilience and community tenure is also seen in the research as options for the reduction in acute admissions. Outcomes of some of these services have been reported to have helped people who accessed their services to successfully stay out of hospital.

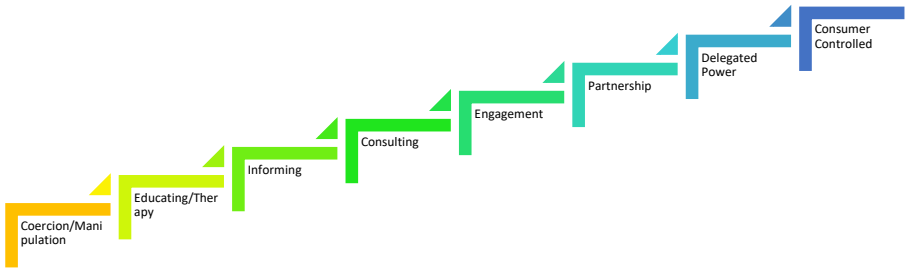
Strong evidence comes from the literature that peer support service delivery consistently shows positive results. This was evidenced by Segal et al (2002) which found positive results for peer-led services, including increased independent social functioning, and individuals taking their back their own power. Other studies also found positive results, including citizenship, social-inclusion and support, housing, employment, hope for the future, overall wellbeing, and improved quality of life. (Nelson et al 2007 and Cambell 2004), This emerging evidence base, both internationally and nationally, supports that peer support service delivery can be effective in promoting improved wellbeing outcomes for those accessing such services, and reduces preventable hospital admission and re-admissions, as well as ED utilisation.

In New Zealand, practice amongst some clinical services has at times not allowed strong enough differentiation between respite and acute alternative options. The Piri Pono evaluation notes this too in that not all clinical services understood the service delivery model. In some instances, pressures within clinical services result that we find ourselves in a place where "a bed is a bed" and clinical

services hoping to use the acute alternative as stepdown, respite and for DHB overflow. By clearly differentiating between respite (a short break to focus on one's wellbeing before it reaches crisis or at a time of transition) and acute alternative treatment option (an option that is utilised at a time of crisis, and possibly to prevent hospitalisation, or instead of hospitalisation) treatment and support could potentially look considerably different. This might allow respite services to be utilised in ways that will prevent access to both acute alternatives and hospitalisation, when distress is minimised prior to it escalating to such a level that an admission needs to be considered. Respite services is usually considered as a short term, overnight sta. Currently day stays or visits are limited, and only occurs at Tupu Ake. Such respite services could also be peer run, and we currently have no peer run respite services within the Auckland and Waitemata DHB regions. A shared language around these concepts would be important.

Structural Support and Potential Enablers and Barriers

Before considering structural support, it will be important to consider the degrees of delegated power given to peer support services. The Arnstein ladder of participation gives us a format by which to explain the differences in degree of consumer control and empowerment in the management of services (using the top four steps of the ladder only in this instance).



These are:

1. Consumer Controlled: where a service or project is initiated and run by people with lived experience e.g., a consumer governed, managed, and operated services.
2. Delegated Power: where space is created within a non-consumer-controlled environment and offered to consumers to control e.g., peer support group in an acute inpatient ward
3. Partnership: where consumers and non-consumers collaboratively create, design and implement a service or project e.g., where consumers and non-consumer staff work together on a project with equitable power distribution
4. Engagement: where consumers are employed in consumer roles, but hold no power over any management processes, e.g., peer support workers employed in services but managed by clinical staff

Within New Zealand, none of our acute alternative services fit under the Consumer Controlled banner, and the majority would fit within a partnership or engagement model, where some services are managed by consumers and others are managed by clinical staff whilst employing consumers as peer support workers.

Research in the USA that specifically asked questions about effectiveness of such models and their implementation, whilst looking at the enablers and barriers associated with effectiveness. The Evidence Check Review by Grey & O'Hagan (2015) found the enablers and/or barriers could be divided into three categories

1. **Organisational commitment to consumer work**
   It is important that the work of peer support workers is seen as something that is of value, rather than being assigned tasks that e.g., other staff are too busy to perform, e.g., clinical staff directing a peer worker to transport a peer to appointments. A shared understanding of the overarching values and principles of peer support would be key and should be reflected in policies and standard operating protocol that are applicable to peer service delivery. Furthermore, it would be essential to ensure that the leadership and management of peer support services and peer support staff facilitate and empower the delivery of peer support that is in line with strong efficacy to this model. Faulkner and Kalathil (2012) describe a lack of value or recognition for peer workers as "the corridors of power were just impenetrable" and in addition raised the concern of a tendency for peer workers to be seen as "cheap labour" to do the things clinical staff did not have the time for, at the risk of the role becoming diluted or lost. They further state that without the user-led base or ethos, that sustains model efficacy, peer support is at risk of just being fitted into the all-pervading medical models of working rather than be considered a way of exploring other models of working within mental health

2. **Attitudes and practices of non-consumer colleagues**
   Non-peer colleagues' attitudes, behaviours and practices can be both enablers and barriers to peer support practice within an organisation. Where peer support values are not understood or seen as less than clinical values, peer practices are placed at risk.
   In some instances, peer workers have felt that they must prove themselves to their colleagues (Bierdzrycki 2008). Nestor et al (2008) point to non-consumer staff fears of being replaced by peer staff, especially when seen as a cheaper alternative and this is understandable since some peer support roles share considerable similarities with other non-peer roles, such as community support work. This could potentially raise tensions between peer and other staff, and importantly create tension for peer support practice, when expectations are set for the roles, which do not align with the peer support philosophy and principles.
   Where working in mainstream organisations, consumer roles are most effective when actively supported by non-consumer colleagues in terms of having "allies" who actively support and champion the peer workforce. Mancinini and Lawson (2009) describe consumer workers as performing significant emotional labour in negotiating their working relationships, as requiring relevant support to avoid emotional exhaustion and burnout. Consumers working in consumer-operated services are often shielded from having to negotiate these attitudinal barriers on a daily bias, but these issues remain relevant at the interface between the peer workforce and other services too. Faulkner and Kalathil (2012) found what people described as professional resistance and a lack of power. Specific training for management and colleagues is seen as necessary and needed to prepare organisations to engage with the peer workforce and to prevent potential discriminatory practices, including measures to ensure the person is "well enough" to work, such as a mandatory WRAP for peer support staff only.

3. **Supports and conditions for lived experience and peer workers**
   In much of the literature across America and Australia there is concern about sub-optimal working conditions for the lived experience and peer workforce, and this was described by Byrne (2014) in a PhD study as a "risk to self" – in that peer workers are put under stress by inadequate working conditions.

It is important to state that employment conditions need to be understood in line with relevant legislation that has an impact on the workplace. Literature speaks to the need to be equitable and ensure role clarity, training and development opportunities, supervision, and reasonable accommodation within the workplace.

Supervision has been identified in numerous instances and has been seen as the most critical issue in successful peer support, by Orwin (2008). Ockwell et al (2011), in the evaluation of CAPITAL's inpatient peer support service, emphasised the importance of building strong support and supervision for peer support workers. The Key We Way evaluation (2009) too recommended exploring ways to support staff with access to supervision.

Clarity of role and a clear job description too, are seen as important to the successful implementation of peer support roles (Carlson et al 2001, Davidson et al 2012, Bennetts et all 2013, Walker 2013) and supporting colleagues to have a clear understanding of the roles too. A risk of having peer workers alongside clinical staff without having role clarity, or a peer community to support them and maintain a strong community of practice, is that the peer worker can become isolated, disempowered and that their role will ultimately not be supported to maintain its efficacy.

There is currently a skills shortage as far as leadership and management of peer support services, with services often struggling to find appropriate people, with their own lived experience, who could manage and lead such services. Peer leadership development has seen limited input, and as with most "minority group empowerment strategies", such development usually needs to be targeted and specific to reach the audience it is supposed to reach. Consumer scholarships to further their education, leadership coaching and mentoring, and other equity and empowerment approaches has real value in ensuring we build capacity, capability and competence within the peer workforce and its future.

The development of external peer supervisors is a further area that has had limited input and support, and suitably qualified and experienced peer supervisors are limited in numbers. Peer support staff are often not afforded professional supervision, outside of a line management function due to the cost implications. This has a potential impact on service provision, considering the emotional impact that "the use of self" could have on people – most other helping professions access professional supervision and it is seen as imperative to their practice.

Training, and opportunities for growth and development is another point that requires specific attention. Walker (2013) and Alberta et al (2012) observed that the wrong kinds of training can potentially lead to the "professionalization" of the peer workforce - namely, to adopt the values, practices, and principles of other helping professions. Training needs to be faithful to the philosophical underpinning of the consumer workforce, rather than generic training such as strengths-based approaches, suicide prevention, and de-escalation training. (Davidson et al 2012) and needs to be presented by other consumers rather than educators with no experience in peer work (Orwin 2008; Faulkner & Kalathil 2012). Training needs to be on-going and be building capacity (Bierdrycki 2008).

In the Waitemata and Auckland regions, there are limited opportunities for people to access training that will adequately prepare them for the role of peer support worker. Pay equity implementation has created an issue for the current peer workforce, having to complete the Level 4 Health and Wellbeing Certificate to not be financially disadvantaged. This training is not peer specific, and therefore also not necessarily in line with the peer principles, ethos, and values. Specific training in peer support is largely dependent on organisations, and the capacity they hold internally to train their staff. Opportunities for advanced peer-specific training are limited. Releasing staff to attend training can also be a barrier, particularly in smaller organisations, or in residential services where staff are working rostered shifts.

Implications

Peer delivered services, and in this instance acute alternative treatment options, are highly valued by those who access such services, and according to the evaluations done and other research, has at least similar outcomes to mainstream or clinical services.

According to the evaluation reports, people valued the fact that staff had their own lived experience and came from a place of non-judgement. This was particularly noted in the Piri Pono evaluation, where the value of nurses with their own lived experience was highlighted. Whilst this signals the high value placed on nurse practitioners who overtly share their personal lived experience, it should also be noted that nurse practitioners need to maintain a scope of clinical practice, that is currently still strongly informed by a medical model. This will probably need some additional work to support nurse practitioners to move beyond the stigma associated with sharing their own lived experience, as well as other practice implications i.t.o. ethics and boundaries.

The evaluations and literature have some clear indicators of the value of peer delivered services in the health and wellbeing of people who access such services, whether resulting in reduced distress, or increased levels of self-responsibility, and empowerment. This shows the potential of this model for future consideration in reducing preventable hospital admissions.

The implementation of peer support services needs some specific consideration and support and whilst consumer-controlled services offers the highest level of consumer empowerment, the reality is that this is not something that is current in the WDHB and ADHB regions, nor in the wider New Zealand. It does still allow organisations to consider their internal reporting structures to allow for and ensure the highest possible level of participation and empowerment. And, from the literature search, and evaluations, it is clear that no one consistent model, or staffing model exists that is predominant, and peer-only as well as hybrid or integrated models are common.

Not all organisations have the current capacity and/or capability to offer the workplace conditions for people that will be conducive to good peer support practices – those that are productive and adhere to best practice. This would be including organisational structures, HR practices, learning and development opportunities etc. Issues to do with workplace conditions for the peer workforce should be considered a high priority, as well as active support and championing from funding & planning, senior and executive management and of any other auspicing bodies. Consumer run and managed services (and other organisations) who have overcome any, some or all the barriers or concerns identified in the research and noted in this report, should be encouraged, and resourced to share their knowledge and experiences through active collaboration.

Organisational commitment would be key, supported by attitude, and other supports being in place to allow peer service delivery that is in line with the values, ethos and principles that guide peer support practice and that will allow the peer workforce to operate from its own wheelhouse. Peer

leadership has seen limited developmental input over the past 10 years, and as with any “minority group” empowerment, a targeted approach is often necessary.

There are some clear areas that could be considered for future development of the peer workforce within the ADHB and WDHB regions as well as nationally.

Recommendations

1. That there is support for development of initiatives that will support the development of peer service delivery and will contribute towards the on-going development of peer leadership, skills training, qualification, moderation, research, and promotion of peer led services within the ADHB and WDHB regions.

2. That the peer workforce development is targeted as a specific strategy, with support for the growth and development of the workforce and its competency base.

3. That expertise in peer support service delivery is shared to strengthen the sector with fewer silos

4. That funding is prioritised for a range of peer services, both stand-alone peer-led, and collaboratively led peer and NGO/DHB services within a range of community based, transitional, respite and acute alternative focus areas, as a preventative approach to hospitalisation for tangata whaiora and whānau.

5. That most of these services are peer led, and appropriately resourced to ensure there is training across providers, based on peer support values, early intervention, holistic wellbeing principals and trauma informed care models.

6. That a shared data platform is utilised for any new services to ensure information sharing and transparency between both NGO and Clinical Services.

7. That a shared language and understanding is created to ensure service models are understood and utilised appropriately

8. Funding models and size/scope of services are considered to ensure adequate resourcing of peer delivered acute alternatives

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