

Peer Support Workforce Insights Paper

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A paper issued by Te Hiringa Mahara - Mental Health and Wellbeing Commission (Te Hiringa Mahara).

Authored by Te Hiringa Mahara.

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Te Hiringa Mahara - the Mental Health and Wellbeing Commission - was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mhwc.govt.nz

The mission statement in our Strategy is “Whakawāteatia e tātou he ara oranga / clearing pathways to wellbeing for all.” Te Hiringa Mahara acknowledges the inequities present in how different communities in Aotearoa experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance or gambling harm, are prioritised.

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Foreword

Globally and in Aotearoa, the mental health and addiction sector is facing unprecedented workforce challenges. There is a commitment to transformation with people with lived experience leading the way.

This paper shines a light on the peer support workforce. Peer support workers connect with people in a unique way that is founded on the rich experiences that they bring to the relationship. Through connection, a mutual relationship, and its focus on strengths, this approach is empowering and inspires hope. This workforce has a critical role in supporting recovery and transforming the landscape of service delivery.

Longstanding research demonstrates the benefits of the peer support workforce, supporting the intention to expand this workforce. Yet neither this intention nor the potential of the peer support workforce has been realised.

The growth of the lived experience workforce is a critical enabler in transforming the mental health and addiction system, by embedding respect, rights, and hope at its core. It brings to life the concept of ‘nothing about us without us’. This is the paradigm shift that people have called for, in which peer support work and clinical approaches are equally valued and work alongside each other.

We can take steps towards that paradigm shift now. The peer workforce, including kaimahi tāngata whaiora Māori, must be an essential part of the roadmap to address the mental health and addiction workforce challenges. Improved training, better information and evaluation, and strategies to attract people to the workforce are all steps required for this purpose.

This paper highlights the importance of the peer support workforce and many challenges that it currently faces. **As we** keep building our collective knowledge, we will continue to advocate for substantial growth of the peer support workforce. We are calling on agencies to listen to the voices and evidence in this paper, and to act with urgency to make such growth happen.

The peer support workforce must be a fundamental feature of the mental health and addiction system in Aotearoa if we are to achieve transformation and better outcomes for tāngata whaiora, whānau, and family.



Hayden Wano
Board Chair, Te Hiringa Mahara

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We are indebted to the people with lived experience of distress as well as whānau and family who shared their views with us. We honour your feedback and will use your stories to advocate for a better mental health and addiction system.

We thank Te Pou for providing additional detail on its published data on the full-time equivalent (FTE) positions in the workforce and for sharing its lived experience workforce survey findings, not yet published, so that we can include them in this paper.

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Overall summary

This paper draws from multiple data sources to shine a light on the peer support and lived experience workforce

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction highlighted the vision tāngata whaiora had for a mental health and addiction system that provides peer support in a range of settings (Government Inquiry into Mental Health and Addiction, 2018). Following the inquiry, a number of policy and strategy shifts have occurred that support this vision, including the Oranga Hinengaro System and Service Framework (Ministry of Health, 2023c). This paper brings together evidence on the value of the peer workforce, information about the workforce, and the voices of people with lived experience. It establishes a baseline from which we can grow our collective understanding and advocate for growth of this important workforce.

Evidence shows that the peer support workforce benefits people using services

Available research findings from Aotearoa New Zealand as well as internationally show that the use of peer support within mental health services contributes to greater hope, satisfaction, and quality of life for tāngata whaiora. It also contributes to modest improvements in psycho-social outcomes and probably a small reduction in admission or readmission to crisis services, including hospital services. We need more research on the effectiveness of peer support in Aotearoa, including studies that focus on measuring outcomes that are important from a lived experience perspective, effectiveness of peer support in alcohol and other drug services, and the delivery and effectiveness of Māori models of peer support based on a Te Ao Māori worldview.

Peer support FTE positions are increasing in number but remain a small proportion of the workforce

The number of peer support¹ full-time equivalent (FTE) positions increased by 18 per cent across four years, from 361 FTE in 2018 to 425 FTE in 2022. At the same time, the total mental health and alcohol and drug workforce has grown, with the result that peer support within adult mental health and addiction non-government organisations (NGOs) remains at 3.4 per cent of the total adult mental health and addiction

¹ These data include both peer support (consumer and service user) workers and peer support (family and whānau) workers.

workforce (including Te Whatu Ora). In addition, the proportion of peer support contacts being delivered in specialist mental health and alcohol and drug services has remained constant.²

Lived experience leadership roles are critical enablers for growing and developing the peer support workforce

Growing the capacity of the peer support workforce is an important goal that also requires a shift towards a recovery-focused paradigm. Achieving this shift needs leadership from people with lived experience across all levels of the system to clearly present the ‘value proposition’ for peer support and shift the attitudes of other staff working in the health sector. The health reforms, including the establishment of Te Whatu Ora—Health New Zealand and Te Aka Whai Ora—Māori Health Authority, provide an opportunity to embed lived experience positions in places where they can lead and influence policy, planning, monitoring, and commissioning discussions.

Development of peer support needs to include models based on a Te Ao Māori worldview

We have a significant opportunity to improve the mental health and alcohol and drug workforce by developing and delivering models embedded in mātauranga Māori. Māori told us that they want to establish ‘by Māori, for Māori’ models of peer support and develop their own roles, language, training, and resources to deliver what whānau need.

Developing and embedding Māori models of peer support means Māori are involved at all levels of the system. It requires development of a workforce of kaimahi tāngata whaiora Māori to reflect the service user population and different cultural worldviews that tāngata whaiora hold. Current guidance from Te Rau Ora (2019a, 2019b) on developing the Māori workforce includes acknowledging the Māori workforce will require ongoing professional and cultural development that enhances mātauranga Māori and cultural capabilities, as well as supporting opportunities for leadership development.

The peer support workforce presents an opportunity to transform the system and address workforce challenges

A workforce strategy and roadmap are required to determine what our health workforce of the future looks like and how we will get there from our current position. Expanding the peer support and lived experience workforce should be an objective in the workforce planning roadmap, which itself should be developed in partnership

² Based on analysis of T45 code (peer support) within PRIMHD over the last five years.

with lived experience leaders, who include Māori with lived experience, so it reflects what is most important to people. The roadmap should also cover:

- development of the workforce of kaimahi tāngata whaiora Māori
- training and education for the health workforce
- strategies to attract the peer support workforce.

Introduction

Te Hīringa Mahara has a legislated role to independently monitor mental health and addiction services, assess approaches to mental health and wellbeing, and make recommendations to improve these approaches and services in Aotearoa. We also have a role to advocate for the collective interests of people who experience distress, people who experience addiction, and those who support them, including whānau and family. In our [Nau Mai te Ao: Lived Experience Position Statement](#), we commit to monitoring lived experience participation and leadership across the mental health and addiction system, and advocating alongside tāngata whaiora and lived experience communities (Te Hīringa Mahara, 2022a).

Lived experience communities have long called for a growth in peer support, peer advocates, and other lived experience workforce. The peer support and lived experience workforce has a long and rich history over more than 30 years. This workforce provides the opportunity to drive transformation in the mental health and addiction system. Strong evidence confirms the benefits of peer support, yet little appears to have been done in practice to make the most of those benefits: the workforce remains small, often undervalued, and not well understood.

The purpose and scope of this paper

The purpose of this paper is to provide insights for service providers, policy makers, and commissioners who are responsible for the ongoing development of the mental health and addiction sector. The paper synthesises the policy, research evidence, and lived experience voices about the lived experience workforce and shines a light on its current state. It is our start to informing collective understanding of the peer workforce and advocating for growth.

The paper focuses on the peer support workforce, including kaimahi tāngata whaiora Māori, that walk alongside tāngata whaiora, whānau, and family on their pathways to wellbeing and recovery in mental health and/or alcohol and drug services. The peer workforce is diverse with a long history across alcohol and drug, public health, and mental health services. It is not within the scope of this paper to provide a full history nor a comprehensive list of peer services and workforce. Other organisations have explored and reported on many aspects of the peer workforce, so we refer to their material where relevant rather than duplicating those insights. We give a broad overview of the recent research on the benefits of the peer workforce, without repeating the more detailed analysis already available through numerous comprehensive reviews of the literature on peer workforce (Repper and Carter, 2011; Gaiser et al, 2021; de Beer et al, 2022; Fortuna et al, 2022; Richard et al, 2022).

This paper draws together existing literature, quantitative data, and qualitative focus group insights

For this paper, we have woven together evidence from multiple sources. We have collected primary qualitative data from focus groups of people with lived experience of mental distress and/or addiction, including tāngata whaiora Māori, and whānau and family. Many of the people we engaged with work in lived experience roles. We also draw from previous engagement with tāngata whaiora in hui about the lived experience workforce. Quantitative data come from our descriptive analysis of peer support contacts recorded within the Programme for Integration of Mental Health Data (PRIMHD) data set and from workforce data from a survey of people working in lived experience roles (Te Pou, 2023a). A literature review of grey literature and journal articles both from Aotearoa and internationally also supports the evidence base within this paper. For more detail on each of these methods, see [Appendix 3: Methodology](#).

Background to the lived experience workforce

The lived experience workforce has had a long and important role in mental health and alcohol and drug services

People in peer support roles use what they have learned from their lived experience of distress and/or substance abuse challenges to directly support tāngata whaiora within a peer relationship. There are others in lived experience roles who use their experience to support changes in service delivery and system policy (Te Pou, 2023b). Across the health sector more generally, there are consumer roles in which people use their experience of the health system to engage in system development and improvement.

The lived experience workforce in mental health has its roots in a long history of social movements and mutual support practice by people with lived experience. People who had been in psychiatric hospitals developed peer support to support each other as part of an ‘on our own’ philosophy of patient-led alternatives to mental health services (Chamberlin, 1978). Lived experience roles within alcohol and drug services grew from a practice of mutual support and a history of peer support volunteers. Further, public health concerns surrounding HIV/AIDS prompted the establishment of a needle exchange programme across Aotearoa that continues to be staffed mostly by peers.

Peer advocacy developed in a context of human rights and patient rights advocacy among the consumer/survivor movements in Aotearoa and overseas. As part of their wider systemic advocacy, these consumer/survivor movements called for ‘nothing about us without us’ and in this way contributed to the development of formal advisory roles within mental health services over time.

As well as being defined by the use of their experience, the lived experience workforce has key values that underpin it. While some differences exist between cultures and organisations,³ some common themes across them are: power relationships that are reciprocal and enable self-determination; identification with each other, which involves empathy and acceptance; and an understanding of mental health issues with a holistic and recovery focus (O’Hagan et al, 2009).

³ Te Pou describes peer workforce values in its publications including within its guide to the consumer, peer support, and lived experience workforce (Te Pou, 2023b).

Understanding the language we use

This paper uses ‘lived experience workforce’ as an umbrella term that includes many different roles that are employed for their lived experience. It uses ‘peer support workforce’ or ‘peer workforce’ more specifically to refer to those employed in roles where they use their own experience and competencies to work directly with tāngata whaiora in a relational space—supporting peers to find their own way to recovery. See [Appendix 1](#) for more information on key terms we have used in this paper.

We note, however, that groups, organisations, and people differ in the terms they use and what they mean by those terms. The language in this area also continues to evolve to become more inclusive of diverse worldviews. These differences enable Māori, Pacific peoples, and all cultures to define the peer support and lived experience leadership workforce in ways that are meaningful to them. While use of terms may not be completely consistent, there should be some common understanding of language to support shared conversations. For example, Te Pou refers to the consumer, peer support, and lived experience (CPSLE) workforce and the mātau ā-wheako⁴ CPSLE workforce.

Lived experience roles work across different levels of consumer engagement

The Health Quality & Safety Commission (2015) promotes consumer engagement in health care and refers to the framework developed by Carman et al (2013), which has three levels of engagement. This framework is applicable to the wider consumer movement across health services and has similarities with the lived experience movement in the mental health and addiction sector at each of the three levels:

- **direct care**, where tāngata whaiora can lead and self-determine pathways to recovery
- **organisational design and governance**, which can include roles such as lived experience/consumer advisors and peer service managers
- **policy-making**, which can include roles such as lived experience directors and lived experience/consumer advisors within groups or committees making policy decisions.

The mental health and alcohol and drug sector has an additional level of engagement in the form of peer roles in service delivery. These may be:

- **peer roles supporting service delivery**, such as peer team leaders, peer supervisors, and peer educators

⁴ Te Pou (2023b) defines this as the workforce that includes all consumer, peer support, and lived experience roles within the context of Aotearoa.

- **peer roles working directly with tāngata whaiora**, such as peer support workers, peer advocates, and peer navigators.

Within health services, the peer support workforce is unique to the mental health and addiction sector. However, the lived experience roles at other levels are a significant enabler to the development and effectiveness of that workforce. It is these lived experience roles that promote a recovery paradigm in policy and service development that will enable peer support workers to stay true to peer values in their work.

Peer support involves a mutual relationship that supports recovery

Peer support is provided by someone with their own lived experience of mental distress and/or addiction. They deliver that support based on key principles of respect, shared responsibility, a mutual relationship, and choice (Southern District, 2022; Te Pou, 2023b). It is an equal relationship in which two (or more) people give and receive support. This may include sharing experiences, information, social, and/or emotional support. The Peer Support in Practice Aotearoa NZ (Scott et al, 2011) describe the critical components of peer support as:

1. relationships and whakawhanaungatanga
2. recovery-focused with self-determination and empowerment as central
3. a learning experience.

In contrast, in clinical relationships the clinician is the ‘expert’ with boundaries around the personal experiences they disclose.

It is also important to note that not all support is peer support even when it is provided by someone who has their own lived experience. Activities that are not aligned with the principles of peer support or are outside its scope include: enforcing a treatment, activity, or behaviour; motivation through fear; requiring clinical language; giving direct medical advice; and diagnosing, clinically assessing, or prescribing treatment to people (Te Pou, 2023b).

Peer support training

While there is no formal registration or qualification required to work as a peer support worker (because their lived experience is their expertise), employing organisations often require or facilitate training and development. Peer support training is valuable in helping people to gain key competencies and to be able to use their lived experience effectively when supporting peers.

Employers often look for Level 4 qualifications related to health and wellbeing, such as the Certificate in Health and Wellbeing (Peer Support), when recruiting in peer support roles. Some training programmes are specifically designed for peer support (e.g. Intentional Peer Support) and a number of large NGOs are developing or delivering their own peer support training. There is potential to build on existing work

under way to continuously improve training opportunities, including development of training that achieves New Zealand Qualifications Authority (NZQA) higher qualifications, and mātauranga Māori development opportunities.

Lived experience workforce in Aotearoa

He Ara Oranga highlighted the important role of the lived experience workforce in transforming the system

For many years, tāngata whaiora have expressed a desire to access peer support and peer advocacy, including in their submissions to the pivotal 2018 Government Inquiry into Mental Health and Addiction. The inquiry reports [He Ara Oranga](#) and [Oranga Tāngata, Oranga Whānau](#) described the changes needed to transform the mental health and addiction system, including diversifying the workforce to include more peer workers in a mix of peer, cultural support, and clinical workforces (Government Inquiry into Mental Health and Addiction, 2018; Inquiry into Mental Health and Addiction, 2019). He Ara Oranga highlighted the importance of strengths-based peer support for people experiencing addiction and pointed to the success of Pacific approaches to peer support (Government Inquiry into Mental Health and Addiction, 2018). Oranga Tāngata, Oranga Whānau described peer relationships as key in services for Māori and called for an increase in the size of the peer workforce as well as a greater use of tuakana-teina models for support (Inquiry into Mental Health and Addiction, 2019).

He Ara Oranga envisioned a mental health and addiction system that provides peer support in a range of settings, along with stronger inclusion and leadership by people with lived experience at all levels of the system (placing people at the centre). Having lived experience roles at both service and system levels has been central in achieving tāngata whaiora participation in governance, service design, delivery, evaluation, and improvement, as well as their involvement in broader system leadership and oversight. He Ara Oranga called for the health system to report on and expand this participation and leadership.

Peer leadership needs to increase across the board, in governance and management of both peer-led and mainstream organisations. A substantial increase in the peer workforce is needed across all services, including within specific peer-support services, and providing peer support as a part of all other services including alcohol and other drug services, crisis services, multidisciplinary mental health teams, and support services ... (Government Inquiry into Mental Health and Addiction, 2018, p. 123)

The call for expansion of lived experience and peer support roles was not new. In 2004, the Mental Health Commission (2004) shared a [vision](#) to guide the Ministry of

Health’s mental health and addiction plan. It called for a fundamental shift in the way services respond to mental distress—towards a strengths-based approach that recognises human rights and focuses on recovery. Progress towards this vision had been slow and He Ara Oranga highlighted the shift still required for this to happen (Government Inquiry into Mental Health and Addiction, 2018). Now, the call for expansion of lived experience and peer support roles is part of [Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing](#) (Ministry of Health, 2021a). Within that document, Manatū Hauora—the Ministry of Health refers to the peer workforce as a core component for transformation.

We will support a diverse range of workforces, with a focus on the peer workforce as a core component of our transformed approach ...
(Ministry of Health, 2021a, p. 52)

Te Tiriti o Waitangi recognises and guarantees tino rangatiratanga to Māori in Aotearoa

Te Tiriti o Waitangi recognises and guarantees the right of Māori to govern and lead their own affairs. This founding document provides obligations to have an authentic partnership between Māori and the Crown. This includes enabling Māori leadership through all levels of the health system and the mental health and addiction sector. The development of the lived experience workforce also needs to involve Māori leadership and worldviews.

Te Hiringa Mahara acknowledges the past failures to uphold Te Tiriti o Waitangi have had a harmful impact on the wellbeing of Māori (Te Hiringa Mahara, 2022b). Among the inequities Māori now experience are higher rates of mental health distress, substance abuse, and suicide (Russell, 2018; NZ Drug Foundation, 2022; Te Whatu Ora, 2022). All mental health and addiction services need to act in reducing this inequity. Manatū Hauora has outlined the plan to achieve this in [Whakamaua: Māori Health Action Plan 2020–2025](#) (Ministry of Health, 2020b).⁵ Steps required include: ensuring access to services that are culturally competent; acknowledging different understandings of wellbeing, such as the contributions of wairuatanga and spirituality; and providing access to traditional healing practice grounded in Te Ao Māori.

Organisations that employ the lived experience workforce still vary in the extent to which they uphold Te Tiriti o Waitangi principles. Te Pou (2023a) surveyed people working in lived experience roles, asking, ‘How does your employer support you to implement Te Tiriti o Waitangi principles in your practice?’ Responses highlighted differences between different types of organisations: in their responses, participants

⁵ [Whakamaua: Māori Health Action Plan 2020–2025](#) is the guiding document for the implementation of [He Korowai Oranga](#), the Māori Health Strategy (Ministry of Health, 2020a, 2020b).

employed by kaupapa Māori organisations were more likely to indicate a high level of commitment to implementing the principles compared with those employed by other types of organisations.

Recent policy and strategy support lived experience transformation across the mental health and addiction system

Recent policy changes expanded on the vision for lived experience transformation across the mental health and addiction system. This is a positive shift and implementing the policy will require greater capacity for involvement of lived experience roles.

In particular, significant shifts that require greater involvement of consumer roles in the health system or of lived experience roles in the mental health and addiction system include:

- [Ngā Paerewa](#), the Health and Disability Services Standard (Standards New Zealand, 2021)
- [Code of expectations for health entities' engagement with consumer and whānau](#), which includes greater consumer engagement across direct organisation and policy levels (Health Quality & Safety Commission, 2022)
- the work to [repeal and replace the Mental Health Act](#) and the Law Commission's related work on [adult decision-making](#) (Ministry of Health, 2022c; Te Aka Matua o te Ture | Law Commission, 2022)
- [Guidelines to the Mental Health \(Compulsory Assessment and Treatment\) Act](#) and the [companion document focused on human rights](#) (Ministry of Health, 2022a, 2022b)
- [Guidelines for Reducing and Eliminating Seclusion and Restraint under the Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#) (Ministry of Health 2023b)
- [Oranga Hinengaro System and Service Framework](#), which identifies transformation led by lived experience as a critical shift required for mental health and addiction services (Ministry of Health, 2023c).
- [Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing](#), which provides a framework with principles and enablers for achieving transformation, including a focus on the peer workforce (Ministry of Health, 2021a).

Progress is evident in building the foundations for developing the lived experience workforce

A number of organisations have progressed activities or publications to support the development of the lived experience workforce. This includes work to provide knowledge and understanding of the workforce, along with direction and guidance for workforce development. Work has also begun on integrating more peer-led and peer-supported options for people accessing services. The following are some notable developments, but this list is by no means exhaustive:

- Lived experience leadership training is being delivered around Aotearoa with a tuakana-teina approach and includes growing lived experience leaders both within and external to the mental health and alcohol and drug workforce as well as growing leaders in intersectional spaces.
- Te Pou has published [Consumer, Peer Support and Lived Experience: Mental Health and Addiction Workforce Development Strategy \(2020\)](#), [competencies for the mental health and addiction CPSLE workforce \(2021a\)](#), [a CPSLE workforce development action plan \(2021b\)](#), [a guide to the CPSLE workforce in mental health and addiction settings \(2023b\)](#), [a report on NGO challenges for lived experience development \(2023c\)](#), and [a report on workforce numbers for NGO service delivery and estimates \(2023d\)](#).⁶
- Whāraurau, the national centre for infant, child and adolescent mental health workforce development, has developed resources and training to support leadership by young people with lived experience. Resources include [Youth Consumer Advisor Guide: A resource for new YCAs \(2020\)](#), [Employing a Youth Consumer Advisor \(YCA\) \(2022a\)](#) and [Orientation for Youth Consumer Advisors \(2022b\)](#). Its training has included [Ka Rangatahi](#), a youth lived experience workforce development workshop. Whāraurau (2021) has also reported on [workforce numbers for youth peer support and consumer advisor roles](#).⁷
- Te Kete Pounamu—National Māori Lived Experience Leadership network has advocated at a national level for Māori lived experience perspectives (under the umbrella of Te Rau Ora). Its work includes undertaking national education campaigns to reduce the stigma of mental distress as well as advocating for development of kaupapa Māori services (Wikaire et al, 2022). Earlier, Te Rau Ora⁸ shared [Hanga i te Tū o te Huringa: Making a stand for change](#) (Te Rau

⁶ For more information on Te Pou, visit its website: www.tepou.co.nz.

⁷ For more information on Whāraurau, visit its website: <https://wharaurau.org.nz/>.

⁸ Te Rau Ora was formerly named Te Rau Matatini.

Matatini, 2015) to call for a change in the way mental health services were treating Māori.

- [Oranga Hinengaro System and Service Framework](#) has been published by Manatū Hauora, which states ‘lived experience-led transformation’ is a critical system shift required (Ministry of Health, 2023c). It is also gathering data on the lived experience roles within Te Whatu Ora—Health New Zealand services, particularly data on how many consumer advisor roles, lived experience partner roles, and funded consumer advisory groups exist.
- Lived experience strategic leadership roles, including a National Director of Lived Experience, have been established within Te Aka Whai Ora.
- New contracts to embed peer support workers within multidisciplinary teams in specialist mental health services are in the process of being developed by Te Whatu Ora. This is supported by training for the peer workers and the wider teams that they join.

Research on the benefits of peer support

Strong international evidence confirms the benefits of peer support

As far back as the 1990s, the research literature has noted the benefits of peer support (Solomon and Draine, 1995; Davidson et al, 1999). Within Aotearoa, while the development of peer support practice and workforce is ongoing, we have seen relatively few published research papers or evaluations. One reason for this shortage is that the practice has developed organically over its history, particularly within the alcohol and drug sector.

In a key study, Scott (2011) conducted an interview-based exploration of peer support in mental health services while it was a new and emerging service model and supported other publications in Aotearoa, such as [Peer Support Practice in Aotearoa New Zealand](#) (Scott et al, 2011). As well as highlighting the key principle of authenticity within peer support, this study described differences in peer support models being used and in the type and structure of the services that were delivering peer support. It also noted that peer support draws on the relationality that is central to Te Ao Māori and that, while peer support was not defined from a Māori worldview, it is a good fit with kaupapa Māori ways of more holistic approaches to service provision (Scott, 2011).

In terms of benefits, the services that Scott (2011) interviewed considered that peer support provides an opportunity to encourage recovery through the empathy, reciprocity, validation, and hope that come from the authentic relationship between peers. An evaluation of Tupu Ake, a peer-led acute alternative mental health service in South Auckland, found that tāngata whaiora, staff, and the wider sector valued the service, and that it plays a role in decreasing stigma for people who experience mental health distress. It also reduced levels of distress for those who used the alternative service and 93 per cent of people were not readmitted to Tupu Ake overnight services within a 28-day period (Take Notice and Te Pou, 2017). Similarly, an evaluation of Piri Pono, an acute residential service that is completely peer-led and peer-staffed, highlighted the benefits from this community-based alternative. In the first 18 months, 84 per cent of service users reported a reduction in distress following their stay at Piri Pono (Connect Supporting Recovery and Waitemātā District Health Board, 2016).

Internationally, a range of studies have reported on the benefits of peer support services. They vary in their methodological approaches: several are qualitative studies

based on interviews, some are survey-based designs, and a small number of experimental designs typically explore the impact of peer support on clinical outcomes. Research in this area also faces the challenge of quantifying social wellbeing outcomes and recovery outcomes, which are self-defined. Despite such issues, the findings have a consistency that suggests they are credible. Further, international systematic reviews of the evidence, such as Gaiser et al (2021), Fortuna et al (2022) and de Beer et al (2022), all conclude that peer support shows positive effects.

The evidence shows peer support improves hope, empowerment, and quality of life

Internationally, a wealth of qualitative evidence points to the benefit of peer support in contributing to individual feelings, beliefs, and skills that enable people to recover and flourish.

Several qualitative articles explore peer support in different contexts that speak to the impact that it has had on people, through validating their experiences and giving them hope for the future. For example, Barr et al (2020) found that the use of peer support workers to share their experiences with people diagnosed with borderline personality disorder in Australia helped to validate experiences, bring connection, and inspire hope for the future. Other qualitative studies also discuss the value of peer support workers in supporting the accessibility of mental health services in rural settings (Cheesmond et al, 2020) and the capability of emergency departments to address the needs of people with lived experience (Brasier et al, 2022).

Both Gaiser et al (2021) and Fortuna et al (2022) concluded that the body of evidence gives confidence that peer support contributes to improvement in self-esteem, resilience, empowerment, and engagement in 'self-management'. In addition, it helps increase measures of quality of life and general satisfaction.

Tāngata whaiora in our focus groups likewise talked about the hope they gained through peer support.

We all know that hope that we get when we sit down with somebody who can sit there and go, 'Man, I so get it. I so understand, I've been there. You're not alone.' —Lived experience focus group

Peer support contributes to improved psycho-social outcomes and may also benefit clinical outcomes

Across the international literature, a consistent finding is that peer support improves recovery and psycho-social outcomes. Recent survey evidence from Chisholm and Petrakis (2022) found that 9 out of 10 clinicians believed peer workers add value to

the mental health outcomes of people with lived experience. However, the strongest evidence comes from an Australian observational study (Parker et al, 2023) and a meta-analysis of data across several studies on the effectiveness of one-to one peer support (White et al, 2020).

Both Parker et al (2023) and White et al (2020) identified benefits for psycho-social outcomes⁹ but no statistically significant change in clinical outcomes.¹⁰ Parker et al (2023) compared the outcomes of a clinical staffing model with those of a community-based residential mental health rehabilitation service using an integrated staffing model that had a majority of peer support workers. They concluded the integrated model was ‘at least as effective’ as the clinical staffing model because, while the study found no significant difference in the ‘reliable and clinically significant’ outcomes, it did find greater improvement in ‘general psychiatric symptoms’ and ‘social functioning’ measures assessed. White et al (2020) identified that one-to-one peer support is likely to improve psycho-social outcomes but is unlikely to improve clinical outcomes. This is consistent with the recovery focus of peer support.

Four articles within our review explored the impact of peer support on a measure of hospitalisations or readmission. Among them, only White et al (2020) did not identify a beneficial impact. Johnson et al (2018) conducted a randomised control trial, which suggested that the involvement of peer support for people discharged from a mental health crisis team reduced rates of readmission to acute care. Similarly, de Beer et al (2022) found a reduction in ‘relapse’ for young people and Gaiser et al (2021) concluded that peer support reduced rate of hospitalisations.

While the quantum of evidence is not large, some international evidence (Johnson et al, 2018; Barr et al, 2020; White et al, 2020; Gaiser et al, 2021; de Beer et al, 2022; Fortuna et al, 2022; Parker et al, 2023) suggests the use of peer support within mental health services (either in addition to or in place of clinical services) provides greater benefits than clinical services. Among these benefits are that peer support contributes to:

- a greater improvement in hope, satisfaction, and quality of life.
- a small reduction in admission or readmission rates to crisis services, such as hospitals
- a greater improvement in psycho-social outcomes such as social functioning.

⁹ Outcomes across all studies were diverse but psycho-social outcomes included empowerment, recovery, and social functioning including tools such as Social Functioning Scale (SFS).

¹⁰ Clinical outcomes included psychiatric or psychotic symptoms and used tools such as the Discharge Mental Health Index (MH-38).

Research and evaluation of peer support should focus on what matters most in supporting recovery

Aotearoa needs to build research and evaluation focused on the ongoing development of its peer support workforce and services, including both mental health and addiction settings. This focus will help to develop the body of evidence about the benefits of peer support. Research and evaluation of peer support roles should consider what is important from a lived experience perspective. Peer support is intentionally ‘recovery focused’, which means that it aims for outcomes related to the self-determined recovery goals of tāngata whaiora.

Aotearoa in particular needs evaluation based on an understanding of the world from a perspective of Te Ao Māori. Evidence from this perspective does not exist in the international literature. However, conducting this kind of evaluation will require different ways of working and thinking about quality of evidence. As we have heard through our engagement with people who have lived experience, there is a tension between what can be measured from a western perspective and what is important from a Te Ao Māori worldview.

There’s so many issues around indigenous models of practice because it cannot be measured. But what can be measured is how well we stay, how well we can be, how well we can be in our community and how well we are doing as a community, and our contribution to the community. Those things can be measured, our pūrākau, our stories. —Previous lived experience engagement

The classic tension that sits between indigenous knowledge versus science, whereas science is kind of based around being analytical, sceptical, measurement, and replicable evidence. That’s kind of what accountability looks like in that westernised framework, whereas indigenous knowledge, it’s more holistic ... and the evidence is in what’s been spoken about—the pūrākau and the relationships that happen between people and their environment. —Previous lived experience engagement

Snapshot of the current peer support workforce

The peer support workforce is growing slowly

Comprehensive data for the peer workforce across primary, community, and specialist Te Whatu Ora services are not readily available. It is estimated that the lived experience roles make up at least 4 per cent of the total adult specialist mental health and alcohol and drug workforce across both NGO and Te Whatu Ora services (Te Pou, 2023a). This estimate is based on NGO workforce estimates (Te Pou, 2023d), Te Whatu Ora estimates¹¹ (Te Pou, 2023e), and a youth peer stocktake (Whāraurau, 2021). We know that there are gaps in the available peer support workforce data. For example, roles within Te Whatu Ora and the Aotearoa needle exchange programme. We would like to see a more comprehensive view of the peer support workforce, which will require an effort to improve coding of workforce data within Te Whatu Ora.

Table 1 shows the workforce FTE for adult mental health and alcohol and drug specialist services in 2018 and 2022. It also shows the peer workforce employed into NGO specialist services. Te Whatu Ora does not routinely collect and report data on the peer workforce in its services. For this reason, relevant data are not available for this paper and our snapshot of the peer workforce, as in other publications, is incomplete. This is a significant limitation for monitoring the growth in peer workforce and must be addressed given the Government's commitment to growing this workforce.

Recent NGO workforce surveys indicate that NGOs in total had an estimated 425 FTE peer support workers in 2022, an 18 per cent increase from 361 FTE in 2018. The peer support workforce equates to 8.2 per cent of the NGO adult specialist workforce and at least 3.4 per cent of the total adult specialist mental health and addiction workforce (including NGO and Te Whatu Ora) in 2022.¹² It is encouraging that the rate of growth in the peer support workforce was greater than the growth in the total NGO

¹¹ An estimate of 44.1 FTE consumer and whānau advisors within Te Whatu Ora mental health and alcohol and drug services was calculated from information received by the National Association of Mental Health Service Consumer Advisors and Family Whānau Advisors Aotearoa network. Other lived experience roles, including peer support workers, were unable to be identified in the Te Whatu Ora workforce information.

¹² This is calculated from the peer support worker FTE within adult mental health and alcohol and drug NGOs as a proportion of the total NGO and Te Whatu Ora workforce. As a result, this will underestimate the proportion of the workforce because peer support workers within Te Whatu Ora services are unable to be counted, although it is broadly estimated that the peer support workforce within Te Whatu Ora services is small.

and Te Whatu Ora workforce; however, the peer workforce remains a small proportion of the total workforce.

Table 1: Workforce FTE in adult mental health and alcohol and drug specialist services, 2018 and 2022

	2018	2022	Growth (%)
Within NGO services:			
Peer support (consumer and service user) worker	316	354	12%
Peer support (family and whānau) worker	45	71	58%
Total peer support workers	361	425	18%
Other lived experience roles ¹³	43	59	38%
Total lived experience roles	404	484	20%
Total NGO workforce	4,556	5,165	13%
Within Te Whatu Ora services:			
Peer support workforce unable to be identified separately from other support workers.			
Other lived experience roles	44.1		
Total Te Whatu Ora workforce	6,603	7,311	11%
Total NGO and Te Whatu Ora workforce	11,158	12,476	12%

Source: Te Pou, More than numbers: Adult mental health and alcohol and drug workforce 2018 and 2022

FTE = Full-time equivalent roles (both employed and vacant)

* Peer support worker 2018 data may differ slightly from our dashboard as in 2018 some NGO administrative, management, and strategic roles were reported separately.

The contracted growth in lived experience FTE has not been fully realised, with vacancy rates also increasing from 2018 to 2022. For the peer support (consumer and service user) workforce in NGO adult services, the vacancy rate increased by 5.0 percentage points from 2.7 per cent in 2018 to 7.7 per cent in 2022. Vacancy rates are increasing across the mental health and alcohol and drug workforce, and peer support vacancy rates are lower than the average for all roles; the mental health and addiction adult NGO workforce vacancy rate increased by 6.1 percentage points from 4.7 per cent in 2018 to 10.8 per cent in 2022.

¹³ Includes 'consumer advisors', 'whānau advisors', 'peer leaders', and 'other lived experience roles', which were reported as part of different group categories across years but were provided directly by Te Pou for comparability across years.

Access to peer support workforce remains constant

Information about tāngata whaiora contacts for the purpose of peer support¹⁴ is routinely collected within the current PRIMHD data set. While there are concerns that peer support data recorded in PRIMHD do not accurately represent all the activity of peer support workers, we use this source in the absence of higher-quality data.¹⁵ At a summary level of activity in 2021/22, there were 59,432 peer support contacts (2.3 per cent of all PRIMHD contacts) provided to 5,652 tāngata whaiora who received at least one peer support contact (3.0 per cent of unique service users recorded in PRIMHD).

These totals represent a small decrease in the number of peer support contacts and people receiving peer support over the past five years. In addition, the percentages reduce as a proportion of total people within PRIMHD, as a proportion of total contacts recorded in PRIMHD, and as a probability of receiving first peer support contact after referral. However, the reduction is small and only 2020/21 (when COVID-19 changed patterns of service delivery) shows a statistically significant reduction in the accessibility of peer support for tāngata whaiora who have entered specialist services. For the probability curves from time-to-event analysis, see Figure 1 in [Appendix 2](#).

Over the last five years, 293 (16.6 per cent) specialist mental health and alcohol and drug teams across Aotearoa provided peer support. There are differences across team types with 20 per cent of alcohol and drug teams providing peer support contacts, while only two (5 per cent) inpatient teams provided peer support contacts. For more detail on how access to peer support contacts differed by team type, see Table 2 in [Appendix 2](#).

There has also been an emergence of virtual peer support outside of the peer support provided by specialist services. Whakarongorau Aotearoa set up its Peer Support telehealth service line in 2020 (in addition to existing telehealth services, such as Need to Talk, 1737). In 2021/22 this telehealth peer support service had 24,163 contacts with 7,312 unique users.

¹⁴ Peer support contacts are coded as T45. We have excluded contacts that are coded as text or written messages, but we have included face-to-face and phone contacts. We have not included T44 advocacy contacts because no code is available that specifically indicates when this is peer advocacy.

¹⁵ Because our analysis is of 'T45 contacts', it is subject to the limitations of this data entry and quality. One known concern is that only a person contracted to provide peer support is permitted to enter T45, and they may misunderstand 'peer support' when entering activity data. Some other codes that may represent different activities provided by peer support workers, such as T44 for advocacy.

Lived experience workers report high satisfaction from connecting with peers

A survey of lived experience employees and volunteers in 2022 provides insight into the experiences of the lived experience workforce within Aotearoa (Te Pou, 2023a). The survey estimated that people working in lived experience roles have good levels of role satisfaction.¹⁶ Among their comments were that working with and building relationships with their peers is one of the most satisfying aspects of their roles. Most people employed in lived experience roles are working full time¹⁷ and a substantial proportion of the workforce has a long history of service in lived experience roles.¹⁸

The wellbeing and development support available to lived experience staff varies. It was common for lived experience respondents to report access to some organisational support for their wellbeing.¹⁹ However, the lived experience survey found that where respondents received reflective practice, organisations varied in how they provided this (Te Pou, 2023a). Further, our focus group participants suggested that peer support staff need improved support, including supervision, to look after their wellbeing.

If we are going to have a peer-led lived experience workforce there needs to be streams where you can upskill, where you can have support, where you can have supervision, where if you are struggling you can call someone. You can't just be expected to work at that support level role and not have any group around support yourself. And I feel like there's not enough support ... around that self-care stuff. —Lived experience focus group

¹⁶ An estimated 74 per cent (n=203) of people reported being somewhat or very satisfied in their roles.

¹⁷ An estimated 70 per cent (n=200) of people employed in lived experience roles worked more than 32 hours each week.

¹⁸ From the 206 respondents, it was estimated that one-third have worked or volunteered in lived experience roles for more than 10 years while over half were in these types of roles for more than 5 years.

¹⁹ As reported by the 244 respondents, 77 per cent received 'supervision, coaching, and mentoring (reflective practice)', 61 per cent had access to employee assistance programmes, 23 per cent had access to cultural supervision, and 13 per cent had access to other organisation support for their wellbeing.

The voices of lived experience on the peer support workforce

Whakatauki:

Te kai a te rangatira, he kōrero

The food of leaders/chiefs is discussion (communication and knowledge)

The participants in our focus groups talked about the changes they had seen, or not seen, in the lived experience and peer support workforce since the publication of He Ara Oranga. These themes were interrelated and ranged from the workforce growth and working environment, to the underlying structures and values that were contributing to these experiences. Another theme was the need for leadership and communication of knowledge to contribute to better understanding of the peer support workforce and its benefits.

The way lived experience is valued is connected to the experiences and development of the peer support workforce

He Ara Oranga enabled the voices of tāngata whaiora, including those working in peer support roles, to feel heard and gave them hope that a shift in the mental health and addiction system would happen. Throughout our focus groups, however, people felt this hope had not been realised. Participants felt the values that underpin the mental health and addiction system need to change.

I feel like there is this call to have lived experience front and centre, but the attitude behind it still isn't there. I still feel like we are not treated as equals ... —Lived experience focus group

That's about our country's values and what we really value. And whether what we say we value is as congruent with how we spend our money and as a country. So that's for me a bigger picture. — Lived experience focus group

People want their lived experience to be recognised as a valuable qualification

A strong theme that came through our focus groups was that the system sees 'a piece of paper' as more important than years of lived experience and the knowledge and skills that people gain through this. Participants believe that lived experience has inherent value and that services and the wider mental health and addiction system should recognise and value sharing from a place of lived experience more than they

currently do. This was frequently connected to showing value in a variety of ways, such as through trust, genuine partnership, leadership roles, and remuneration rates.

Because I don't know, maybe we don't have some fancy degree or I don't know, but what I do have is very valuable experience that can help you shift and change. –Lived experience focus group

People commented on there being a clinical hierarchy that they felt gave more power to clinicians and saw their work and knowledge as more important. While they talked about clinical and peer worldviews, and ways of working, as different to one another, participants saw both as important, as were other sources of knowledge, including mātauranga Māori.

I think what we need to do to make that [lived experience] have more significance in ... the system is find a way to make that knowledge as equally valued as clinical knowledge. I think obviously they're completely different, but I think we need to have a space where clinicians as well are recognising ... [lived experience] knowledge as valuable, and also having Māori world perspective as another form of knowledge. –Māori focus group

I think if we start to change the narrative and make sure that those roles [are] equally important, and I think, especially make sure clinicians know that those roles are equally important, we might start to get somewhere. –Previous lived experience engagement

The peer support workforce has the potential to be part of the shift towards a strengths-based focus on recovery

While growing and adding capacity to the peer support workforce is an important goal, people in the focus groups talked about this being only part of the change needed. They also talked about how ways of thinking need to change so that the mental health and addiction system can shift towards a recovery-focused paradigm. This includes a change in culture across all levels of the system which is consistent with international research from Mirbahaeddin and Chreim (2022).

It's not government and it's not frontline, it's the middleman, it's the middle executive directors and these services that have the power to commission change that don't. –Lived experience focus group

Lived experience leadership roles are also important to enable the peer support workforce to be part of the system transformation. When the lived experience workforce is central to workforce and policy discussions, they can advocate for the role of peer support in delivering recovery-focused models of care. As a key enabler for developing the potential of the peer support workforce, the involvement of lived experience leadership has progressed in some regions. However, connected to this

was frustration that this good work is not consistently embedded across the whole country. With the health reforms, including the establishment of Te Whatu Ora and Te Aka Whai Ora, there are the foundations for embedding lived experience positions in areas where they can lead and influence policy, planning, monitoring, and commissioning discussions.

These are changes that I think that need to happen at a largely ... systemic level ... To change the system, we need to be involved in the system, we need to be in it. We increasingly are, I understand that, but there is a significant policy conversation about workforce shortage at the moment. And I don't know whether lived experience workforce is part of that, but it needs to be. —Lived experience focus group

I trust the intention is positive ... I think that part of the problem is, it's mistranslated ... [We're] not all having the same conversation ... I think that's part of the reason why you then get a location variability ... You could have this conversation in 20-plus different places and get a different answer. But that in itself is not necessarily acceptable. So, at a systemic level, the location variability is an issue. —Lived experience focus group

People felt that the current system too often adds peer approaches as an afterthought rather than embedding them in system and service design. They described how the structure of the system would look different if it were informed by a lived experience or Te Ao Māori worldview.

It's not enough to say we will have more peer workforce. Because if that peer workforce increase is driven by a system and a service approach, you're going to get what you've got now, right. That's not a bad thing, but that's not the full answer. —Lived experience focus group

What I've found being in this space now is a lot of the commissioning and funding is tied to the previous or historical models of care. —Māori focus group

People felt the large financial investment in the mental health and addiction system from the 2019 Wellbeing Budget was a positive opportunity for sustainable change. However, most people talked about the need to better allocate funds because money is not reaching places they believed it needs to go. Participants felt that more investment needs to go towards developing and supporting the peer support and lived experience workforce and scaling innovative models using peer support. The intention to grow the peer support workforce needs to be followed by the resources to do it well. People felt that increased funding would help a peer workforce to feel

valued and supported, whereas with a lack of funding the risk was that new roles would be poorly implemented in a tokenistic nod towards the direction of He Ara Oranga, without fulfilling its intent.

This funding won't be around forever, so we've got to future-proof what we currently have and make the most of what we currently got. –Lived experience focus group

When you get to the point where we have been trying to be innovative and be creative with the money we currently have, any time we look to create roles, new roles, it can come across as tokenism because you just don't have the support, the training, and the staff to support that service. So, you could approach these areas with absolute best intentions, but if you don't have the structure or the funding or the support wrapped around all the training, then it can come across as tokenism. –Lived experience focus group

Enabling the peer support workforce to stay true to their lived experience values

The peer support workforce operates with different underlying values and goals compared to clinical roles when working with tāngata whaiora. They need lived experience leadership to influence health systems and services to become more compatible with these values but achieving that can be challenging. Focus group participants noted structural challenges, particularly around coordinating people when funding for only a few FTEs is available, that made it more difficult for lived experience leadership to collaborate.

We are always trying to protect ours going into those environments. So, there's a lot of that fragmenting FTEs, which means that we can't coordinate ourselves in our roles because we've all got fragmented roles. –Lived experience focus group

People also talked about the value of having lived experience leadership within organisations and services. Support for this view comes from international literature that discusses how an essential component of developing a peer workforce within services is for management to be committed to and understand peer support (Byrne et al, 2019, 2021).

Embedding Te Tiriti o Waitangi within the peer support workforce

While all our focus groups acknowledged diverse cultural worldviews, the Māori focus group in particular emphasised the need for authentic honouring of Te Tiriti o

Waitangi throughout the system from governance, leadership, and management, to all staff. A further perception was that there have been many discussions about Te Tiriti o Waitangi, kaupapa Māori services, Māori models, and being responsive to Māori without following through with meaningful action. Respondents to the lived experience survey likewise felt that the talk has not yet led to real change to the way health services and peer services are delivered (Te Pou, 2023a).

We need to actually walk the talk and do this... And also, opportunities to create contracts or looking at scoping up services to ensure that those differences or those aspects are in there. Really having a platform and a space to write in kaupapa Māori, write it from a kaupapa Māori to Māori worldview. –Māori focus group

Rangatiratanga could change the system structure around the peer support workforce

A system that integrates Te Ao Māori and lived experience perspectives would look different to the current system. Māori focus group participants talked about changes needed ‘at the top’ such as organisational relationships, contract management approaches, and reporting. They felt that starting with fundamental changes to the way of contracting and managing services would establish the foundation for changing what tāngata whaiora Māori experience when accessing peer support services.

We are now coming to the table to set about the modelling of what those relationships look like, contract management looks like ... It’s those ticket items that we should be going for, and the rest drops down out of that. Because if we don’t get the systemic change at the top, we are not going to get it at the bottom. –Māori focus group

People felt system leadership is moving towards including more kaimahi tāngata whaiora Māori. However, further progress is needed. Some perceive tokenism when ‘Māori roles’ are established, pointing out simply having these roles is not enough; they also need to have the structure, resource, and influence to fulfil their purpose.

Developing kaimahi tāngata whaiora Māori can lead to significant improvements

Having Māori models of peer support means Māori are involved at all levels. There is huge potential for making real change through developing a Māori workforce to work in Te Ao Māori ways as well as in peer support and leadership roles. With this workforce, Māori can bring shared experiences to peer support, provide advice at service levels, and be authentic partners at the system leadership level. Developing the kaimahi tāngata whaiora Māori workforce will support the implementation of

Māori models of peer support and shift the system to one that reflects a Te Ao Māori worldview.

There is a need to increase the Māori workforce across all spaces in health and this will enable the kaimahi tāngata whaiora Māori to strengthen and develop. Te Rau Ora (2019a, 2019b, 2023) has [resources](#) (2023) on the [recruitment](#) (2019b) and [employment](#) (2019a) of a Māori workforce. This guidance includes acknowledging the Māori workforce will require ongoing professional development that enhances their cultural capabilities and supporting opportunities for leadership development. Efforts to develop Māori leadership in the workforce are already under way, such as [Mā Purapura Mai: Māori Lived Experience Leadership](#) (Butler and Te Kīwai Rangahau, 2019).

The dynamic is we're [Māori] actually pushing to be involved in workforce planning. This is not something I'm leaving to others to do, I'm asking to be involved in because we are advocating around our own Māori and their health journey and actually, we've said to them to re-look at what that workforce could look like potentially by growing our own people. —Māori focus group

Māori models of peer support should integrate mātauranga Māori

Participants discussed the need to identify what peer support would look like from a Te Ao Māori worldview. Māori told us that they want to establish 'by Māori, for Māori' models of peer support, and develop their own roles, language, training, and resources to deliver what whānau need.

The scripting that's written, the training that's written around peer support and advocacy belongs to tauīwi, it does not belong to ngāi Māori. So, one of the things that we have to consider is what would that look like from our world? Immediately mātāmua/pēpi, tuākana/tēina and what do those relationships look like? Because let me tell you, our whānau with lived experience are the tuākana. And we should be writing those programmes specifically to be able to deliver to our people the way that it needs to be delivered. — Māori focus group

Progress depends on a wider understanding of the benefits of the peer support workforce

People in the focus groups talked about needing to be clear about the 'value proposition' of peer support. To support the progress of the peer support workforce, we need a clear understanding of what they contribute across the wider health sector, including organisations that employ them and the workforce alongside them. The lived experience workforce has a role to play in enhancing understanding of lived

experience values and the value peer support brings to tāngata whaiora experiences of care and recovery.

A lot of recent work by Te Pou (2020, 2021a, 2021b, 2021c, 2023b), such as its strategy, competencies, and action plan, supports the work to understand and plan for lived experience and peer support roles. Whāraurau (2020, 2021, 2022b) has also released guidance to support understanding of youth lived and living experience roles. Te Kete Pounamu has shared its change management strategy, [Tūmata Kōkiritia—Shifting the Paradigm](#), and advocates for Māori lived experience perspective through its national leadership and regional networks (Butler and Te Kīwai Rangahau, 2017).

The whole system needs to understand the value of peer support

Within the focus groups, there was a consistent understanding of the unique value and benefits the peer support workforce brings to the mental health and addiction sector. However, participants also saw that, to get everyone working together effectively, it is necessary to communicate this value so the wider sector can understand how peer support roles work and what benefits they bring.

We need to be clear about what the lived experience value is. And we need to be able to articulate why we are an important part of this conversation. Lived experience provides option, right. Not choice, option. And that's important. Choice to me is about one thing or another thing, whereas option is about one thing and another thing. So, why can't you have specialist services and peer services? —Lived experience focus group

To make progress, we need better information and data

Currently, it is difficult to collect and communicate data on the lived experience and peer workforce. Even identifying peer support roles is difficult as different places differ in the role titles they use. For example, Te Pou has estimated the size of the peer workforce in the NGO sector using a survey of managers. Te Pou was unable to do the same for peer support roles within Te Whatu Ora services because the source data set from the Health Workforce Information Programme did not identify those roles (Te Pou, 2023d, 2023e). Manatū Hauora is now doing a stocktake to understand the lived experience advisory roles within Te Whatu Ora (which Te Pou reports to be around 44 FTE positions in adult services, based on information from the National Association of Mental Health Service Consumer Advisors and Family Whānau Advisors Aotearoa). Having more information will help in understanding the size, spread, and setting of the lived experience workforce, as well as the diversity of roles that exist.

Data can also help to communicate the value and benefits of the lived experience workforce, particularly the peer workforce. These data need to fit with the self-

determination philosophy of lived experience, with appropriate tools to measure outcomes that are considered meaningful from a lived experience perspective.

Development of the peer support workforce needs to remain true to peer support principles

Views differ on how to increase the size of the peer support workforce. In response to the currently high vacancy rates for clinical roles, a pragmatic view is to take this opportunity to grow the peer support workforce by transferring unfilled clinical FTE into peer support roles. However, it is important to design the service to recognise the difference between a peer support role and a clinical role so a peer support worker does not end up doing the role of a clinician or support worker. We have heard from focus group participants that when non-peer roles have been converted to peer roles in the past, without the foundational change needed in service specifications, contracts, and role descriptions, the workforce can struggle with role strain and erosion of peer values-based practice. The literature also addresses challenges peer support workers have faced internationally in staying true to the principles of their work when they are co-opted to other roles or tasks (Roennfeldt and Byrne, 2020; Greer et al, 2021). People from our focus groups told us that following their peer support principles is paramount and that co-opting peer work to suit service needs rather than peer aspirations is a risk to that work.

Add infrastructure around lived experience so these people do not become 'peer-nicians'. So that they become lived experience peer support workers as opposed to being co-opted to become ... basically, doing some clinical work that's actually outside the realms of what my understanding is of the consumer peer support and lived experience workforce. –Lived experience focus group

It's about making sure that lived experience, philosophies and values, and practices are recognised for what they are. And not squeezed into somebody else's service, or squeezed into somebody else's system. –Lived experience focus group

Developing the peer workforce is easier when clinician team members understand peer support

Other members of the organisations and teams in which peer support workers operate also need knowledge of peer support roles. The understanding and attitudes of team members, including managers, clinicians, and other support staff, have a large impact on the ability of peer support workers to be effective in their roles. Commonly participants described wanting team members to have an improved understanding of the skills and knowledge of peer support in addition to having trust in their competence. With this understanding and trust, colleagues can be

comfortable about introducing tāngata whaiora to peer support workers so that tāngata whaiora have the option of receiving this type of support.

That relationship that you have with the clinical team, I used to always think that's just as important. If we're going to advocate for the people seeking help, we need to have the respect and trust of the clinical team and they need to know the value of what we bring and we need to know the value of what they offer in order for us to be able to, I guess, translate a lot of that language in a way which the people we support can understand. —Lived experience focus group

The evaluation of Tupu Ake, a peer-led acute admission alternative in South Auckland, described the challenge of gaining trust from clinicians due to lack of understanding when establishing the service. It observed how the understanding of peer support roles improved and attitudes changed throughout delivery of the service to enable more options to tāngata whaiora (Take Notice and Te Pou, 2017).

The international literature identifies the same challenges with integrating peer support workers in a team. Some papers discuss how it is difficult for peer support workers to gain credibility with clinical staff (Mancini, 2018; Edan et al, 2021; Scannell, 2021; Wall et al, 2022); others highlight the challenge of understanding the role (Barr et al, 2020; Ibrahim et al, 2020; Greer et al, 2021; Wall et al, 2022). The literature has also pointed to the potential for training non-peer staff to help integrate peer support into a service (Edan et al, 2021; Mirbahaeddin and Chreim, 2022).

Developing a strong and sustainable peer support workforce

To strengthen the peer support workforce, we need to address several different aspects in developing it. At a broad level, these include: growing capacity or size of the peer support workforce in Aotearoa; sustaining the wellbeing of the existing peer support workforce; and building their skills and capabilities.

Growing the capacity of the peer support workforce

Financial investment needs to reach the right places

The peer support workforce has been growing since the publication of He Ara Oranga but not at the pace required to transform the mental health and addiction workforce. To increase the capacity of the peer support workforce sufficiently, it is necessary to invest in additional FTE. While expenditure on peer support services has increased overall,²⁰ its distribution across the country has been uneven. Some people in the

²⁰ District health boards and Manatū Hauora increased their expenditure on peer support services by 46 per cent, from \$32 million in 2017/18 to \$46.65 million in total in 2021/22.

focus groups talked about the lack of investment in non-clinical workforce while others talked about the inconsistency in investment.

There have been wide investments in both cultural and lived experience roles, but very inconsistent. Some districts are overtly trying to action recommendation 20 of He Ara Oranga. Others are just status quo. Some districts have established roles or amalgamated some and other districts have brought new roles in cultural and lived experience roles, but only on fixed-term contracts.
—Māori focus group

We've seen very little investment in the workforce other than clinicians ... But I have seen some movement around the employment of more peer support and whānau support. However, this seems to be the provider arms capturing what has historically been NGO. —Māori focus group

Converting clinical to peer FTE provides opportunity for workforce growth if well implemented

Along with growing through additional investment in mental health and alcohol and drug services, peer support roles may increase through reallocation of funds. A number of people talked about how investment in peer support services could come from reallocating funds for clinical roles that are unable to be filled.

As noted earlier, this approach can only be effective if foundations are in place to ensure new peer support roles can stay true to peer support principles. Relying on this form of funding may also put the sustainability of peer support workforce growth at risk, given it depends on continued shortages in clinical roles. Participants noted that current roles funded in this way are fixed term because leaders do not want to commit to this arrangement in the long term.

Peer support roles also struggle with increasing vacancies

Although the shortage in the clinical workforce has led to reallocation of FTE in some regions, another issue is that the vacancy rate for peer support workers is high and growing (from 2.5 per cent in 2018 to 7.7 per cent in 2022—see '[Snapshot of the current peer support workforce](#)'). This demonstrates that we need more than increased investment to build the peer support workforce. Other areas needing attention are making the roles more attractive, developing capacity and capability, and having supportive infrastructure for new staff to enter the peer support workforce.

It is just difficult to recruit currently. Finding workforce has been our major issue and so we've gone into a bit of work around how we might do that and how we might improve that. —Māori focus group

Sustaining the wellbeing of the existing peer support workforce

Burnout is too common

Although people in lived experience and peer support roles report good work satisfaction, that satisfaction came from the purpose of the roles rather than from a supportive environment. Participants in focus groups talked about services where it was common for peer support workers to experience burnout. Contributing factors to burnout they identified included fragmented leadership, pressure, lack of support, and few opportunities for career progression.

During previous engagement, people with lived experience also talked about how they struggled when their employer did not provide reasonable accommodations for their needs²¹ in their employment. This further diminishes the wellbeing of people working in these roles and leads to ineffective work and poor staff retention at a time when the peer support workforce needs to grow.

[In our secondary services it looks like there is] just a tendency to chew up their peer workers, burn them out and spit them out ... So token role, that's not what secondary services or not completely managed by NGO, sort of in the middle, don't really know where they sit, don't really have clear leadership and as a result can't do their job effectively or can't maintain self-care. This feels like meat to a grinder, really. –Māori focus group

The difficulty being inside an organisation was that they got no professional development plans, they had no supervision and there was a slim chance that they were even going to get some form of training in those roles. We've experienced a lot of burnout because they came in with a desire and went out absolutely diminished if you like. –Māori focus group

The type of leadership peer support workers experience has a large impact on them

Focus group participants saw good leadership within organisations as invaluable for integrating and developing peer support roles within services. This view gains support from the literature (Byrne et al, 2019, 2021). Participants value leadership and management from a lived experience perspective and called for more peer-led and peer-governed services.

Because often what I hear, and what I've seen over the years, is, 'Oh yes, we need a peer support worker.' We just get them and throw

²¹ Under the [Human Rights Act 1993](#), an employer must take reasonable steps to create a work environment that enables staff with equal opportunities in fulfilling the role—for example, by providing accessible technology, flexible work schedules, and restructuring work sites.

them into the role, and there's no consideration of that leadership.
—Lived experience focus group

During previous engagement, a participant described the positive difference of having an 'unapologetically lived experience' manager.

So, all those things [roll on, roll off; clinical case study] that are so against our ethos, having a leader who just really unapologetically says, 'No, that doesn't fit with the ethos of our programme' ... There's something about that, which actually is unique. —Previous lived experience engagement

Reflective practice and supportive relationships need to support peer values

As well as leadership, peer support workers need other types of support to gain confidence in the peer role and look after themselves. They often talked about access to high-quality supervision and have highlighted some unique requirements to support peer support workers, which literature supports (Eddie et al, 2019; Byrne et al, 2021). Supervision of peer support roles should come from supervisors who have a peer practice background (Te Pou, 2022).

Cultural safety in the workforce needs further improvement

Focus group participants highlighted the need for cultural support to kaimahi tāngata whaiora Māori, with most people saying it is not currently sufficient. The findings of Te Pou's survey reinforce this observation, showing that an estimated 23 per cent of lived experience workers have access to cultural support (Te Pou, 2023a).

I think it's really important that we provide Māori peer support, Māori supervision, cultural supervision for people in peer support roles. —Māori focus group

There's no professional development for our Māori workers. There's no supervision culturally, which is on the table for discussions right now because we've been jumping up and down about it long enough. What they rely on is peer supervision amongst themselves and that's how our whānau get by. But we are burning out, we are burning out. —Māori focus group

Building the skills and confidence of the peer support workforce

Training helps people to work safely and effectively

A number of people in the focus groups talked about the need for high-quality training for people entering peer support roles. In their view, insufficient training (among other concerns) often left people feeling unconfident and under pressure and it accounted for a lot of burnout within the peer support workforce.

Te Pou has developed and published lived experience competencies to support workforce development activities (Te Pou, 2021a). In addition, a number of NGOs have developed or are developing their own peer support training. Such training helps to support new staff from the start of their employment with the NGO. These training programmes have been locally designed and aim to respond to the cultural requirements needed to serve the population. This is in addition to the foundation of how to use lived experience as a peer support worker. A further opportunity to support workforce mobility and system understanding is to have consistent sector-wide training opportunities that clarify the peer support role and improves national consistency.

Peer support workers are likely to benefit from additional development that is relevant to their specific role or community and is not delivered through a programme with a formal qualification such as Level 4 certificates. For example, developing mātauranga Māori capability through Mahi-a-Atua does not deliver a qualification but provides great value to the peer support workforce in supporting the wellbeing of tāngata whaiora Māori.

Staff need more training to understand a Māori worldview

A number of NGOs are making progress on cultural training for their workforce and clinicians, as well as peer support staff. This includes training in areas such as decolonisation, and also learning about the world from a perspective of Te Ao Māori. Both the intention and actions taken represent positive progress towards ensuring all of our mental health and alcohol and drug services can provide culturally responsive care that meets the needs for all tāngata whaiora and so improves equity of experience and outcomes.

We are rolling out training for our clinicians at the moment who are said to be open to wanting to see what a Māori worldview looks like. They're open to it because it's those support workers that they're talking to with the psychiatrists that say they need to know. —Māori focus group

The path forward for the workforce

The government must deliver on its commitment to transformation led by lived experience

Kia Manawanui prioritises the growth and development of the peer support workforce. Added to that, one of the ‘critical shifts’ signposted in the recently released **Oranga Hinengaro System and Service Framework** is for system transformation led by lived experience. We believe realising this transformation will improve the quality of our mental health and addiction system because the evidence shows that peer support provides additional benefits aligned to a recovery philosophy.

The snapshot of the current state of our peer support workforce in this report demonstrates that the workforce is currently small. It has lots of room to expand as a valuable part of the mental health and alcohol and drug workforce. Growth of this peer support workforce will support transformation led by lived experience but achieving that growth requires lived experience leadership, whole-of-workforce development, and a collective effort.

We have called for a mental health and addiction workforce strategy and roadmap – this must include the development of the lived experience workforce

We have called for a workforce strategy and roadmap to determine what our health workforce of the future looks like and how we will get there. Expanding the peer support and lived experience workforce should be an objective in that strategy and roadmap. Moreover, lived experience and Māori lived experience leaders should be partners in the development of this strategy and roadmap so that it reflects what is most important to tāngata whaiora.

Within our focus groups, people also talked about the need for a workforce plan as well as the changes they want to see in order to realise the shift in lived experience workforce envisaged in He Ara Oranga.

The policy objective to grow the lived experience workforce needs to be translated into change that tāngata whaiora can experience and benefit from when using mental health and addiction services. This requires the roadmap to outline and facilitate steps to enabling these objectives to be achieved. What is needed is a robust specialist MH&A workforce strategy & action plan facilitated by Te Aka Whai Ora and Te Whatu Ora. —Māori focus group

Workforce plans could include how organisation and their leadership prepare the ground to attract, support, train, and retain youth, peer, and lived experience workers. Also, how we give voice to whānau. — Māori focus group

These changes are relevant considerations for a roadmap that outlines the steps to expand the lived experience workforce.

1. Develop the tāngata whaiora Māori workforce

There is huge potential to further develop the Māori workforce to work from a perspective of Te Ao Māori, incorporating mātauranga Māori, tikanga, and kawa. Realising this potential requires a shift in attitudes and values to see Māori models of care as equally valid to both the medical model and western peer support. The benefits of this shift are that we meet our obligations to Te Tiriti o Waitangi, improve equity, and expand the options for care that are available to everyone in Aotearoa.

Some services have already adopted Te Ao Māori approaches, such as pūrākau Atua and pūrākau Tipuna, into their practice. Kaimahi also have opportunities to develop their capability to incorporate mātauranga Māori such as Mahi-a-Atua. Communication and sharing of knowledge about what approaches are working will support the spread of change across Aotearoa.

2. Provide training and education for the health workforce

While people with lived experience can support the critical shift towards a system led by lived experience, making that shift requires a change in attitude from all people working in the health system. Changing attitudes also requires discussion, communication, and sharing of knowledge. One barrier to achieving such change is the lack of clarity about what peer support and lived experience roles are, and the value they bring.

Growth in the lived experience workforce will naturally support the shift towards a system led by lived experience by making that workforce more visible, but other actions can accelerate this change. There should be training for teams across the mental health and addiction sector in the peer support approach, education about peer roles and what they do, and training on unconscious bias that can discriminate against people with lived experience. Roles such as lived experience advisors and peer educators can make an important contribution to training and changing attitudes.

Improved information, data, and evaluation will also support a better understanding of the approach and benefits of this workforce. These improvements need to include space for lived experience knowledge and mātauranga Māori to be valid contributions to the evidence base, with access to health research and evaluation funding. It also requires data collection systems that have adequate codes to reflect their activity

(e.g., a code within PRIMHD for peer advocacy) and that collect data on outcomes relevant to the recovery-focused values of the peer support workforce.

3. Establish strategies to attract people to the peer support workforce

Growth of the peer support workforce depends on people choosing to enter peer support roles, and our ability to retain people already working in these roles. While building relationships with tāngata whaiora is a rewarding aspect of the role, people also talked about a number of changes that would make peer support roles more attractive. These changes involve providing: rates of remuneration that adequately value the role of peer support staff; leadership, training, mentoring, and supervision that enable staff to feel supported in both their work and wellbeing; roles that are ‘by Māori, for Māori’; and career pathways that give people opportunities for growth.

Implementing strategies to make peer support work more attractive will require financial investment in lived experience leadership and peer support infrastructure. This is important for enabling collective voice and coordination, leadership development, and career pathways, as well as for supporting people in system and service roles, and supporting the peer workforce and services to stay true to peer support values.

References

- Barr KR, Townsend ML, Grenyer BFS. 2020. Using peer workers with lived experience to support the treatment of borderline personality disorder: a qualitative study of consumer, carer and clinician perspectives. **Borderline Personality Disorder and Emotion Dysregulation** 7(1): 20. DOI: 10.1186/s40479-020-00135-5.
- Brasier C, Roennfeldt H, Hamilton B, et al. 2022. Peer support work for people experiencing mental distress attending the emergency department: exploring the potential. **Emergency Medicine Australasia** 34(1): 78–84. DOI: 10.1111/1742-6723.13848.
- Braun V, Clarke V. **Thematic Analysis: A practical guide**. London: Sage.
- Butler K, Te Kīwai Rangahau. 2017. **Tūmata Kōkiritia—Shifting the Paradigm 2017**. Wellington: Te Rau Matatini. terauora.com/wp-content/uploads/2022/04/Tumata-Kokiritia-Report-2018.pdf (accessed 1 June 2023).
- Butler K, Te Kīwai Rangahau. 2019. **Mā Purapura Mai 2018 Māori Lived Experience Leadership Wānanga Report 2019**. Wellington: Te Rau Ora. terauora.com/wp-content/uploads/2022/04/Ma_Purapura_mai_Doc..pdf (accessed 1 June 2023).
- Byrne L, Roennfeldt H, Wang Y. 2019. ‘You don’t know what you don’t know’: the essential role of management exposure, understanding and commitment in peer workforce development. **International Journal of Mental Health Nursing** 28(2): 572–81. DOI: 10.1111/inm.12562.
- Byrne L, Roennfeldt H, Wolf J, et al. 2021. Effective peer employment within multidisciplinary organizations: model for best practice. **Administration and Policy in Mental Health** 49(2): 283–97. DOI: 10.1007/s10488-021-01162-2.
- Carman KL, Dardess P, Maurer M, et al. 2013. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. **Health Affairs** 32(2): 223–31. DOI: 10.1377/hlthaff.2012.1133.
- Chamberlin J. 1978. **On Our Own: Patient-controlled alternatives to the mental health system**. New York: McGraw-Hill.
- Cheesmond N, Davies K, Inder KJ. 2020. The role of the peer support worker in increasing rural mental health help-seeking. **The Australian Journal of Rural Health** 28(2): 203–8. DOI: 10.1111/ajr.12603.
- Chisholm J, Petrakis M. 2022. Perspectives about working alongside mental health peer workers in service teams. **Advances in Mental Health** 20(1): 51–63. DOI: 10.1080/18387357.2021.2020138.

- Connect Supporting Recovery, Waitematā District Health Board. 2016. **Piri Pono: Evaluation of the peer led acute alternative service**. Auckland: Connect Supporting Recovery and Waitematā District Health Board.
- Davidson L, Chinman M, Kloos B, et al. 1999. Peer support among individuals with severe mental illness: a review of the evidence. **Clinical Psychology Science and Practice** 6: 165–87.
- de Beer CRM, Nooteboom LA, van Domburgh L, et al. 2022. A systematic review exploring youth peer support for young people with mental health problems. **European Child & Adolescent Psychiatry**. DOI: 10.1007/s00787-022-02120-5.
- Edan V, Sellick K, Ainsworth S, et al. 2021. Employed but not included: the case of consumer-workers in mental health care services. **The International Journal of Human Resource Management** 32(15): 3272–301. DOI: 10.1080/09585192.2020.1863248.
- Eddie D, Hoffman K, Vilsaint C, et al. 2019. Lived experience in new models of care for substance use disorder: a systematic review of peer recovery support services and recovery coaching. **Frontiers in Psychology** 10: 1052. DOI: 10.3389/fpsyg.2019.01052.
- Fortuna KL, Solomon P, Rivera J. 2022. An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. **The Psychiatric Quarterly** 93(2): 571–86. DOI: 10.1007/s11126-022-09971-w.
- Gaiser MG, Buche JL, Wayment CC, et al. 2021. A systematic review of the roles and contributions of peer providers in the behavioral health workforce. **American Journal of Preventive Medicine** 61(4): e203–e210. DOI: 10.1016/j.amepre.2021.03.025.
- Greer A, Buxton JA, Pauly B, et al. 2021. Organizational support for frontline harm reduction and systems navigation work among workers with living and lived experience: qualitative findings from British Columbia, Canada. **Harm Reduction Journal** 18(1): 60. DOI: 10.1186/s12954-021-00507-2.
- Government Inquiry into Mental Health and Addiction. 2018. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Wellington: Government Inquiry into Mental Health and Addiction. [mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/](https://www.mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/) (accessed 19 April 2023).
- Health Information Standards Organisation, Ministry of Health. 2019. **HISO 10023.3:2017 PRIMHD Code Set Standard**. Wellington: Ministry of Health. www.tewhātuora.govt.nz/publications/hiso-10023-32017-primhd-code-set-standard (accessed 23 May 2023).

- Health Quality & Safety Commission. 2015. **Engaging with Consumers: A guide for district health boards**. Wellington: Health Quality & Safety Commission. www.hqsc.govt.nz/assets/Consumer-hub/Partners-in-Care/Publications-resources/engaging-with-consumers-3-Jul-2015.pdf (accessed 1 June 2023).
- Health Quality & Safety Commission. 2022. **Code of expectations for health entities' engagement with consumers and whānau**. Wellington: Health Quality & Safety Commission. www.hqsc.govt.nz/resources/resource-library/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/ (accessed 1 June 2023).
- Ibrahim N, Thompson D, Nixdorf R, et al. 2020. A systematic review of influences on implementation of peer support work for adults with mental health problems. **Social Psychiatry and Psychiatric Epidemiology** 55(3): 285–93. DOI: 10.1007/s00127-019-01739-1.
- Inquiry into Mental Health and Addiction. 2019. **Oranga Tāngata, Oranga Whānau: A kaupapa Māori analysis of consultation with Māori for the Government Inquiry into Mental Health and Addiction**. Wellington: Department of Internal Affairs. mentalhealth.inquiry.govt.nz/assets/Uploads/Summary-of-submissions-featuring-Maori-voice.pdf (accessed 19 May 2023).
- Johnson S, Lamb D, Marston L, et al. 2018. Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. **The Lancet** 392(10145): 409–18. DOI: 10.1016/S0140-6736(18)31470-3.
- Mancini MA. 2018. An exploration of factors that effect the implementation of peer support services in community mental health settings. **Community Mental Health Journal** 54(2): 127–37. DOI: 10.1007/s10597-017-0145-4.
- Mental Health Commission. 2004. **Our Lives in 2014: A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors**. Wellington: Mental Health Commission. www.maryohagan.com/resources/Text_Files/Our%20Lives%20in%202014.pdf (accessed 1 June 2023).
- Ministry of Health. 2020a. **He Korowai Oranga**. www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga (accessed 1 June 2023).
- Ministry of Health. 2020b. **Whakamaua: Māori Health Action Plan 2020–2025**. Wellington: Ministry of Health. www.health.govt.nz/our-work/populations/maori-health/whakamaua-maori-health-action-plan-2020-2025 (accessed 1 June 2023).

- Ministry of Health. 2021a. **Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing**. Wellington: Ministry of Health. www.health.govt.nz/publication/kia-manawanui-aotearoa-long-term-pathway-mental-wellbeing (accessed 1 June 2023).
- Ministry of Health. 2021b. **Guide to PRIMHD Activity Collection and Use (version 1.1)**. Wellington: Ministry of Health. www.health.govt.nz/system/files/documents/publications/guide_to_primhd_activity_collection_and_use_v1.1_final.pdf (accessed 23 May 2023)
- Ministry of Health. 2022a. **Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992**. Wellington: Ministry of Health. www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992 (accessed 25 May 2023).
- Ministry of Health. 2022b. **Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992**. Wellington: Ministry of Health. www.health.govt.nz/publication/human-rights-and-mental-health-compulsory-assessment-and-treatment-act-1992 (accessed 25 May 2023).
- Ministry of Health. 2022c. **Repealing and replacing the Mental Health Act**. www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/repealing-and-replacing-mental-health-act (accessed 1 June 2023).
- Ministry of Health. 2023a. **Mental health and addiction support workers pay equity settlement**. Wellington: Ministry of Health. www.tewhatauora.govt.nz/our-health-system/pay-equity-settlements/mental-health-and-addiction-support-workers-pay-equity-settlement/ (accessed 26 May 2023).
- Ministry of Health. 2023b. **Guidelines for Reducing and Eliminating Seclusion and Restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992**. Wellington: Ministry of Health. www.health.govt.nz/publication/guidelines-reducing-and-eliminating-seclusion-and-restraint-under-mental-health-compulsory (accessed 25 May 2023).
- Ministry of Health. 2023c. **Oranga Hinengaro System and Service Framework**. Wellington: Ministry of Health. www.health.govt.nz/publication/oranga-hinengaro-system-and-service-framework (accessed 19 May 2023).
- Mirbahaeddin E, Chreim S. 2022. A narrative review of factors influencing peer support role implementation in mental health systems: implications for research, policy and practice. **Administration and Policy in Mental Health** 49(4): 596-612. DOI: 10.1007/s10488-021-01186-8.

- NZ Drug Foundation. 2022. **State of the Nation 2022: Stocktake of how New Zealand is dealing with drug use and drug harm.** Wellington: NZ Drug Foundation. www.drugfoundation.org.nz/assets/uploads/2022-uploads/State-of-the-Nation-2022/State-of-the-Nation-2022-web.pdf (accessed 1 June 2023).
- O'Hagan M, McKee H, Priest R. 2009. **Consumer survivor initiatives in Ontario: building for an equitable future.** Toronto: Ontario Federation of Community Mental Health and Addiction Programmes.
- Parker S, Arnautovska U, Korman N, et al. 2023. Comparative effectiveness of integrated peer support and clinical staffing models for community-based residential mental health rehabilitation: a prospective observational study. **Community Mental Health Journal** 59(3): 459–70. DOI: 10.1007/s10597-022-01023-8.
- R Core Team. 2022. **R: A language and environment for statistical computing.** Vienna: R Foundation for Statistical Computing. www.R-project.org (accessed 30 May 2023).
- Repper J, Carter T. 2011. A review of the literature on peer support in mental health services. **Journal of Mental Health** 20(4): 392–411. DOI: 10.3109/09638237.2011.583947.
- Richard J, Rebinsky R, Suresh R, et al. 2022. Scoping review to evaluate the effects of peer support on the mental health of young adults. **BMJ Open** 12(8): e061336. DOI: 10.1136/bmjopen-2022-061336.
- Roennfeldt H, Byrne L. 2020. How much 'lived experience' is enough? Understanding mental health lived experience work from a management perspective. **Australian Health Review** 44(6): 898–903. DOI: 10.1071/AH19261.
- Russell L. 2018. **Oranga Hinengaro: Report on Māori mental wellbeing results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey.** Wellington: Health Promotion Agency/Te Hiringa Hauora. www.hpa.org.nz/sites/default/files/Final-report-TeOrangaHinengaro-M%C4%81ori-Mental-Wellbeing-Oct2018.pdf (accessed 1 June 2023).
- Scannell C. 2021. Voices of hope: substance use peer support in a system of care. **Substance Abuse: Research and Treatment** 15: 1–7. DOI: 10.1177/11782218211050360.
- Scott A. 2011. Authenticity work: mutuality and boundaries in peer support. **Society and Mental Health** 1(3): 173–84. DOI: 10.1177/2156869311431101 2011/11/01.

- Scott A, Doughty C, Kahu H. 2011. **Peer Support Practice in Aotearoa New Zealand**. Christchurch: University of Canterbury. <https://ir.canterbury.ac.nz/handle/10092/5258> (accessed 23 June 2023).
- Solomon P, Draine J. 1995. The efficacy of a consumer case management team: two year outcomes of a randomized trial. *Journal of Mental Health Administration* 22: 135–46.
- Southern District. 2022. **Background paper: Designing Peer-led Mental Health & Addiction Services for the Southern District**. New Zealand: Southern District. www.southernhealth.nz/sites/default/files/2023-02/Background%20paper%20B%20-%20Designing%20peer-led%20services.pdf (accessed 19 May 2023).
- Standards New Zealand. 2021. **Ngā Paerewa Health and Disability Services Standard**. NZS 8134:2021. www.standards.govt.nz/shop/nzs-81342021/ (accessed 2 May 2023).
- Take Notice, Te Pou. 2017. **Evaluation of Tupu Ake: A peer-led acute alternative mental health service**. Auckland: Te Pou. d2ew8vb2gktr0m.cloudfront.net/files/resources/Tupu-Ake-Evaluation-Final.pdf (accessed 1 June 2023).
- Te Hiringa Mahara. 2022a. **Nau Mai te Ao: Lived Experience Position Statement**. Wellington: Te Hiringa Mahara. www.mhwc.govt.nz/assets/Nau-Mai-te-Ao/Final-Nau-Mai-te-Ao-A2-v2 (accessed 1 June 2023).
- Te Hiringa Mahara. 2022b. **Te Tauaki ki Te Tiriti o Waitangi**. Wellington: Te Hiringa Mahara. www.mhwc.govt.nz/assets/Te-Tiriti-Position-Statement/Te-Tiriti-Doc-English.pdf (accessed 1 June 2023).
- Te Aka Matua o te Ture | Law Commission. 2022. **Ngā Huarahi Whakatau: Review of adult decision-making capacity law**. huarahi-whakatau.lawcom.govt.nz/ (accessed 1 June 2023).
- Te Pou. 2020. **Consumer, Peer Support and Lived Experience: Mental Health and Addiction Workforce Development Strategy: 2020–2025**. Auckland: Te Pou. www.tepou.co.nz/resources/consumer-peer-support-and-lived-experience-mental-health-and-addiction-workforce-development-strategy-2020-2025 (accessed 2 May 2023).
- Te Pou. 2021a. **Competencies for the Mental Health and Addiction Consumer, Peer Support and Lived Experience Workforce**. Auckland: Te Pou. www.tepou.co.nz/resources/competencies-for-the-mental-health-and-addiction-consumer-peer-support-and-lived-experience-workforce-1 (accessed 2 May 2023).

- Te Pou. 2021b. **Consumer, Peer Support and Lived Experience Workforce Development Action Plan: 2020–2025**. Auckland: Te Pou. www.tepou.co.nz/resources/consumer-peer-support-and-lived-experience-workforce-development-action-plan (accessed 2 May 2023).
- Te Pou. 2021c. **Glossary of Terms Used in the Consumer, Peer Support and Lived Experience Workforce**. Auckland: Te Pou. www.tepou.co.nz/resources/glossary-of-terms-used-in-the-consumer-peer-support-and-lived-experience-workforce (accessed 2 May 2023).
- Te Pou. 2022. **Supervision for the Consumer, Peer Support and Lived Experience Workforce**. Auckland: Te Pou. www.tepou.co.nz/resources/supervision-for-the-cpsle-workforce (accessed 25 May 2023).
- Te Pou. 2023a. **2022 Lived Experience Worker Survey: Consumer, peer support, and lived experience employees and volunteers**. Auckland: Te Pou (unpublished).
- Te Pou. 2023b. **He Arataki ki ngā Kaimahi Mātau ā-wheako: A guide to the consumer, peer support, and lived experience workforce in mental health and addiction settings**. Auckland: Te Pou. www.tepou.co.nz/resources/cpsle-guide (accessed 2 May 2023).
- Te Pou. 2023c. **NGO Workforce Development Challenges: 2022 survey of adult alcohol and drug and mental health services report**. Auckland: Te Pou. www.tepou.co.nz/resources/ngo-workforce-development-challenges-2022 (accessed 1 June 2023).
- Te Pou. 2023d. **NGO Workforce Estimates: 2022 Survey of Adult Alcohol and Drug and Mental Health Services Report**. Auckland: Te Pou. www.tepou.co.nz/resources/ngo-workforce-estimates-2022 (accessed 2 May 2023).
- Te Pou. 2023e. **Te Whatu Ora Adult Mental Health and Addiction Workforce: 2022 adult alcohol and drug and mental health services report**. Auckland: Te Pou. www.tepou.co.nz/resources/te-whatu-ora-adult-mental-health-and-addiction-workforce-2022-adult-alcohol-and-drug-and-mental-health-services-report (accessed 19 May 2023).
- Te Rau Matatini. 2015. **Hanga i te Tū o te Huringa: Making a stand for change**. Wellington: Te Rau Matatini. terauora.com/wp-content/uploads/2022/05/Making_a_stand_for_change_Doc..pdf (accessed 1 June 2023).
- Te Rau Ora. 2019a. **Employment of Māori Staff**. terauora.com/employment-of-maori-staff/ (accessed 1 June 2023).

- Te Rau Ora. 2019b. **Recruiting Māori Health Infographic 2019**. terauora.com/employment-of-maori-staff/ (accessed 1 June 2023).
- Te Rau Ora. 2023. **Workforce**. terauora.com/workforce/ (accessed 1 June 2023).
- Te Whatu Ora. 2022. **Suicide web tool** [Data File]. tewhatuora.shinyapps.io/suicide-web-tool/ (accessed 1 June 2023).
- Therneau T. 2023. **A Package for Survival Analysis in R. R package version 3.5-5**. CRAN.R-project.org/package=survival (accessed 30 May 2023).
- Therneau T, Grambsch P. 2000. **Modeling Survival Data: Extending the Cox model**. New York: Springer.
- Wall A, Lovheden T, Landgren K, et al. 2022. Experiences and challenges in the role as peer support workers in a Swedish mental health context: an interview study. **Issues in Mental Health Nursing** 43(4): 344-55. DOI: 10.1080/01612840.2021.1978596.
- Whāraurau. 2020. **Youth Consumer Advisor Guide: A resource for new YCAs**. Auckland: Whāraurau. wharaurau.org.nz/sites/default/files/2020-WWW-YCA-Guide-UpdatedLogo.pdf (accessed 23 May 2023).
- Whāraurau. 2021. **2020 Stocktake of the Infant, Child and Adolescent Mental Health / Alcohol and Other Drug Services in New Zealand**. Auckland: Whāraurau. wharaurau.org.nz/sites/default/files/pdf/Stocktake/2020%20ICAMH_AOD%20Workforce%20Stocktake%20National%20Report%202021%20Final.pdf (accessed 23 May 2023).
- Whāraurau. 2022a. **Employing a Youth Consumer Advisor (YCA)**. Auckland: Whāraurau. wharaurau.org.nz/sites/default/files/YCA_Toolkit_08-22%20UPDATED-compressed.pdf (accessed 23 May 2023).
- Whāraurau. 2022b. **Orientation for Youth Consumer Advisors**. Auckland: Whāraurau. wharaurau.org.nz/sites/default/files/YAT%20Orientation%20Template%20August%202022.pdf (accessed 23 May 2023).
- White S, Foster R, Marks J, et al. 2020. The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. **BMC Psychiatry** 20(1): 534. DOI: 10.1186/s12888-020-02923-3.
- Wickham H, Averick M, Bryan J, et al. 2019. Welcome to the tidyverse. **Journal of Open Source Software** 443: 1686. DOI: 10.21105/joss.01686.
- Wikaire E, Wikaire-Mackey K, Graham S, et al. 2022. **Nōku te Ao: Sovereignty of the Māori mind**. Wellington: Te Whatu Ora. www.hpa.org.nz/research-library/research-publications/n%C5%8Dku-te-ao-sovereignty-of-the-m%C4%81ori-mind (accessed 1 June 2023).

Appendix 1: Key terms we use in this paper

Kaimahi tāngata whaiora Māori	Māori with lived experience who work within mental health and addiction services.
Lived experience	Having personal experience of an issue or situation. It may be a person or a group that has this personal experience, and it can be current, recent, or in the past. For Te Hiringa Mahara, ‘lived experience’ relates to personal experiences of distress/mental distress, substance harm, gambling harm, psychiatric diagnosis, addiction, using mental health or addiction supports or services, or experience of barriers to accessing these support and services when someone needs them. Lived experience relates to how people self-identify and share their identity with others, so it is not our role to determine whether people have ‘lived experience’—it is each person’s decision as to how they identify.
Lived experience workforce	Designated roles within the mental health and addiction system where people use their personal or whānau and family experiences of distress, substance harm, or gambling harm to build and monitor the mental health and addiction system, services, policies, and evidence.
Peer support	Support provided by someone with their own lived experience of mental health distress and/or addiction. It is an equal relationship where two (or more) people give and receive support.
Recovery/recovery focused	‘Recovery’ may be used in the general sense of restoring previous functioning and reducing symptoms. However, in the context of peer support, ‘recovery’ or being ‘recovery focused’ relates to having the right to and the possibility of living well. The conditions and environment for this form of recovery must be actively created. Peer support facilitates

	<p>this within the recovery-orientated services of the mental health sector as a whole.</p>
Specialist services	<p>Specialist mental health and alcohol and drug services (‘specialist services’) are also known as secondary care services. They are publicly funded services provided by former district health boards or NGOs.</p> <p>Specialist services include a range of services across inpatient and community settings. Most specialist services are community based, such as adult community, rehabilitation, and alcohol and drug services.</p>
Tāngata whaiora	<p>People of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these).</p> <p>Tāngata whaiora include people who have accessed or are accessing supports and services. They also include people who want mental health or addiction support but are not accessing supports or services.</p>
Tuakana-teina	<p>A way of relating, mentoring, and supporting one another that is located in Te Ao Māori (the relationship of an older and younger sibling or between people with different levels of experience).</p>
Whānau	<p>‘Whānau’ has its whakapapa (history) and origins located in Te Ao Māori (Māori worldview). It refers specifically to blood connections that exist between generations of lineage that descend from atua Māori.</p> <p>Today ‘whānau’ is also commonly used to include people who have close relationships and/or who come together for a common purpose. Tāngata whaiora can determine who their whānau and/or kaupapa whānau are when they are seeking or receiving support.</p>

Appendix 2: PRIMHD data analysis

Table 2 presents descriptive statistics on how many teams within different types of specialist mental health and addiction services provide peer support. For those teams providing peer support, it also shows how many people received peer support and compares this with the total number of people each team type saw. These data include all active teams in the five financial years from 2017/18 to 2021/22.

Table 2: Access to peer support by team type, 2017/18 to 2021/22

Description of team type	Number of teams meeting this description	Number (and %) of teams providing peer support	Among teams that provide peer support	
			Total number of people seen	Number (and %) of people who received peer support
Alcohol and drug	370	75 (20%)	23,985	4,950 (21%)
Co-existing problems	36	7 (19%)	506	20 (4%)
Community	1,008	186 (18%)	47,397	7,080 (15%)
Early intervention	19	3 (16%)	654	117 (18%)
Eating disorder	19	0		
Forensic	51	0		
Inpatient	44	2 (5%)	83	21 (25%)
Intellectual disability	5	0		
Intellectual disability dual diagnosis	10	0		
Kaupapa Māori	2	0		
Maternal mental health	49	4 (8%)	3,480	15 (<1%)
Needs assessment and service coordination	35	4 (11%)	160	23 (14%)
Residential/accommodation	45	5 (11%)	46	26 (57%)
Specialist psychotherapy	2	0		
Specialty	71	7 (10%)	4,978	93 (2%)

We also conducted time-to-event analyses to identify the proportion of tāngata whaiora who were likely to engage with peer support at different times following referral. We limited these analyses to teams who have provided peer support so that we could calculate Kaplan-Meier curves and estimate a Cox regression model to

examine the probability of tāngata whaiora engaging in the first peer support contact from the time of first referral.

As Figure 1 indicates, the probability of tāngata whaiora gaining access to a peer support contact increases fastest immediately after referral. While the probability continues to increase in the years following referral, it does so more gradually. This may suggest that most tāngata whaiora who choose to access peer support are able to access this early in their journey. However, the continuing rise in probability of first contact suggests that some people may struggle to gain this early access or choose to access peer support later in their treatment journey.

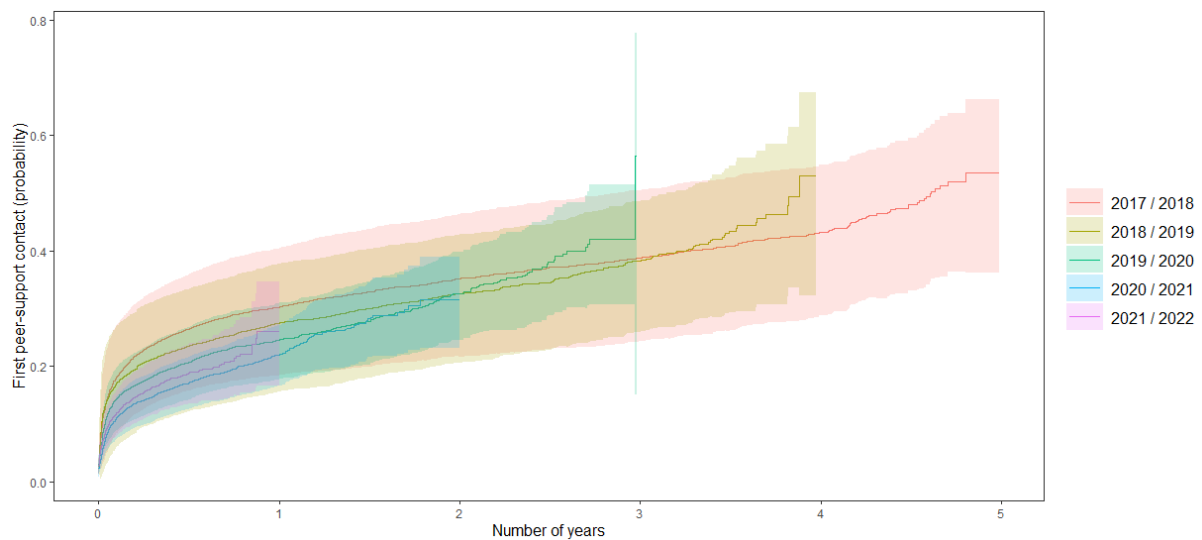


Figure 1: Kaplan-Meier curves of time to first peer support contact, 2017/18-2021/22

The Cox regression model indicates that the rate of peer support contact following first referral declined slightly across consecutive years, although this was only statistically significant for referrals made during 2020/21 relative to 2017/18 (hazards ratio = 0.65, 95 per cent confidence interval: 0.43, 0.96, $p = 0.03$). This analysis shows that, compared with referrals during 2017/18, clients referred during 2020/21 were 0.65 times as likely to receive peer support at any given point in time after referral.

Appendix 3: Methodology

Quantitative data and analysis

In our use of quantitative data, we aimed to identify how much peer support activity that services were delivering to tāngata whaiora overall as well as within different specialist mental health and addiction teams. We also wanted to identify patterns in these data over the last five years.

Data source

Te Hiringa Mahara receives extracts from the Programme for the Integration of Mental Health Data (PRIMHD) provided by Manatū Hauora. Analyses for this paper were conducted on PRIMHD data provided in November 2022.

Approach to quantitative analysis

We followed Manatū Hauora guidelines, in particular HISO 10023.3:2017 PRIMHD Code Set Standard (Health Information Standards Organisation and Ministry of Health, 2019) and the **Guide to PRIMHD Activity Collection and Use** (version 1.1) (Ministry of Health, 2021b) to obtain data on peer support activity recorded in PRIMHD. We included PRIMHD data that fell between 30 June 2017 and 1 July 2022. We excluded data related to a referral that a service declined because it considered no face-to-face contact was required or another service was more appropriate, or because it was unable to provide the requested service. We also excluded data that related to the coordination of care, non-attendance, or a contact via text messaging or written correspondence.

For the included PRIMHD data, we started by calculating (a) the proportion of all days when a service provided an activity contact that included a peer support contact and (b) the proportion of tāngata whaiora who received at least one peer support contact during a given financial year (including those who received peer support contacts across multiple years).

Second, we examined peer support contacts as a function of type of specialist mental health and addiction service team, for teams active between 30 June 2017 and 1 July 2022. This analysis included calculating the number of teams that provided at least one peer support contact. In addition, among the teams that did provide a peer support contact we calculated the proportion of tāngata whaiora who received one or more peer support contacts.

Third, among all tāngata whaiora who had contact with a team that provided peer support contact we conducted time-to-event analyses. Specifically, for teams who provide peer support, we examined the probability of people engaging in the first peer

support contact from the time of first referral by calculating Kaplan-Meier curves and estimating a Cox regression model.

We conducted our analyses in R 4.2.1 (R Core Team, 2022) using the tidyverse (Wickham et al, 2019) and survival packages (Therneau, 2023; Therneau and Grambsch, 2000).

Literature review

We conducted the literature review with support from Knowledge Services at Manatū Hauora. We began by meeting the senior reference librarian at Manatū Hauora to plan the approach and scope for the literature review. The senior reference librarian then searched for and sourced the literature. Finally, Te Hiringa Mahara reviewed the search results to decide which studies to include, analysed the chosen literature, and reported its findings.

Approach to literature review

The purpose of the literature review was to understand the current body of knowledge by taking a systematic approach to collecting and synthesising previous research and documents published in peer-reviewed journals and the grey literature available on the internet. We asked the following key questions for the literature review.

1. What does the peer support workforce, including peer support in Māori culture, look like in Aotearoa?
2. What are the benefits of peer support roles in the mental health and/or addiction workforce, and what evidence shows they are effective?
3. What are the key considerations, barriers, and enablers for successfully delivering peer support and developing a peer support workforce?

Search strategy

In March 2023, the Manatū Hauora senior reference librarian conducted the following searches using academic databases (Medline, PsychInfo, Scopus, Cochrane, Research NZ, and Index New Zealand) in addition to an internet search. They prioritised Aotearoa-based research conducted within the last 15 years, while also including international literature published within the last 5 years.

Terms and searches for the Aotearoa literature

1. (peer adj3 (worker* or workforce)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]

2. (“lived experience” adj3 (worker or workforce)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
3. (peer adj3 provider*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
4. (peer adj3 specialist*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
5. ((“mental health” adj3 consumer*) and (worker or workforce or advisor*)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
6. ((“mental health” adj3 survivor*) and (worker* or workforce)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
7. (peer* adj3 (counsellor* or led)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
8. 1 or 2 or 3 or 4 or 5 or 6 or 7 (
9. (zealand or māori or aotearoa or iwi or Kaumatua or Rangatahi or pakeke or tamariki).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier,

synonyms, population supplementary concept word, anatomy supplementary concept word]

10. 8 and 9

Terms and searches for the international literature:

- 1 (peer adj3 (worker* or workforce)).mp.
- 2 (“lived experience” adj3 (worker or workforce)).mp.
- 3 (peer adj3 provider*).mp.
- 4 (peer adj3 specialist*).mp.
- 5 (“mental health” adj3 consumer*) and (worker or workforce or advisor*).mp.
- 6 (“mental health” adj3 survivor*) and (worker* or workforce)).mp.
- 7 1 or 2 or 3 or 4 or 5 or 6
- 11 limit 7 to (english language and yr=“2018 -Current”)

Search results

The literature search identified a total of 151 results in the following categories.

	Grey literature	Journal literature
Aotearoa	14	6
International	15	116

All grey literature was sourced, and reviewed the abstracts of the journal literature to identify which articles we should include and source the full text for. We excluded literature if it was not relevant to answering our key questions or focused on a context that does not apply to Aotearoa (e.g., impact of health insurance legislation in the United States of America on the peer support workforce), or if its findings duplicated or were superseded by another article within the search results.

Our initial selection for the literature review included 82 articles. However, we could not source the full texts of 5 international journal articles, so our final selection 77 articles consisted of the following.

	Grey literature	Journal literature
Aotearoa	14	4
International	15	44

Qualitative data and analysis

When we started this paper, our intention was to investigate whether the changes people envisaged to the specialist mental health and addiction workforces (including in NGO services) had occurred. We set out to hold focus groups with people with lived

experience, including tāngata whaiora Māori, and whānau and family, to hear their views on this and what else they think needs to happen.

However, when we began analysing what we heard during our focus groups, we found that people mainly discussed the CPSLE workforce. This was likely because most people who responded to our invitation to participate in focus groups were a part of the CPSLE workforce rather than ‘grassroots’ people with lived experience. For this reason, the scope of this paper shifted to focus on the CPSLE workforce, with a particular emphasis on those working in secondary services.

Recruiting people to focus groups

We emailed everyone in our lived experience database,²² inviting them to participate in a focus group to share their views on specialist mental health and addiction workforces. The email contained information about the scope of the focus group and who we were particularly interested in hearing from, including: people who have personal experience of distress or addiction; whānau and family members of people with personal experience of distress and addiction; people who were involved in advocating from a lived experience perspective in He Ara Oranga and can reflect on any changes made since the inquiry; and advocates, advisors, or leaders who know about the mental health and addiction workforce and how workforce issues or changes might be impacting peers / tāngata whaiora.

Where people expressed an interest in participating, we asked them to choose whether they would like to participate in a lived experience focus group, a whānau and family focus group, or a Māori focus group that would be facilitated by Māori staff. We also asked people to forward the invitation on to their networks so that we could reach people we hadn’t connected with before.

Collecting the voices of tāngata whaiora, family, and whānau

Focus groups

We held five focus groups via Microsoft Teams, which consisted of:

- three lived experience focus groups attended by six, seven, and seven people respectively. Many people attending these focus groups work within the mental health and addiction sector, including in CPSLE roles.
- one whānau and family focus group attended by four people, three of whom were Māori.

²² The lived experience database consists of 250 people who have lived experience of distress, alcohol or other drug harm, gambling harm, or addiction. Some people in this database also work within the mental health and addiction sector in various roles, including within the CPSLE workforce across the motu.

- one Māori focus group, consisting of both tāngata whaiora and whānau, attended by 16 people. Many people attending this focus group also work within the mental health and addiction sector, including in CPSLE roles.

Two people, one of whom was a lived experience advisor, facilitated each focus group.

Online form

We sent a link to an online form to people who couldn't attend a focus group, but still wanted to share their thoughts with us, as well as people who had registered for a focus group but were unable to attend. For consistency, the questions in the online form were the same as those asked during the focus group. In total, we received eight online form submissions. Five respondents identified as Māori. Some people who submitted via the online form work within the mental health and addiction sector, including in CPSLE roles.

Focus group questions

We asked the following two questions, which we sent to participants in advance.

1. What workforce changes have you seen since He Ara Oranga was released in 2018?
2. What workforce changes do you think still need to happen?

How we made sense of what people said

We took a team-based approach to qualitative analysis. Team members included people with Te Ao Māori perspectives, lived experience perspectives, and qualitative research experience.

We analysed data from the focus groups²³ and the online forms using a reflexive thematic analysis approach. Reflexive thematic analysis offered flexible guidelines, rather than a set of rules, to follow and provided us with a rigorous approach to organise what people had shared in the focus groups into the key themes identified in this paper.

To make sense of our data, we individually familiarised ourselves with the focus group discussions by watching and listening to the recordings before coding²⁴ extracts in transcripts relevant to the paper's scope. In multiple team sessions, we combined our coded data and then sorted these into groups by searching for patterns of meaning. Together, we also generated initial themes that were shared across the three focus groups and these themes were refined in our writing process.

²³ By 'data', we are referring to the recordings of each focus group and their associated transcripts. Each focus group was recorded with the consent of every participant.

²⁴ By 'codes', we are referring to labels consisting of a couple of words or short phrases that described what a particular passage or sentence was about.

Incorporating previous lived experience engagement

In early 2022, we began work on a separate lived experience workforce insights paper. For that paper, we intended to investigate the value of the lived experience workforce, the current realities of the workforce, and the barriers to this expansion. We held interviews and focus groups with people with lived experience who have an understanding of the peer workforce, including people who have used services and/or service providers.

However, with the shift in focus from the specialist workforce more broadly to the CPSLE workforce, we decided to combine both papers because they were so similar. In doing so, we have incorporated quotes throughout this paper that were from the focus groups and interviews for the previous lived experience workforce insights paper. Our purpose is to use those earlier insights to support the themes from the reflexive thematic analysis process of the qualitative data from the more recent focus groups, which focused on the changes to the specialist workforce since He Ara Oranga. We have identified these quotes as 'previous lived experience engagement'.

