I talked earlier about the fact that a couple of people went and saw the Phoenix services and thought 'that would be great' and we began oaths amazing journey, but there's another context that we haven't talked about bad i think is probably useful to talk about - and it goes something like this; that six or seven years ago , where i worked in counties Manakau there were real problems for us and our whole system. And the problem was we seemed to have gotten into this terrible cycle where people were getting sick, they were getting into hospital beds, they were unable to move out because of a lack of other social supports - and because they stayed unwell and didn't get better real quickly, and it seemed like we needed more beds but when we really looked at this whole system it wasn't the bed numbers that was the problem. It felt like it but actually our system had become kind of a crisis management system with only the people who are really really unwell ever getting access to service. The whole system had backed up so that people couldn't get into hospital, people in the community were running around looking after people who were really sick, so all of the things we knew we needed to be doing which was getting in early, good relationships, good recovery orientation were kind of failing. And what was worse.. although people felt they were working really hard - really well - with clients, with the best intentions, and out multidisciplinary teams were working their hardest to get things working, there were quit a reasonable number of people who just didn't seem to be doing what they were told to do! So as soon as they were no longer compelled to do things they would become unwell again - take control of their own lives in a way that didn't seem to comply with what people we thought people should be doing. So we had this kind of vicious cycle of a system that was overloaded, of people getting unwell, of a bunch of people, not all of them by any means, but a bunch of people whose lives were really badly affected by their illness who just didn't seem to want to do what they needed to do. So that was kind of the conundrum for us, and a lot of our innovations in Counties were about put in place options and alternatives that would unplug the system, so social supports, alternatives, and that would inspire people who want to recover - create possibilities - social inclusion possibilities and possibilities in the community. This initiative was also geared at helping people remember they could recover - helping to stop that battle over 'this is what we tell you to do' and 'it's not what i want to do' and start to recognise that people do need to have a say and actually if people don't have a hope for the future why would they want to drive their own recovery? If they don't think that it's going to take them anywhere? So that whole notion we needed to inject; hope, a

future, dreams, aspirations, and build up the will amongst people so that they could drive their recovery themselves and so it was a part of solving the complex problems within the system - although i don't ink we've enunciated it in that way, a part of it was really about inspiring people and enabling them to step up and take control and certainly our system now manages on fewer acute beds than most parts of New Zealand - and this has been one of the innovations that's made that possible, and i believe it's helping with that issue of tension between service user and provider.

You've told us a lot about how successful and positive, subject to the evaluation, but presumably there were a lot of challenges along the way?

there were… there were… it would be good to talk abut them, and it's easy when there's something that seems as successful and great as this, and it does, you know, you've had people come and visit our services and of all the innovations we've done it's probably the one that does that - you just meet and talk with people in these roles and you kind of know intuitively it's something a bit bigger - it's going to get it's own momentum up. And it's easy to forget it's hard - it's hard work and everybody's had to work at making this a success. For me some of the most important learning was, we started here with the peers in the multidisciplinary team but if you notice we've trained i think in the order of one-twenty one-thirty people now, and fifty or so are in employment. We had nothing else to bring forward, very considerable talents and expertise in those who haven't yet gained employment, or to provide alternatives to this kind of recovery coaching that it would also help develop people's capacity to recover.

Clearly introducing new specialist into this field, coming from a different background may raise some concerns by more traditional people working in the service about 'how do you actually know that this is ok… how do you know that this is actually not raising any issues that are going to be difficult to deal with for the person using the service?'

I guess something I haven't talked about is the whole structure for this - again there are others more equipped to talk about it than i am, but i do know around not only do the people who come and work in these

services have the training we talked about but once they're employed they're also a part of the same structure as the rest of the team members - so they have accountability, they have some line accountability to their team member. They also have a professional leader now I mentioned before who has some overall responsibility for development and development of the role but also the individuals in the roles. each one of them also has supervision; so one to one supervision and some group supervision which is really important to the whole concept of staying peer and the way in which they operate. Then because they're a part of the multidisciplinary team meeting, they're also a part of the collaborative meetings around people and their recovery journey, around the service users so there are quitte a number of checks around that and the day to day operation of the service, they're subject to the same kind of employment conditions that any other team member would be. I guess those meetings will identify if there are any concerns about this making things worse rather than better and all indications at the moment are that our professionals, our other team embers are saying they're seeing other people's recoveries speeded up by contact with peer support specialists. And the way that they're trained is really to enable that. Really to enable the recovery journey to speed up, and people are seeing that, people are seeing service users exceed expectations in terms of what they can achieve and what happens with their lives - but none of this has yet been formally evaluated - so to come to your other question, in terms of the evaluation we are kind of excited about how we're going to evaluate this.

We've got two separate evaluations, one is for the peer support specialists in the multidisciplinary teams - we've got an independent evaluator and that's just been framed up now - the questions that we're asking are essentially the original assumptions we had about this; how does it works in terms of the peers who are in the roles, how's it working for them; how's it working for the people who use those services; and how's it working in terms of the system and the other professionals involved in it. So we'll be looking at both qualitative and quantitative data. we'll be analysing that quite comprehensively to get a bit of an answer to what's working and what's not.
In terms of the alternative to in-patient admission which is called 'tupowake' - that service will be evaluated and it's posed a bit of a challenge to us because as we're starting to design how we wanted to evaluate that service; again in similar terms what's it doing for the health of people what's it doing for the peers in the service, how's it seen by the

system. we also want to know what's it's impact on the wider acute care system. So we've had to start work developing a kind of framework that describes that really interconnected system of acute care that… where everything affects everything else. Your home based treatment, crisis services, in-patient services, respite services so that interconnectedness, making a change in the system may have flow on effects outside of those on the individuals using it. So we're trying to create a way of evaluating this that will look at all of the bits that we've talked about before in terms of the impact on the actual people directly involved, but also the 'flow on' impacts; do we have more available beds in our acute in-patient unit as a result of this.. you know all of that.. that's a very small example but all of the ways that impacts not only on those involved but on the wider system.

So that's actually capturing how it impacts on individuals, how these new services operate, but as importantly, what impact this will have across the system.

From my perspective I would have done it differently, if I was starting all over again. So I would have put in place more initiatives to develop up peer ability to recover in addition to the peer supper specialists, so what i'm meaning is that what we saw in recovery innovations was not just peer support or recovery coaching roles - we also saw educational initiatives that provided tools for people to manage their own well being. For example classes around wellness recovery action planning, classes around getting and keeping housing, employment, classes round, i think they've got one called 'medication for success' , or managing the relationship with your doctor; those sorts of wellness classes that are more about how you behave and do things and control your own life - not about what your diagnosis is or what your treatment should be. That's left, still, to the multidisciplinary team and XXX education.
So classes about well being, classes about wellness and living and other classes and opportunities for people to deliver these classes. So you could not just be a peer support specialist which is quite a high level role - there were sort of some starter roles - things that might engage with people around activities in the community; classes like the ones i've talked about , all delivered by peers, so that's just a much wider range of roles for people but also a wider range of choices for people who might want to build their own ability, to manage their own recovery. So… if i was doing it all over again I think maybe i would have started with that at the same time as beginning to build the peer workforce - that was one of

the pitfalls from my perspective - that there were those one hundred and twenty-odd trained people, but very much fewer in work and all of these would have created opportunities that would continue either the learning experience for those people of provide them with other options in terms of employment and ability to deliver support to other service users. So I would have done that.
Other things; i think probably we needed to have some peers be prepared … we would have probably need to be more prepared to do the developments, prepare the team, once we had some peer support specialists employed. We tried to do that work before they'd been trained or employed and actually we were in the dark - the way we were working with the team to get them to have these new team members was kind of in the absence of really understanding the role ourselves and the best people to have done that dialogue would have been people who knew the role, that had just done the training. So in fact this really took off once the peers came into working. what we'd done was done some ground work with the teams and then they started to take that as 'gospel'   … 'this is the way it should be' and of course when the peers came into their roles it wasn't the way it should be and it needed to change and it took us quite awhile to recognise that theory were being constrained by ideas that my team had, ideas that we'd all had about how this should work in the absence of really understanding it so I think having trained people earlier and engaged them right from the start in the design of this .. i would definitely have done that.
So… a range of different things that i would have worked on .. the other thing i don't know.. i don't know. This is a bit of a conundrum because getting a joined up view of what recovery is or what a recovery oriented organisation is is very very difficult and the peers play a major role in our .. defining that for ourselves and they're kind of influencing our organisational development if you like. I kind of think we might have needed some more work around that - well I know we needed some more work around that before we introduced peers to this setting but it's a bit of a catch-22 because introducing them is actually changing the way we think about that and we might well have defined things in a less than useful way if we'd done more work on that before peers came into the role.

In a way it's that close link with a recovery based organisation, but what you're describing is a change that's come about because you've changed something in the system by introducing peer support specialists.

One thing we haven't touched on yet is how do you actually set about recruiting people into that role ?

We haven't talked about the fact that there are other peer roles also other non government organisations have themselves seen this as a good thing and started converting support worker roles or whatever into peer roles, quite reasonably, and so there are actually peers in non-specifically funded roles now. Just because it's taking off people are seeing the powerful effect of this relationship in terms of a person's recovery and saying 'well why couldn't we have peers in lt. of the .. particularly the support roles that we historically have had non-peers in and trained people just from the community.

So it's a really good question about how do we set this up? One of the underpinning premises that we had was they should be team members like any other - so within the district health board services and multidisciplinary teams it's the same as any recruitment. It's advertised, people get to apply, get to submit their CVs, and they have an interview and they're selected in that way. All of the same HR policies and procedures apply to peers as would to any other team member. I think our services would say they had to think a little bit more carefully about their policies and procedures as a part of putting peers in the workforce and on reflection i've heard them say this is probably because those were not good for anyone and this just made them improve those procedures. The issues were as relevant for all of our workers as they were for peers; there really aren't a lot of different issues so they did do some work revising and looking at policies and procedures, but for the whole team not specifically for this sub-group of workers.

Any last point, messages; I mean you've given us a model there of some very exciting things and i know you've emphasised that it's still to be evaluated, but we know people in England, and indeed in Scotland, have had training from colleagues in Arizona - they'll be keen to get XXXX any last points and messages you'd like to give?

Yeas i think one thing we haven't talked about is that this is kind of contentious and the reason it's kind of contentious is that there's pretty much universal agreement (we're not the only place that's doing peer support in some way or other) - There's pretty much agreement about the core elements of what works in peer support - these kind of

relationships that are enabling and empowering for service users and some of the key concepts we've talked about….. there is not agreement about what is the best way to introduce this for service users in a particular system. So we've had quite a lot of conversations with peer leaders in our country and there's been quite a lot of debate amongst them, there's been a commissioned paper done, around what's the best way to do these services, and as I say there's universal agreement about the core elements that make peer support pretty successful; there's disagreement about where they should be located.

A lot of the service leader leadership in our country feel pretty passionately that peers hould be employed in separate peer-run services and that having this as a part of a multidisciplinary team kind of taints the role and in some ways it's not possible to retain the role in its true form in the way that it should be.
I think they're good concerns - they were certainly concerns I had when we set out - and role identity has been one of the big issues and lots of work and training and supervision and refresher courses around 'staying peer' have been needed - it's another one of those questions about 'what have been the pitfalls' - we needed to do a lot of work around that. The catch is, keeping people separate means you don't have that transformative, in my opinion, you've got a bit of distance so you've got the teams less caught up in the changes and less challenged perhaps by that. And also there's a real risk of a bit of 'tug of war' really because the approaches are quite different - the approach to helping with an illness and the approach to building a person's capability - there's a natural tension between them - it can be resolved - it's about honouring people's own expertise and providing them with the tools they need to manage their own recovery, so there's a resolution there that's really healthy. I've seen the separate services turn into a bit of a tug of war, that's very uncomfortable for the service user - different approaches, different ideas , so that joined up partnership becomes more difficult from outside the team. So I don't think there's a 'right' and 'wrong' I think that these are both viable options - each of them's going to have to address a different issue; one of them's going to have to address working in partnership, not creating this tension for the service user, the other's going to have to address keeping the role and preserving the role and not getting caught up in a different view of the world, so they're both possible.

So from my perspective I think what we've done is a good example of

using peer support and a good example of the way you really can do this, and you can do it in partnership with established services - ours were not a lot different from many of the services around the world - they just had the will.
So you can do it, it's a real example of that; it's not *the* way, i think we're still evolving and learning, we're looking to our evaluation to tell us what's working, what's not, how we will change it. we may one day decide 'yep - we want to make this completely different', we might turn it on its head, we might separate the services, in fact right now we're also working on building a peer run organisation just to deliver some of the peer services or to help partner-up with an education provider for some of the new things that we're talking about - we've got Phoenix, we've got recovery innovations to help us with. So, we are setting up a peer organisation and this will deliver some of our services; who knows what will happen in the future … at the moment it's looking like we'll keep going with what we're doing but we haven't evaluated it so i guess my closing message would be to say ' I think this is exciting, I think the notions of peer support are going to transform the way services work and transform the way people engage with their own recovery and their own lives across the world, i'm pretty sure of it; but there isn't a 'right' and a 'wrong' way ; I think the concept's really sound and I think that it's a really good innovation to be a part of; but don't listen to this podcast and decide that there's only one way to do things, that's absolutely not the message.

Sue, thank you very much, I look forward to working with you in future and learning from your experience and hopefully building on that for what we do in England, thanks a lot.

We'll look forward to learning from the things that other people try in other parts of the world

Thanks

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