Feedback and Responses

Consultation on the model of care for peer-governed services

In November 2022 eight workshops were held across the Southern district to discuss developing peer-governed services.

A draft model of care for peer-governed services was then developed based on feedback from the workshops, as well as a literature review and background papers.

The draft model of care was released to the sector on 6 December 2022. Feedback was requested by 16 January 2023.

This document represents the feedback received on the draft model of care and our responses to it. Written feedback was received from 11 people. One organisational submission was received, representing a team of people. One phone call was received. Oral feedback from the Dunedin co-design workshop on 12 December (attended by 24 people), and two co-design workshops in Invercargill on 9 February (attended by 41 people) has also been included.

All written feedback has been included, except for:

- 2 comments relating to grammar/typos, which have been corrected.
- part of one submission, which was treated as a complaint about a service.

Feedback has not been edited, except for one piece of feedback that included a personal comment.

The model of care for peer-governed services needs to be a high-level document that provides guidance on what type of services we need, and how they need to work. Some feedback was too detailed to include in a high-level model of care, or related to how the model of care should be implemented. We have decided to produce *Guidelines on Implementing the Southern Peer-Governed Services Model of Care*, to utilise some

of this feedback and provide some further guidance to peer-governed services. Other feedback around implementation has been included in the workshop notes from the co-design workshops, which have been made publicly available.

Thank you to everyone who has contributed their thoughts and expertise to help to develop the model of care for peer-governed services.

The feedback	Our response
What do you think about the values and principles?	
Self-determination: right to define oneself. For example, within, or outside of, the mental health lexicon and diagnostic frameworks	*"I have the right to define myself"* has been added to the self-determination principle.
Mutuality: 'co-create' new ways…	*"Co-create new ways of seeing, thinking and doing"* has been added to the mutuality principle.
Accessibility: include awareness of services, i.e., 'I am aware of and able to access…' ○ Also, choice in the services and supports that I access ○ Anticipate barriers; note commonly experienced barriers and build in systems/policy to address these	*Choice of services and supports* is already included under the self-determination principle. *Anticipating barriers and building in systems and policies to address these* will be added to the Guidelines to Implement the Model of Care.
Hope and wellbeing: ability to address and counter unhelpful and stigmatizing narratives	This will be added to the Guidelines to Implement the Model of Care.
Holistic: links to rights upheld and respected – being treated as a whole human being is our right	We consider that the existing principles adequately cover this *("My rights are upheld and respected" and "I am treated as a whole person".)*

Include whānau in the **holistic** value.	Agreed.
Supported decision-making: flexibility to review, adjust pathway, change one's mind	This will be added to the Guidelines to Implement the Model of Care.
Mana-enhancing: respecting and valuing the lived experience of extreme states, what peers with this shared lived experience can offer one another. Choice to access peer workers who have similarity in lived experience as well as age and developmental stage	We consider that respecting and valuing lived experience is adequately covered under the experiential knowledge principle. We have added respecting *the diversity* of lived experience to the objectives. We have strengthened content in the workforce section about recruiting a diverse workforce so people can access peer support workers of different ages and experiences.
Regarding the value about **equity for Māori,** someone at a codesign workshop said that the value should not include "I have the right to be Māori". They felt that this didn't need to be said, and that it excludes people from other cultures.	The following is taken directly from the prinicples of Te Tiriti o Waitangi, the priniciple of *Tino rangatiratanga.* Tino Rangatiratanga provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services. Key questions that follow are – • Whose worldview is privelegd in the present mental health system? • Māori self determination and mana motuhake speak to the desire of Māori to be Māori. How is this

	reflected in the development of the project, programme, policy or service?
Are there other values or principles that could be included?	
Consider the values and principles to extend to the CPSLE workers themselves. Peer workers can often experience barriers to participation, particularly in non-peer services. For example, limited trust in the value and expertise of experiential knowledge can lead to PSWs having limited access to consumers and exclusion from clinical matters or multidisciplinary teams. CPSLE workers need a solid base upon which to justify and affirm their place within services. Also consider added complexity of CPSLE workers also accessing tertiary MH services themselves; anticipate negotiating and communicating with community teams around this **Values and principles could also extend to the service itself.** For example, upholding mutuality could give scope for service-wide co-design integrated with feedback processes	We have added content clarifying that the values and principles extend to CPSLE staff and peer-governed organisations.
Consider accessibility as a community-wide issue; utilize the CPSLE network to report and track the changing needs and landscape of various local communities	While this is an important issue, we consider it beyond the scope of peer-governed organisations or the CPSLE network..
Awareness of intersectionality and power differentials. Acknowledge, address, and respond to impacts of coercive treatment. Educate clinicians on possible antecedents of coercive treatment, for example poor communication, risk aversive practice/low tolerance for risk; promote and enable self-management	We will add content on intersectionality to the Guidelines to Implement the Model of Care, under the accessibility principle. The Model of Care mentions having CPSLE Educator roles. Educators would be expected to reflect CPSLE values, and could cover the suggested topics.

Values and principles not relevant to all roles. We felt that the application of the values and principles might not be relevant to some of the types of peer services outlined in your list of services so there needs to be some flexibility in the recognition of this and in the definition (e.g. one of the values says about 'my peer support worker will,' This wouldn't apply if it was an educator or peer support group provider.)	The "I" and "my" statements are only intended to provide examples to help people to understand how the value/principle might apply in practice. They do not cover every way that the value or principle could be applied.
Objectives	
'enable transformational change' – include a focus on innovation; the ability to consistently and flexibly respond to changing needs and landscape of local communities	We have added a new objective about innovation.
'recognize trauma' – this could encompass more, i.e., impacts of stigma and discrimination, also acknowledging impacts of socio-political determinants of distress, including housing, cost of living, climate crisis (particularly for young people). Actively build traction and support for policy that addresses these issues	These issues are relevant to multiple objectives. Peer-governed services need to be aware of the impact of these issues on peers, and actively supporting policy to address them could be within the scope of CPSLE systemic advocacy roles. To be added to the Guidelines on Implementing the Model of Care. We have added a new objective about working in ways that address the wider determinants of health.
'**value lived experience'** – acknowledge diversity of lived experience, including of racism, coercive treatment, discrimination, violence – gives rise of a lived knowledge of power imbalance. Consider lived experience through an intersectional lens	"To value the diversity of lived experience" added to the lived experience objective.
'value lived experience' – raise profile of lived experience within the national discourse, including safe media and social media guidelines	To be added to the Guidelines on Implementing the Model of Care.

'work together with other services' – strong relationship with Te Whatu Ora	We consider that strong relationships across all organisations are important, so we have decided not to specifically name Te Whatu Ora.
'pae ora as whanau' – centre rights of children and young people	We have added a new objective about the rights of children and young people.
The document clearly recognizes the need for **working with whanau** and recognizes the value of relationships in the values and principle, but maybe we can enhance positive ways of utilising whanau resources ,without infringing on the rights of our consumers by having some clear objectives around family engagement. For example, we could add as an objective : To provide a service that can form a collaborative partnership with our whanau should we wish so (or to provide a service that can utilize whanau resources in a meaningful and positive way that is recovery enhancing ?	Further guidance on working with whānau will be included in the Guidelines on Implementing the Model of Care.
Another objective could be: **To provide a safe space for our whanau to support us** .. I believe there is value in having clear objectives of whanau engagement, and probably they can be worded better then I have done. Psychological research consistently reveals that fostering connectedness decreases distress and facilitates recovery and sense of wellbeing. And, if we want to work equitably with tangata whai ora Māori and Pacifica , we need a service that can provide whanau inclusive practice. I think you have reflected that in the peer support journey, I believe we could add it as an objective.	The model of care includes strengthening relationships with whānau as a value and principle - *"Relationship-building, whānau-enhancing" – I am supported to build and strengthen relationships with my whānau and community, if I would like to. I am empowered to explore whānau as directed by me.".*
Current objective - To provide safe spaces for us to **share ourselves,** and our journey. Proposed objective - To provide safe spaces for us to be ourselves and share our	The language of "share ourselves" was chosen to reflect the core peer values of mutuality and reciprocity.

journey. Commentary - Being ourselves was seen as a more tangible objective than sharing ourselves	Sharing ourselves is an integral part of peer support, and what makes peer support different from most other types of support.
Current objective - To provide **opportunities for connection,** so we can know that. we are not alone. Proposed objective - To strengthen connection at an individual, whanau, community and environmental level. Commentary - We felt this language was too assumptive/personal for an objective	We purposely used language in this document that we felt peers would connect to.
Current objective - To enhance the **aspirations of mauri ora** for all whānau – to live with good health and wellbeing. Proposed objective - To advance the aspirations of mauri ora for all whānau – to live with good health and wellbeing. Commentary - We felt advance we a clearer objective and talked to our role better.	This particluar point is based on Māori worldview; to **enhance** is acknowledgement of the **person/tangta whaiora/whānau** possessing the neccessary skills, knowledge and mana to aspire to live with good health and wellbeing. As outlined in the commentary; To **advance** is the role of the **peer support practitioner/provider** to support the aspirations of the **person/tangata whaiora/whānau** to grow/develop/gain the neccessary skills, knowledge to aspire to live with good health and wellbeing. Two distinct views and acknowledgement of mana/power/authority
Current objective - **To work together with other services and supports**, as one system	The current objective is part of the Te Hurihanga Time for Change vision, which our project needs to

Proposed objective - To foster effective mutual relationships with other service providers and health systems that support improved health outcomes for communities and peer service users Commentary - We wanted a more descriptive objective that would not just 'work together' but talked to the reason for this and the desired approach/scope.	contribute to. We will provide further guidance in the Guidelines on Implementing the Model of Care.
Would also like to see comment about **having relationships with other stakeholders in the system** it is in the objectives but think needs to be strengthened.	
Current objective - To **recognise trauma**, and be trauma-responsive services. Proposed objective - No alternative given – this needs further definition in the context of the scope of peer service provision Commentary - We felt this was more of a clinical service and wasn't relevant to some peer services e.g. education, and needed more support/definition as it might be outside of our realistic scope of service.	We agree that further definition is required. All types of services can be trauma-responsive. We will provide further guidance in the Guidelines on Implementing the Model of Care.
Current objective - To **enable transformative change** through the power of lived experience and peer support. Proposed objective - To enable transformative change through leveraging the power of lived experience and peer support. Commentary - This was a really powerful objective that we felt was almost the overarching goal -and have proposed the addition of the word leveraging/utilising	We agree this is a powerful objective. We have not added the additional term "leveraging" or "utilising" because we feel it could give the impression that the power is one step removed from the person with lived experience.
At a workshop it was noted that the draft model of care does not discuss a **lifecourse approach** It was then suggested that the model of care should support people across the continuum of life from young people to the end of life.	We have added an objective about taking a lifecourse approach.

The concept of **safety** is important and should be included.	Safety of the workforce is covered by the health and safety requirements on peer-governed services (under the standards, and employment legislation). Safe practice is also ensured thorugh peer supervision, cultural safety training and hauora (wellbeing) plans.
Does this document focus enough on supporting Māori to access peer-governed services that are culturally appropriate?	
As we are not a Māori led organisation, we don't feel in a position to answer this question.	Noted.
Did you mean to include a comma between Māori and tāngata whaiora in "How peer-governed organisations must commit to delivering equitable services and outcomes for **Māori tāngata whaiora and whanau".** Otherwise it reads as only Māori tāngata whaiora which I don't think is the intent.	This sentence reflects our committment to health equity and improving outcomes for Māori tāngata whaiora. The wording is intentional.
I think it does however there may need to be some **dedicated resources** and support to facilitate culturally safe and competent services.	Training to support cultural competence/confidence is an action in the CPSLE Workforce Development Action Plan.
Enable CPSLE Maori/Pasifika to connect with other Maori/Pasifika working within services; from admin to clinical to pastoral	We will require the new CPSLE network to promote connections between Māori and Pasifika staff.
Encourage **networks specifically for Maori/Pasifika.**	As above.
Address racism and provide learning opportunities for staff who may not have had much connection to tikanga Maori; ensure cultural training for all staff is genuine and not a 'tick-box' exercise.	Under the model of care Peer-governed Organisations are required to provide training to support staff to be culturally safe/confident.

Equity section	
Equity section: We felt that there was not enough of a **broad equity lens** to recognise the challenges faced by culturally diverse communities who are not Māori who we know experience significant barriers engaging with mental health services and peer support. The current section on equity just speaks to mainly Māori and Pasifika populations yet we know locally our diverse migrant populations are more likely to experience poor mental health than other parts of the community (QLDC Quality of life survey) and are less likely to seek clinical support so its important our peer services consider their barriers when designing services.	Agreed. A new diversity section has been added to reflect the needs of a range of cultural groups and tāngata whaikaha (disabled people).
We also felt that for non-Māori organisations the **expectations regarding equity and prioritising support for Māori might be hard to authentically implement** especially if you are a small non-Māori organisation on limited resource, in particular the following requirements: - Recognise and value Mātauranga Māori and engage in tikanga protocols and practices where appropriate. - Support staff to provide manaakitanga, karakia, mihi whakatau, pepeha and waiata. So rather than an expectation this could be more of a recommendation to ensure cultural competency is embedded in your organisation and provide examples of the guideline in practice, allowing for what is achievable within smaller resourced organisations?	We understand that some peer organisations are developing organisations and may not meet all aspects of the model of care immediately. However we consider that even small organisations could meet the requirements in the model of care, over time. Alongside the model of care work we are also progressing our Workforce Development Action Plan, which recognises the need to support the CPSLE workforce to develop cultural confidence.
Does the model of care provide enough guidance to peer-governed organisations for them to understand how they'll be required to work?	
Clear peer support practice – workforce development opportunities made available	Workforce development opportunities will be made available through the implementation of the Workforce Development Action Plan.

Clear peer support practice – At two workshops people suggested that a tau iwi peer support model will not work for Māori, it needs to be tuakana-teina. It can't be Intentional Peer Support.	We have included mention of the tuakana-teina model, as a possible peer support practice, alongside the example of Intentional Peer Support. Other approaches may also be used.
Network – address workplace isolation for peer workers; ensure not working alone	We will be implementing a CPSLE network which will reduce isolation of peer workers.
Recruitment – pathways for volunteer peer workers to move to paid opportunities	Supporting volunteer peer workers to move to paid opportunities has been added to the recruitment section.
'Priority population groups' – those with LE of MHA/coercive treatment	This feedback relates to training about priority population groups. We will add people with experience of the Mental Health Act.
Support – **external peer supervision.** Choice between group and individual supervision	The current wording leaves organisations open to chosing either group or individual supervision.
Support to negotiate peer role whilst engaging with tertiary MH services	It can be difficult to navigate using services while working in a CPSLE role. The Model of Care states that staff wellbeing will be a priority for all organisations. We have added new content about promoting staff wellbeing.
Requirement to be peer-governed We wish to comment on the requirement that "Peer-governed" means that at least half of the governance members of the organisation (trustees/board members) will be peers who have personal experience of mental distress and/or	At the consultation workshop the Te Whatu Ora staff member stated that people with lived experience did **not** need to have a diagnosis.

addiction. And that the people who work in peer-governed organisations, including managers, will be peers too. - Firstly we need to accept that an organisation may choose to recognise lived experience in a way that is inclusive and not specific to clinical diagnosis. Does Te Whatu Ora utilise a consistent definition? At the consultation workshop we were advised it was specific to clinical diagnosis however our team feel that is should encompass a broader definition i.e. include relational and undiagnosed mental distress/lived experience. - We also have recognised that people are typically drawn to this work due to lived experience and yet in that some of our staff and volunteers have taken time to disclose their lived experience. We want to take an inclusive approach in supporting people to feel comfortable with this requirement so ask that is more of a guideline/aspiration than a hard rule so that we can allow organisations space to work with their team members on building trust and inclusion to share their lived experience at a pace and time that suits them.	Defining lived experience is an ongoing discussion throughout the lived experience sector nationally, as well as the wider mental health and addiction sector. For this project, we consider that lived experience means personal lived experience of mental distress and/or addiction. Whether someone discloses their lived experience is always a personal decision. 50% peer governance is a requirement for peer-governed services. We require it because we wish to support and work with organisations that are truly led by people who have experience of mental distress/addiction.
Requirement to be peer-governed I am fully supportive pf peer numbers on boards but am aware in smaller communities it may be a struggle and wonder if whanau should be included there too?	50% peer governance is a requirement for peer-governed services. We require it because we wish to support and work with organisations that are truly led by people who have experience of mental distress/addiction. Whānau could still be involved in governance, but will not count towards the 50% peer governance requirement.
Standards	All contracted health services are required to meet these standards.

We also wish to comment on the requirement that Peer-governed organisations will be required to meet the same standards as all funded health services (Ngā Paerewa Health and Disability Services Standards). As many peer organisations start small due to having leaders with lived experience and a passion to make a difference, we wanted to invite you to consider how this goal could be reframed for all size of peer service providers to support their successful growth. Our suggestion is that this standard is considered through the lens of a tiered model in which the relevant Ngā Paerewa Health and Disability Services Standards are assigned to the level and type of service provision, and number of services that are being delivered. This would support achievement of quality service provision but also support small providers to take the next step in their growth in a sustainable and achievable manner. We need to reconsider these requirements through a lens of empowerment and support for peer services rather than a standard that limits the potential of small providers to grow in quality and service provision.	We do understand that some peer organisations are developing organisations, and may not meet all of the standards initially, however they will need to have a clear commitment and plan to meet the standards. Organisations that cannot meet the standards could investigate other community funding options that do not have this requirement.
Policies Regarding the policy creation, we also invite Te Whatu Ora to consider making policy templates relevant for peer services accessible to smaller organisations to demonstrate best practice in action and support their achievement of this standard.	There are existing services that support organisations with policy development, if required.
Practice We agree in a flexible approach to ensuring a clear practice of peer support is in place (e.g. Intentional peer support) to enable providers to choose the most appropriate practice that supports their workforce and needs.	Noted.
Peer Supervision Regarding the requirement that external peer supervision will be mandatory for all staff working in a funded peer service. We question the extent of this	External peer supervision is a requirement for all peer support workers.

requirement and invite you to see it more as a guideline or specific to client facing roles as some roles may not be client facing and not require active supervision in a traditional sense.	We have clarified that it is not a requirement for other CPSLE roles.
Services provided	
Possibility of **integration of roles**; e.g., advocacy/advisory position within clinical/MDTs	The model of care is purposely high-level. How the roles are implemented is up to organisations.
Online peer support – consider role isolation; opportunities for PSWs to connect	The model of care is purposely high-level. How the roles are implemented is up to organisations.
Connector role – love it!	Noted.
In our community we also see the connector as being a bridge between the individual and the system/ services – connecting the individual to services and support. This hasn't been highlighted in the current definition.	This community connector role, whilst important, is not the same as the connector role in the model of care.
'Identifying needs' – framework for peers to identify needs, e.g., Te Pou **Consumer Self-Assessment tool**	We are not clear which tool this refers to and so have not referenced it.
Co-written notes?	We have added a requirement for organisations to use collaborative note-writing.
How will services work with other services and people who are important to me We feel that this is a requirement for a fully functioning peer services organisation but will not apply to all types of organisations e.g. those just providing one type of service. Especially the requirement of training to work with whānau, and services will need to have policies that support whānau involvement. This may not be applicable for some services at this time	All services must meet the Nga Paerewa standards, which require policies on whānau involvement The model of care is purposely high-level. How the roles are implemented is up to organisations.

e.g. education. Also, there is a lack of clarity in the role of a peer support worker in terms of referrals, as this may be outside of their scope of service currently.	We are not sure what the feedback regarding referrals means.
Regarding the peer support journey We aren't comfortable with the use of the word 'help' in this diagram as peer services are delivered through a mutuality and empowerment lens and this language doesn't reinforce this or apply to some services.	We agree and have removed the word help and replaced it with support.
The message that services will **work with whānau and other services,** if you'd like them to also might be only applicable for larger service providers. Some peer services may be more limited in their scope.	Working with whanāu and other services is relevant for all organisations.
Rural services In regards to services and support rural and urban, totally agree about needing to reach rural communities but believe there needs to be a line there this will include some assertive outreach as well as your next statement about using digital virtual services	Noted.
Rural services At a workshop there was strong feedback that services should not discriminate against rural communities and should include rural outreach.	The model of care already talks about reaching rural communities, so we do not believe a change to the model is required, however we have noted the strong feedback.
Learning and development	
There could be given consideration about adding in support to complete the **apprenticeship in Peer Support** with Careerforce.	The new CPSLE network will connect apprentices who will be able to provide peer support to each other.
We feel that there has not been an acknowledgement of the value of providing and supporting a **pathway of leadership** within peer service organisations, for	We agree and have added content about developing peer leadership.

volunteers and workforce. This would promote sustainable growth and empowerment of individuals with lived experience to realise their full potential through the peer service model.	
Note on **equity and peer support apprenticeships** – consideration for applicants with lived experience of mental health act/coercive and restrictive treatment	Under the Workforce Development Action Plan there is provision for 2 apprenticeships, and at least 1 is prioritised for Māori or Pacifica staff. Allocating the other apprenticeship to people with lived experience of the Mental Health Act would exclude a significant number of people with lived experience from having an opportunity to be considered. People with lived experience of the Mental Health Act will be welcome to apply for an apprenticeship.
Firmly believe in the Learning and development section need to specify as separate from whanau although part of this, **Supporting Parents Healthy Children** is a key requirement for all in mental health?	We have added "Supporting Parents Healthy Children" to the learning and development requirements.
For peer governed organisations, services think it would be great if there was **mentoring** from an area were service is already set up, **learnings**. A commitment like many of the current health workforce have monthly hour long education support session already imbedded from the beginning.	Staff from many non-peer services have engaged in our workshops to develop peer-governed services. A network will be established through our Consumer, Peer Support and Lived Experience Workforce Development Action Plan. This network could work with other services to promote learning from each other.

System changes	
System changes will probably be a work in progress as we hopefully get the chance to have peer-support, but apart from training ,guidance and funding we can also aim to develop pathways for the differential knowledge and practice of peer-support and integrate into organizational structures somehow..	Noted. There are national plans underway for lived experience pathways, including an academic pathway (through AUT) that will contribute to raising organisational awareness and support organisations to embed lived experience.
Totally support the need to **raise awareness and understanding** of the roles this applies not only to peer support but also to community support worker roles as there seems to be a ongoing emphasis on services being delivered by health professionals with registrations and a bias towards the medical model which does not extend the full opportunity of resources to support people in their wellbeing	Noted. Raising awareness is a key system change.
We have a resource on integrating peer support in non-peer organisations and would gladly distribute it.	Distributing this resource is part of the system change about supporting non-peer organisations.
We invite **support for peer organisations to grow their service foundations** such as through tiered standards, and practical support e.g. provision of policy templates, training, mentorship and organisational development funding to help them grow into quality service providers that can complement clinical services. There needs to be a recognition through the RFP process that small organisations may not be able to achieve the high standards of operational infrastructure set by current contract designers but will need a different approach to support them to reach their full potential – through partnership rather than a transactional relationship initially.	Te Whatu Ora understands that some peer organisations in Southern are developing organisations and we are committed to supporting the growth and development of the CPSLE workforce and peer services.
The goal here should be around **sustainable development of the peer workforce,** that meets organisations where they are and helps them take the next step. Funding opportunities that invest in organisational development including its	Organisational development is included in the contract requirements for peer-governed services.

leadership and internal systems so that it can be fit for purpose, rather than which just focus on service provision. This requires a partnership approach by Te Whatu Ora and we welcome the opportunity to work in partnership with you to grow our potential to utilise lived experience and peer services to support the wellbeing of our wider communities.	
Access to clinical support. At a workshop it was decided to elevate the need for clear pathways to other services/clinical input as a risk, and to add it to the wider system changes section in the model of care.	Access to clinical support has been added as a key system change.
Definition of lived experience	
Lived experience definition It still remains unclear for me as people with lived experience that I have heard talking about this all seem to have different views. I think there may need to be clarification of what lived experience of mental distress means, for example does it need to be current, how long ago is considered lived experience, what does distress mean? – a complex question I know but one that seems to be inconsistent in its response within the sector both locally and nationally.	Defining lived experience is an ongoing discussion throughout the lived experience sector nationally, as well as the wider mental health and addiction sector. For this project, we consider that lived experience means personal experience of mental distress and/or addiction. We acknowledge the experience of family and whānau as very valuable and important, however when we say lived experience we mean personal experience, not whānau experience. We do not judge other people's lived experience, so we do not have set requirements about how recent, or how "serious" their experience has been. People can self-identify as a person with lived experience.
Peer/lived experience definitions The definition of "peer" and "lived experience" early on in this document would support shared understanding and application of this document. On this note we believe this should also not be restricted to people with a clinical diagnosis of mental distress/addiction but include familial experience and undiagnosed experience. We recognise there is some disagreement with peer service providers about this term.	
Peer/lived experience definitions Peer support workers have different experiences, but break down into two main categories:	

1. Have lived experience of mental health issues and treatment themselves; or 2. Have lived experience of a family member or close friend who has mental health issues (many of these people have suffered either a suicide or suicide attempt by their family member or friend). There can be a significant disconnect between the experiences of these categories, particularly in regard to the provision of formal hospital treatment provided. To illustrate this, I was admitted to various wards in Dunedin Hospital on multiple occasions. These admissions were almost always against my will (although I did not push back sufficiently as to be sectioned), and saw me criticise and complain bitterly about them to my family. In retrospect, I believe that the admissions are the only reason I did not commit suicide, and that they played a huge part in the better life I am now living. However, my family are largely unaware of the fact that I now appreciate what happened to me, and that hospital treatment was actually so positive. I am concerned that some members of the peer workforce who come from the family/friend lived experience background will not understand the wider picture. This is exacerbated if they have lost someone to suicide, as there is no subsequent personal experience reflection. I believe that matching the background of the peer workforce to patient may be useful – where a personally lived experience peer support worker be matched with the distressed person, while those with family/friend experience are matched with family/friend client. In this way, the lived experience most closely matches the strengths and knowledge of the peer support person. The differences should at least be acknowledged and managed, possibly through a brief induction of what formal treatment actually involves.	However, we do believe in involving people with relevant lived experience to work in peer services. CPSLE staff should ideally have experiences similar to those accessing the service. For example, a peer support service on an inpatient ward would be best delivered by peer support workers who have experienced inpatient treatment. Peers do not need to have identical characteristics or experiences, but being relatable is important. We acknowledge that many people have personal experience of mental distress and/or addiction but chose to not disclose this to others. These experiences are equally valid and we are careful to not make assumptions about the experiences of anyone. However for the purposes of working in the CPSLE workforce, or being a peer on a governance body of a peer-governed organisation, disclosure is necessary. Disclosure should always be a personal choice.

How current does lived experience need to be? Another point to consider is how current a lived experience is? There is often a lag effect between the time an individual member of the peer workforce was unwell and receiving treatment, and when they are working in this area. In the Dunedin Lived Experience meeting of 24 November, several participants said they try to provide the service they would have liked to receive. While this is admirable, do they meet the needs of their clients, or are they stuck in a time warp from their own distress?	
Age range	
Regarding the suggestion that youth 12+ and their whānau should be supported through this **Service**, our view is that, for this RFP, it would be premature to include youth 12+ directly, since no specific consultation was done with youth and their whānau. Having said that, anyone should be supported if they presented to the service using a culturally appropriate response where whānau are the cornerstone of the person's world. The **Service** also needs to work in consultation with other youth services as required. If young people are supported in isolation, it could increase risks around their support and well-being. The **Service** will need to consider how a person's culture impacts their presentation and peer support. It should be safety first when working with vulnerable youth and specific training would be required for peer supporters. Not everyone would be suited to work with youth. This should be done very carefully taking into consideration the Vulnerable Children Act 2014, Children's worker Safety Checks and a Child Protection Policy.	The model of care states that the model is for adult and youth. This comment is in response to a comment made by a Te Whatu Ora staff member at a workshop, that the model of care could apply to people 12 years and older. Four youth peer support workers/consumer advisors engaged in consultation, as well as some youth services. A workshop for rangatahi was held in Invercargill. We consider that, with the addition of a new youth-focused objective about meeting the needs of youth, this model of care can apply to young people. This model of care is very high-level, and youth-specific needs can be addressed through the
Our view is that a peer-led service supporting youth 12+ is of high importance but that more thought needs to go into it and for there to be more extensive	

consultation with youth, their whānau and the support services for the youth sector. It may be that a peer-led service for youth could evolve alongside a peer-led service more specifically targeted at 18+.	Implementation Guidelines, and by organisations when designing youth services. Additional guidance will be provided in the Implementation Guidelines.
One submission included a proposed service, which we have responded to below	
The **"[peer-governed] Service"** which should be a Wellbeing hub as well as Crisis Café to cater for both crisis and usual peer support.	Both options are possible ways to implement the model of care.
The **Service** is to operate during normal working hours and have extended hours that aligns with the Co Response Team's (CRT) hours.	The model of care encourages organisations to operate extended hours.
To encourage and make it a prerequisite for board and staff to have diversity and people with experience of tikanga Maori, Te Tiriti o Waitangi, different age groups, disabilities, lived experience of mental distress, neurodivergency, and/or LGBTQIA+ community.	We have added a statement about diversity amongst the board and staff. For clarity, we note that all staff must have lived experience of mental distress and/or addiction.
The **Service** to be located close to EPS and Dunedin Central Police.	The model of care is high-level. The location of the service is a decision for organisations when they implement the model of care.
To have access to clinical advice which may include taking the person to clinical services or clinical support may come to the **Service** – responsiveness is important.	The model of care requires peer services to work with other services.
The **Service** to have an alternate waiting room which is homely where sensory overload issues can be minimized. That will take the agony out of waiting alone and unsupported in a busy clinical environment which often causes more distress.	The model of care is high-level. This suggestion would be a decision for organisations to make when they implement the model of care.

If people are discharged from EPS they could be discharged to the **Service** where a safety plan can be developed with the person and their whanau. A good follow up procedure need to be in place to ensure there is good ongoing support in place in the community. That may include advocating for the person.	
To work in collaboration with other services and demonstrate good relationships in the community.	The model of care requires peer services to work with other services.
A well-established high model of care peer support training programme based on IPS model bespoke for this **Service.** It has to be a non-clinical model training programme for the **Service** that includes CPSLE values and competencies that aspire to reflect best practice in the provision of peer support services. All peer supporters to attend this training irrelevant of previous experience or trainings to ensure a consistent approach.	The model of care requires all peer support workers to have foundation training in peer support. The model of care requires organisations to have a clear peer support practice and suggests Intentional Peer Support (IPS) as an example, but allows for other models to be used too.
To demonstrate well established policies and procedures on wellbeing, health & safety and practices.	The model of care requires organisations to have policies that reflect the values and principles of the model of care and meet the Ngā Paerewa standards.
The **Service** to demonstrate sustainability and a track record to show they are capable of delivering this service and training programme.	Noted.
The **Service** to cater for online chat options, phone support, in person one on one and group support.	The model of care provides for a range of different service options.

Peer support to be delivered inside the **Service** building and to have the ability to be mobile to provide support elsewhere in the community as required in cafes, walks on the beach, in the wards, in ED/EPS, in the mental health teams, homes, in court, at ACC/WINZ or where the person finds it suits them best. To advocate for them through HDC and coronial processes.	The model of care is high-level. The location of the service is a decision for organisations when they implement the model fo care.
The **Service** to accept self referral, appointments and drop ins.	This is consistent with the model of care.
The **Service** specifically to cater for moderate to severe (Te Whatu Ora requirement) but not exclude others.	The model of care allows for open entry, consistent with strong feedback received during the eight consultation workshops in November.
Newly trained peer supporters to work under supervision provided by more experienced peer supporters for a specified time or until competent.	The model of care requires peer-governed organisations to provide foundation training to peer support workers and to provide peer supervision. Organisations can choose to have peer support workers work under supervision for a period of time.
Regular and robust supervision, continuing education, co-reflection, debriefing and access to counselling if required. This should be built into the costings to ensure staff are well supported.	Supervision/co-reflection and education are all required under the model of care. Debriefing is not specifically, but is standard practice in the mental health sector. Access to counselling would be considered as part of the requirement on organisations to support staff wellbeing. Organisations can include these costs in their proposal.

Demonstrate well established relationships in the local community	The model of care requires peer-governed organisations to work with a range of other services.
Well established pathways how to navigate mental health systems (primary and secondary) in local community.	We have added a specific mention of primary and secondary mental health services, to the section about working with other services.
To set up and be part of a peer network across Dunedin.	This is suggested in the model of care.
To have well established systems to recruit and retain peer supporters.	The model of care has a strong focus on recruitment. A statement has been added about the need to support and retain the workforce.
Access	
Access is the mild to moderate or moderate to severe criteria going to be raised at all – as this has been a barrier to people self-defining their need for access to support.	The model of care allows for open entry, consistent with strong feedback received during the eight consultation workshops in November.
Access to services and times of access This guideline does depend somewhat on the type of peer service and there are typos in this sentence that make it hard to comprehend. There needs to be an intention of flexibility around the needs of the individual and community but also respect the type of service and scope of service provided as some do not provide crisis support.	Apologies for the typo, we have fixed this. During the workshops, people suggested they wanted access to services outside of business hours because they had work, training/education or other committments – not necessarily for crisis support.
Drop in. Crisis. I believe that any peer support expansion has to allow for drop-in clients, particularly if the idea of supporting them through EPS crisis is developed. One of	The model of care allows for open entry (this could be drop in), and for crisis services.

the major problems with the current MHT model is that the clients are effectively required to have their crisis between 9 – 5 on weekdays, or could they please wait until an appointment is available. Obviously, this statement is a bit sarcastic. When I had an appointed PDN, he asked if my 2.30 pm crisis could wait until the next day as he was rather busy, and didn't have the time to take me to EPS. I suggested using a crisis nurse, but apparently it was a point of pride that he always dealt exclusively with his clients – regardless of how inadequate his angry dealing actually was. Imagine a service that actually dealt with clients on a helpful and respectful basis. It would have been a dream for a person like me in an actual crisis. This crisis service would supplement scheduled peer support appointments.	The model of care needs to be very high-level. Services will be designed by organisations when they implement the model of care.
Other feedback	
Address societal attitudinal change, e.g., media and social media guidelines	This could be part of a CPSLE systemic advocacy role. To be included in the Guidelines to Impelementing the Model of Care.
At a workshop rangatahi asked for services to have the Rainbow Tick.	A new diversity section has been added that includes the need to be accessible and welcoming to people of all identities, including people from the LGBTQIA+ community.
Requirement for having trauma-informed offices This may be a guideline /aspiration rather than requirement again considering the size and scope of services provided and how possible this is to achieve. Also, providers may need some support/training to achieve this.	There are principles of trauma-informed environments that can be applied even when there are resource restrictions or space limitations.

We must **avoid the "them and us" divide** that can be driven from either side. And the peer workforce must stop putting their personal beliefs ahead of client needs. Formal clinical and hospital treatment is not always a bad thing!	The model of care requires peer-governed organisations to use the CPSLE competencies. These competencies outline how peer support workers should work. They require peer support workers to work as part of the system, and to respect a range of beliefs and approaches to mental health care and support.
I had a thought about to **professionalism** of new services and in particular **confidentiality** I am assuming this would be covered off in all Peer Training and supervision. Is this area sufficiently covered as it could be a major issue if not.	Peer support workers are expected to respect legislation, standards and policies regarding all aspects of service delivery including confidentiality, and people's right to privacy, just like all staff in the mental health sector. Supervision provides a reflective space for peer support workers to safely bring up concerns around issues like confidentiality and privacy. Professionalism can be a difficult term to translate to peer practice. We have competencies and most models of peer support have a Code of Ethics or similar document. However, peer practice and boundaries can be different to traditional professional boundaries. For peer services to be successsful, there will need to be some awareness-raising work across the sector on what peer support is, and how it works, so that people understand why peer support workers practice the way that they do.

I was thinking about the **many cultures** that make up our wonderful community. I would like to see a path for those from these cultures that have become disconnected from them. To reconnect with them. I see this as a helpful path for some.	We have added a new diversity section to clarify that the cultural needs of all groups must be respected.
At a workshop it was said that peer support workers should be as close as possible (in experience and characteristics) as the person they are supporting. They need to be **relatable**. It was suggested that this needs to be clear in the document or it could be easily forgotten.	We have added content on the need to recruit a diverse workforce. This will help to ensure that people have a choice of peer support worker. We do agree that similar experiences can be important and help people to relate to each other We note however that it is a belief in some models of peer support that peers do not need to have *exactly* the same characteristics, but that they find connection through getting to know each other.
Peer Workforce Safety At the 12 December meeting in Dunedin, I shared my experience of a fellow peer support user who had a reputation for pulling knifes and threatening people coming to a service I was using. He was accompanied into a separate room by a young peer support volunteer. I had concerns for her safety and subsequently shared those with the service involved, and was blacklisted by them as I had breached his right to confidentiality. I consider that a wider issue exists – namely, the safety of the peer workforce volunteer. Would a young lady be able to defend herself against a very angry, large	All workplaces must protect the health and safety of their employees, including peer-governed organisations. The model of care requires peer-governed services to meet the Ngā Paerewa standards, which require them to have robust health and safety policies and practices. Many peer support workers are highly skilled at de-esclating challenging situations.

fit man? He has a criminal record for using his knife, and is also well known for violence and threats against females. My concern is that in expanding peer support as a treatment option we are placing less formally skilled people into potentially dangerous situations. In addition, clients such as this man have burned their formal treatment options, and are therefore limited to seeking crisis help in more informal settings. I do not have the answer to this issue, but the potential danger needs to be acknowledged and addressed. Its simply too dangerous to be ignored!	
Best Practice and Resources Available Database for Peer Support The "CPSLE Workforce Development Action Plan 2022 – 2024" (pg 20) lists proposed actions. Under point 1 (Build a Network), 1.1 states that it will "Support the development of a local network/s to connect peers across different organisations, share information and provide regular development opportunities". In addition, point 7 "Support best practice", 7.1 suggests that new resources/articles relevant to the peer workforce be collated and made available for distribution. At the Dunedin "Lived Experience" meeting held on November 24, the development of a database that shared the various specialty supports available through the peer workforce be progressed. The meeting participants felt that this knowledge would allow clients with complex needs to possibly be referred to a service that would provide the best help. Despite the overwhelming support for this database, there is no mention of it in the "Southern Peer-governed Services" draft for discussion. I would link this database to the best practice resources already planned, as it collates all relevant and up-to-date information in one easily accessible location.	The new CPSLE network will have a key role in connecting peer support workers and sharing information. We will pass on your feedback about developing a database to them.

Clinician Awareness and Genuine Promotion of CPSLE Roles The "Southern Peer-governed Services" draft, on pg 21, discusses "System Changes". The first box refers to "Raise awareness and understanding of roles", rating it as critically important for clinicians and referrers to understand and value CPSLE roles. My personal experience, admittedly with a considerable lag effect, is that many clinicians do not rate those below them in the formal hospital, Mental Health Team, professional service provider framework. Getting those doctors to truly believe in the peer support process may be difficult, and would be a significant barrier to peer support being used to its full potential. I would suggest promoting peer support as an initial option for clients being discharged from a formal Mental Health Team (MHT), at least as a pathway to further support if needed. While peer support is a ground level pathway into receiving help, it could also be considered as a holding method for those awaiting entry into MHT treatment.	The model of care is designed to be very high-level, and to cover the types of services that we need, the values and principles they need to operate on, and how we need them to work. Awareness raising is important. It will take a collective effort from mental health and addiction services and those in peer roles to grow understanding and relationships over time.
Note-taking Although disclosure of discussions is a huge issue for many clients, notes are a valuable resource. Policies need to be developed to set a standard: ✶ Collaborative, or other method ✶ Level of detail to be captured ✶ Note sharing (in what circumstances) ✶ Who within an organisation can access them (and in what circumstances) ✶ Storage and destruction	We agree that notwewriting and disclosure is a huge issue. We missed mentioning collaborative notewriting in the draft model of care. This is an important requirement, and we have now added it in. The model of care requires organisations to have policies that meet peer values and adhere to the Nga Paerewa standards. Their policies should cover the requirements you have listed, except perhaps

✶ Client access to and adding amendments if necessary ✶ Clear disclosure of these policies to clients at all times	the level of detail captured. This is a practice issue that varies within organisations. You can always ask to see your notes, and discuss the level of detail being recorded.
Developing the Peer Workforce The "CPSLE Workforce Development Action Plan 2022 – 2024" contains the results of a peer workforce survey, which had just 29 respondents. While this is a useful resource, I believe it is too small for any meaningful trend analysis. As the peer workforce sector is promoted as a career option, the pathways taken by future individual peer workforce employees is likely to differ from the current pathways. This may well be a very good thing, as a wider cross-section of people enter, creating more connections for service users. The "Training Barriers" (pg 16) is interesting. I feel the categories "Appropriate training not available" and "Lack of knowledge about training options" can be addressed through the Best Practice resource collection plan. An additional benefit could be provided by regularly surveying the peer workforce regarding the type of training they need – hopefully resulting in those needs being reflected in appropriate training and courses being developed (in a national setting as peer support is expanded nationwide). While we naturally focus on the number of clients assisted, focusing on making each individual member of the peer workforce more effective would enhance the experience of all. I believe that a percentage of any service provider funding should be ring-fenced for training and development – with service provider resources also being targeted towards supporting their workforce's training and development.	It is correct that a one-off survey of 29 people cannot be used for trend analysis. We were quite happy with 29 respondents though, because the CPSLE workforce is very small. We agree that focusing on developing the peer workforce is very important. That's why we will be investing in training for the CPSLE workforce this year.
Standardisation of Peer Support While I am personally opposed to the standardisation of peer support, there are a number of areas where a wholly consistent process would be beneficial.	The model of care will provide some standardisation of peer support services, by:

✶ Referral to, and client process for, changing to a more appropriate service provider; ✶ Changing to a different peer support worker within the same organisation; ✶ Supervision practices for all of the peer workforce; ✶ On-boarding, initial and ongoing training and development; ✶ Te Whatu Ora Southern surveying and data collection; ✶ Clear statement of when client statements will be referred elsewhere (e.g., any disclosure of actual or intending self-harm or actual or intended harm to others will be notified); ✶ A minimum standard of care to be developed, implemented and audited; and ✶ A consistent complaint investigation process. There will be other areas that could be standardised. A professional expansion of peer support will require that the standards and client experience be consistent and measurable, in order to further develop best practice and genuinely enhance the current and future lives of those using the service.	• outlining required values, principles and objectives • outlining standards of workforce development and support, especially the requirement for external peer supervision • requiring organisations to use the Consumer, Peer Support and Lived Experience Competencies. Some of the issues you have identified, such as changing between peer support workers, will be up to organisations to develop their own policies, procedures and practices. However, we will advise organisations to develop clear processes for this in the Guidelines to Implementing the Model of Care.
Engagement with current service users have found this planning exercise and consultation process extremely interesting. However, I do have some reservations regarding the identity of the meeting participants, primarily the fact that only service providers (both peer workforce and management) were present in any numbers. The actual service users were conspicuous by their absence. I do realise that some of the peer workforce have current issues requiring intervention, but I also believe the number who will have received intervention or treatment within the last 12 months would be no more than 20% maximum.	The 12 December meeting was a combined co-design workshop with both people who work in the sector, and tāngata whaiora. In November we held a workshop that was only for tāngata whaiora, and this was well attended.

It is a question that I wanted to pose at the 12 December meeting, but I felt it was too personal and potentially confronting. Nevertheless, I also worry that the supposedly patient-led reform is actually a management of the peer support network-led reform. Are we addressing the genuine needs of clients, or the needs management believe they can design an effective funding plan for.	