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Best Practices in Peer Support

2014 FINAL REPORT

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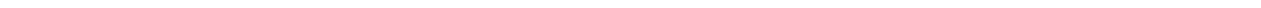


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Introduction

The Best Practices in Peer Support (BPPS) project is one of the 12 Ontario Drug Treatment Funding Programs, funded by Health Canada as part of the Treatment Action Plan under the *Federal National Anti-Drug Strategy (2007)*.

The purpose of the Drug Treatment Funding Program (DTFP) is “to provide the incentive for provinces, territories and key stakeholders to initiate projects that lay the foundation for systemic change leading to sustainable improvement in the quality and organization of substance abuse treatment systems, as well as increase the availability of treatment services to meet the critical illicit drug treatment needs of at risk youth in high needs areas” (*DTFP Framework, Health Canada, 2008*).

The three Ontario DTFP Investment areas are:

1. Implementation of Evidence Informed Practice
2. Strengthening Evaluation and Performance Measurement
3. Linkage and Exchange.

The BPPS is funded under the first investment area. It has participated in the comprehensive systems focused evaluation, whose questions regarding the *Implementation of Evidence Informed Practice* projects are as follows:

1. What can we learn from each of these projects for the feasibility of developing guidelines for strengthening the treatment system?
2. Given the heterogeneities of needs in the substance use populations, are there “multiple” best practices?
3. How do these projects help identify areas of implementation in which evidence is especially inadequate?

Context

In recent years, the role of peers in the health care system has come increasingly into the spotlight, both at a grass roots level and through the lens of policy. The focus has primarily been in the area of mental health; however, peer support in the area of addictions is now garnering more attention.

Regarding the policy perspective, in 2008, the Government of Ontario made a commitment to develop a comprehensive 10-year mental health and addiction strategy that would lead to better services for Ontarians. As part of this process, a Minister's Advisory Group was established, made up of people with lived experience with mental illness and addictions, family members, service providers and researchers. One of the five priorities/themes that they identified was consumer partnerships, and a document was prepared entitled *Ontario Mental Health and Addictions Strategy Consumer Partnerships Theme Paper (2009)*. One of its identified high level goals building towards achieving system transformation is that "peer support, mutual aid, self-help and other programs and services that enhance the capacities, supports and empowerment of people with lived experience are considered an essential part of the mental health and addictions system, and their roles in care provision are clear and well-articulated".

The shift towards policy recognizing the role of consumer partnership and the value of peer support has been married with the focus on both recovery and harm reduction, as follows:

"The recovery approach underlies the delivery of services and supports and emphasizes service user choice, flexibility in services, individualized supports, and the importance of peers, families, significant others and communities in supporting people with mental health, substance use and problem gambling needs. The approach also considers the impact of factors such as poverty, poor housing, unemployment and stigma on people with mental health substance use and problem gambling issues." (*Ontario Ministry of Health and Long-Term Care, 2004*)

"Mental health, substance abuse and problem gambling services based on a harm reduction approach are provided in accordance with the person's choice in the least intrusive setting and least restrictive manner, and, in recognizing that some people are not able to accept a treatment goal of total abstinence, work to reduce harms associated with substance use. Harm reduction strategies can be integrated into all parts of the treatment process". (*Ontario Substance Abuse Bureau, 1999*)

The above-mentioned Minister's Advisory Group released a discussion paper entitled *Every Door is the Right Door* in 2009. Its proposed approach identified seven (7) areas, one of which is: *Transform the System: Provide access to a seamless system of comprehensive, effective, efficient, proactive and population-specific services and supports*. In this section, it is stated that "people with lived experience also need opportunities to participate in peer-based programs, initiatives and collectives – both paid and voluntary. Peer-based services can make a significant difference - *Orwin, D. (2008). Thematic Review of Peer Supports: Literature review and leader interviews. Mental Health Commission: Wellington, New Zealand*. Peer networking among people who use drugs improves health outcomes and reduces the harms and risks of drug use

by sharing health information and providing social support - *Allman, D., Myers, T., Schellenberg, J., et al. (2006), "Peer networking for the reduction of drug related harm," International Journal of Drug Policy.*

In 2011 Ontario released its *Comprehensive Mental Health and Addictions Strategy* document: *Open Minds, Healthy Minds*. It articulated six principles, including that of "person-directed services". "People with lived experience of a mental illness or addictions, and their families, bring their strengths, wisdom, and resilience to their care. They must have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support".

Definitions of Peer Support

There are many different roles in peer support; however, it is often unclear how these roles differ. Some examples include peer advocates, peer educators, and peer navigators. We have addressed the definitions of various roles based on a mental health framework. At the knowledge exchange event, the participants discussed how defined roles in peer support bring a necessary scope of practice, which prevents burn out, emotional strain, and boundary issues. Bringing clarity to roles in peer support will assist in agency implementation of peer support programs. Additionally, defined roles can develop a more cohesive and functional peer support network in the future.

Listed below are a few definitions as to what constitutes peer support:

- “Peer support is a naturally occurring, mutually beneficial support process, where people who share a common experience meet as equals, sharing skills, strengths and hope, allowing people to learn ways of coping from each other. Formalized peer support begins when persons with lived experience, who have received specialized training, assume unique designated roles...to support an individual’s expressed wishes”. (*Ontario Peer Development Initiative*)
- “Peer support is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations” (*Davidson, Chinman, Sells, & Rowe, 2006*).
- Peer support is “a system of giving and receiving help founded on key principles of respect, shared responsibility and agreement of what is helpful. Peer support is...about understanding another’s situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others whom they feel are “like” them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to “be” with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles. This allows members of the peer community to try out new behaviors with one another and move beyond previously held self-concepts built on disability, diagnosis, and trauma worldview.” (*Mead, 2003*)
- “Recovery is supported by peers and allies: mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness”. (*Substance Abuse and Mental Health Services Administration, 2011*)

Literature Search

Articles/Papers: Key Findings

Twenty-two (22) articles were reviewed in detail; the comprehensive analysis of these can be found in *Appendix 1*. From these, one can draw the conclusions listed below.

- It is extremely important to put in place a clear governance model and a fully developed organizational structure, which could include an overseeing board or advisory group. Without this, there will be confusion about decision-making. However, imposing a structure on grassroots organizations does not work. The organization must not be “top-down”. In addition, do not try to build on weak local networks to form stronger larger networks; this does not work.
- There must be statements that clearly articulate the mission, philosophy and values and a definition of “people with lived experience of substance use.” There needs to be an anti-stigma focus. Funding and resources are needed, in order to develop a physical site, and provide services, such as training, a warm line, a drop-in centre, a needle exchange, hospital visits, and so on. In addition, holding an annual conference/event will help give the network profile. Having a role in advocacy is extremely important.
- Clear definitions for network membership inclusion and exclusion must be established, but the network must welcome diverse membership and include families. If developed correctly, the network will provide a sense of community, self-respect and safety.
- Technology must be used in order to disseminate information and provide education. In order for people to inform direction and practices (including evaluation and research), there must be a clear feedback process; this will allow the network to have adaptive sustainability. There must be a clear and responsive complaint mechanism in place.
- The network needs to put in place and nurture partnerships with key stakeholders, and will thrive with strong leadership and “champions”. It must network with other networks, and become linked with both national and international networks.

Peer Networks' Websites: Key Findings

Thirty-one (31) peer network websites were reviewed and analyzed; the list of these can be found in *Appendix 2*. The analysis focused on finding the most commonly found structural elements, which are listed below:

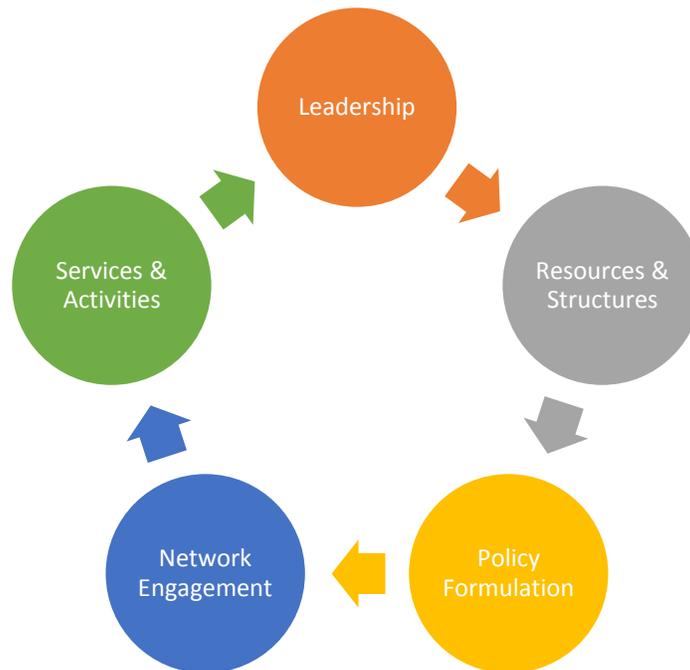
- Home Page (with pictures)
- Who we are; our purpose
- Guiding principles, aims, structure, position statements
- Staffing
- Internal communication: blog; posts; forum; comments; knowledge exchange
- News: sometimes including a newsletter; local, national and/or international

- How to get involved
- Job postings
- Projects
- Publications
- What's on: sometimes including a calendar of upcoming events
- FAQs
- Links: to literature; articles; media
- Contact us: sometimes containing a brochure
- Privacy statement and disclaimer

Doing a further analysis of these findings, one can then conclude that successful network websites need to be peer run, accessible, transparent, current and sustainable. They must address gaps, disseminate information and meet the needs of the membership, including an ability to facilitate member communication. Lastly, they need to be user friendly and easy to navigate.

Network Blueprint

Utilizing the findings from the literature and network review, which were endorsed by the Advisory Committee in March 2012, a network blueprint was developed, which can be used as the framework for developing the peer support network. It contains the following elements:



A. Leadership Framework including:

- Easy to understand governance and leadership framework
- Governance and fully developed organizational structure (this may include an overseeing board or advisory group)
- Leadership and champions
- Mission, vision and values with a focus on substance abuse; values that include but are not limited to:
 - Sense of community, self-respect, safety and anonymity
 - Inclusivity and diversity of membership, including families
 - Anti-stigma
 - A clear and responsive complaint mechanism

B. Resources and Structure including:

- Resources and funding to sustain the network over time
- A physical and technological presence

- Clear feedback process so people inform direction and practices including evaluation and research so the network has "adaptive sustainability"
- Technology, information dissemination and education
- Strong internet capacity
 - Public pages
 - Member only page
 - Keys to a successful peer support network internet site include the following:
 - ✓ Peer run
 - ✓ Accessible
 - ✓ User friendly and easy to navigate
 - ✓ Addressing gaps
 - ✓ Disseminating information
 - ✓ Transparent
 - ✓ Meeting needs of membership
 - ✓ Current
 - ✓ Sustainable
 - ✓ Able to facilitate member communication

C. Ability to Participate in Policy Formulation:

- Advocacy, in order to participate in planning and policy making

D. Engagement with Other networks including:

- A rich mix of strategic partners
- Partnerships with key stakeholders
- Networking with other networks; being part of a national or international network (as opposed to partnerships with key stakeholders)

E. Services and Activities that meet the needs of People engaged in the Network:

- Annual event or conference
- Specialization for substance use
- Service provision e.g. training, warm line, drop-in centre, needle exchange, hospital visits, etc.

Creating a Focus for an Addictions Peer Support Network

An Addictions Peer Support Network is important in the field of Addictions for two reasons. First, there is a need for a Peer Support Network to coordinate, support and enable individuals with lived experience to provide effective leadership for system planning and peer support activities. Second, there must be an effective voice for lived experience individuals at system planning tables. Both reasons provided a framework to establish the principles for building a network and a series of recommendations on how steps could be taken to realize an Addictions Peer Support Network within Ontario in the next 3 to 5 year period.

Description of a Addictions Peer Support Network

The network will focus on addictions and engage individuals with lived experience. It will be a network that provides training, access to information and support to the peers. It will have a governance structure that supports decision making and plan for the long term sustainability of the network. As the network grows, it will work with other established networks in the province.

Principles for Building the Network

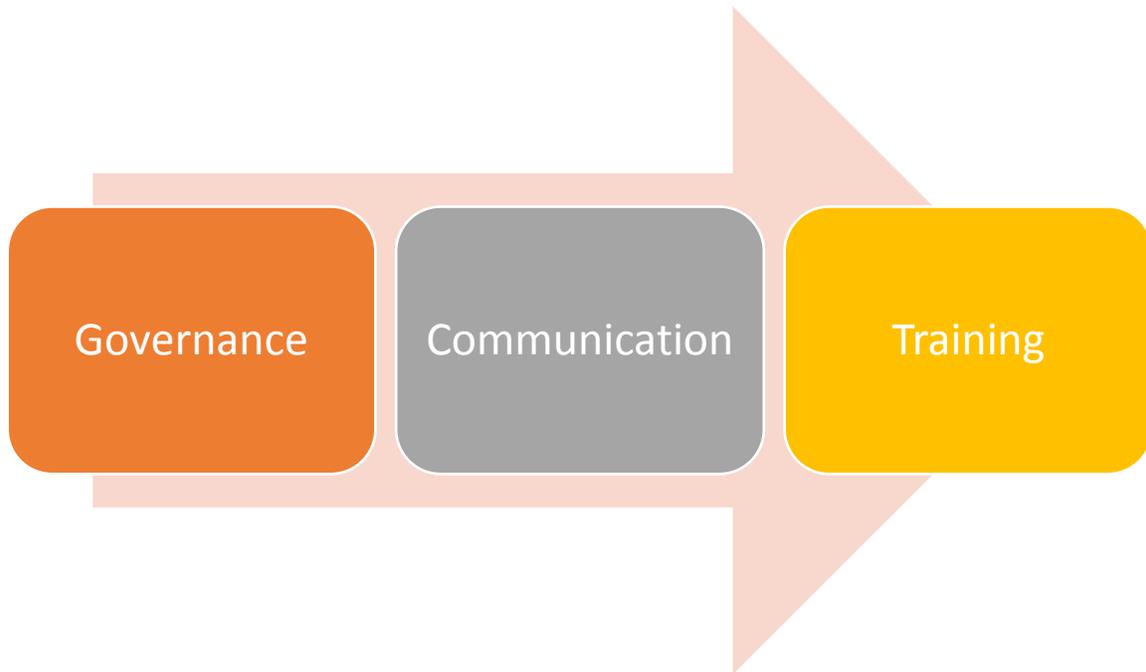
An Addictions Peer Support Network should be based on three fundamental principles. The three principles identified by the members of the steering committee included the following:

1. There needs to be well defined **governance** structure to create a shared sense of purpose
2. Appropriate **training** for the governance volunteers and for those engaged in Peer Support Work
3. There needs to be system to support **communication** between individuals involved in peer support and existing Peer Support Networks.

Building Recommendations for an Addictions Peer Support Network

The elements of the Peer Support Network identified through the literature search were reviewed at a Knowledge Exchange event held on March 14 and 15, 2013. In 2013/14, the work continued to identify appropriate linkages with key leaders, create a network with a peer support governance structure and an operational structure, and engage in regional peer support dialogues. The work was completed by three working groups. One group explored opportunities to identify elements of a governance structure for an addictions network. A second group explored opportunities to build a framework for effective communication and dialogue for an addictions network. The final group focused on the subject of effective training for individuals providing peer support. The three groups met on a regular basis throughout the year reviewing a variety of documents and building a series of recommendations for the final report. The work of the three committees was coordinated through a steering committee which was responsible for building the agenda and framework for the March 6, 2014 knowledge exchange event in Toronto. The day provided an opportunity for individuals engaged in Peer Support Networks to learn about the project, learn from each other and to review and provide feedback on the series of recommendations each working group had developed on how to sustain network activities.

The following pages outline a summary of the results developed by the working groups with a list of the recommendations to guide further work in the development of an Addictions Peer Support Network.



Governance Expert Panel

Introduction

The Peer Support Governance Expert Panel worked as part of the ongoing work of the DTFP Peer Support Project. An important element of the work explored options for an effective governance structure for an addictions peer support network.

The work included exploration of the following topics:

1. Identify governance structure/ Terms of Reference for an Peer Support Network
2. Develop guidelines for strategic partnerships with other networks Create guidelines for an engagement strategy with the LHINs.
3. Identify governance training requirements.

Summary and Recommendations

Principles for Peer Support Network

The Governance Committee identified that is important to provide a set of principles for effective governance. The following principles were identified:

- The governance framework provides a well-defined set of boundaries for those receiving addictions services and those providing governance services as part of the network.
- The governance structure should be inclusive to incorporate all individuals who wish to provide governance leadership
- A focus on advocacy on the subject of addictions and policy
- Foster a willingness to support collaboration and working with other existing networks throughout the province
- Accountability to its stakeholders
- Empower Networks to continue their work by providing governance tools and reference materials to support their ongoing work
- Individuals receive training in leadership and governance models to facilitate network structure that includes mission, vision and accountability processes

Defining Peer Support

The first known reference to using peers to deliver mental health services came from one of Philippe Pinel's colleagues in 1793 when he wrote, 'As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane' (Davidson et al, 2012).

As this workforce develops there is a greater need to create new roles and define the boundaries between them. The peer support roles include but are not limited to¹:

- **Peer support workers** who provide support for personal and social recovery to people with mental health problems, including in acute mental health services, housing, supported employment, community support and so on.
- **Peer advocates** who empower individuals or groups of people with mental health problems to advocate for their rights and needs on a range of issues in a variety of settings.
- **Peer educators** who provide education from a lived experience perspective for other peers, mental health workers or community members.
- **Peer navigators** who assist people to find, choose and gain access to a full range of community resources, networks and services.
- **Peer advisors** who work in partnership with mental health service providers to give consumer perspectives at all levels of planning, implementation and evaluation, and provide feedback to service users.
- **Peer researchers and evaluators** who use lived experience knowledge and participatory processes to inform their work.
- **Peer managers** who lead services.

Recommendation(s)

- It is recommended that a matrix of delineated levels/roles be established for peer support.
- It is recommended that the network develop a scope of practice and engagement for the delineated levels/roles.
- It is recommended that guidelines for effective engagement of “lived experience” voice at the systems level tables. (e.g., Matching, Skills sets, Experience) be developed.
- It is recommended that guidelines for reimbursement and honoraria for peer support participation be developed.

Strategic Partnerships

Strategic partnerships are important to meet the goals and principles of the network and carry the voice of Lived Experience in addictions to whom it needs to be heard (i.e. Faces and Voices of Recovery).

¹ “from PEER WORK IN MENTAL HEALTH - Proposal to develop an international consensus to the International Initiative for Mental Health Leadership (IIMHL)”

Recommendation(s)

- It is recommended that an engagement strategy unique to each LHIN, to attract individuals from across the addictions continuum for network participation; with a target of five (5) members minimum in each LHIN be developed.
- It is recommended that a written set of guidelines the network can use to engage and involve the LHINs in peer support work at the local level be developed.

Knowledge Exchange Event – March, 2014

The following two questions were addressed at the March consultation to promote feedback and discussion on the above recommendations. The table is a summary of the responses.

1. What would you suggest to strengthen or improve the recommendations?
2. What recommendations would you add to strengthen the work of the Governance Expert Panel?

Table 1 - Attendee Responses to Governance Expert Panel Recommendations

<ul style="list-style-type: none"> • Strategic partnership with employers to develop job descriptions/qualifications • Establish clear differentiation between clinician with lived-experience and peer support worker with clinical credentials • Recommend a peer-review/peer-supervision 360° model (“Peer” means PWLE Addiction) • Ensure two-way engagement • Offer the expertise and connections of the CSI to the LHIN • SME panel take the training • Training – defined roles need specific training • Add role: peer support for peer support (e.g. group) Peer Group facilitators • MOHLTC and other ministries level of engagement as well as LHINS 	<ul style="list-style-type: none"> • Peer Support Training in many circumstances should be priority • Develop strong relationships with other healthcare agencies and LHIN peer support initiatives • Define the spectrum of peer support – what we are trying to define? Formalized? • Peers can assist organizations in hiring process (have a voice) • Peer educators can assist/orient clinicians (especially new workers) • How do we ensure engagement is not tokenism? • Use change management strategies with LHINS • LHINS be encouraged to be transparent about the level of engagement of peer networks
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Communications Expert Panel

Introduction

The Peer Support Communication Expert Panel worked as part of the ongoing work of the DTFP Peer Support Project. An important element of the work will include the development of a PWLE Speakers Bureau and identify an ongoing communications strategy for the network.

Summary and Recommendations

Speakers' Bureau

It is a network of individuals with lived experience trained to share their experience and expertise in a number of environments (policy roundtables; one to one; media). It is important because it provides an opportunity get emotion engagement that is real time and impactful from people who are involved and with experience on the subject of additions. Finally, a speakers' bureau can provide the structure and framework to support board involved of individuals in a manner that is both safe and supportive. The group noted there is a wide number of existing opportunities to partner with existing projects throughout the province to support the development of the Speakers' Bureau

Recommendation(s)

- Need to identify provincial activities regarding lived experience for speaking and media training. Explore opportunities to align and work existing structures. Some of the opportunities to explore include and are not limited to “Voices of the Street”, Ministry of Health and Long Term Care.
- Explore developing a partnership with the EEnet project, “Strengthening Your Voice” to adapt the workbook to encompass all aspects of addiction.

Technology of the Network

The Expert Panel supported the ideas identified in the literature search regarding the use of various forms of technology to support communication between peers as a core function of the network. The tools identified included Facebook, Twitter, YouTube, Meeting Support (e.g., WebEx, Skype, OTN) and alternative tools for current information (e.g., Really Simply Syndication – RSS). The use of such tools are important because they provide a methodology to obtain current information on trends and practices and empower individuals to connect and communicate with peers. Technology also provides a means for individuals to engage in self-care and ensure their own safety on an ongoing basis.

Recommendation(s)

- The network should develop a comprehensive strategy for a technology system that will support the needs of the members of a peer support network. The strategy should outline the purpose of the system, how it will be sustained, methods to keeping the content current and plan to engage members in supporting and using the technology.
- The network should provide training for participants in the network. Training could be in the form of workshops on the effective use and implementation of social media (e.g., Twitter) and other technology tools.

Knowledge Exchange Event – March, 2014

The following two questions were addressed at the March consultation to promote feedback and discussion on the above recommendations. The table is a summary of the responses.

1. What would you suggest to strengthen or improve the recommendations?
2. What recommendations would you add to strengthen the work of the Governance Expert Panel?

Table 2 - Attendee Responses to Communication Expert Panel Recommendations

<ul style="list-style-type: none"> • System needs to be trained on the purpose of peers; so it does not end up as tokenism • Need to prepare both peer as well as agency regarding speaking engagements. • ‘Enough structure’ to make the relationship mutually beneficial • Language, stigmatization: having a count of at least two individuals attend events. • Stigma created through anti-stigma: shifting the way we think. • Telling your life journey without the impact of affecting family members • Toastmasters • Create rules of engagement: role, purpose, function • Training specific for telling your life journey vs. teaching • Networking initiative capturing data • Look at overall cost for training; is funding available? • Menu of options needs to be available but each network is the architect of options they use • Learning to read audience signs 	<ul style="list-style-type: none"> • Recommend a selection criteria for speakers bureau candidates • Mechanism to protect individuals who become involved with media and support safety and self-care • Technology mentors to support people after training • What resources will be available? (computers support, manuals) • Create guidelines for speakers bureau (i.e. minimum sobriety/recovery required) • Telling your story without losing the integrity of your lived experience • Create a set of media guidelines (help speakers and media) • Best practice to avoid reinforcing stigma • Ensure collaboration with other relevant sites. Ensure we do not recreate the wheel. • Train-the-trainer; peer coaching, you-tube training. • Discuss how to engage people with lived experience • Have moderators for social media (e.g. someone in distress posting on social media)
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Peer Support Training Expert Panel

Introduction

The Peer Support Training Expert Panel worked as part of the ongoing work of the DTFP Peer Support Project. This panel identified a core set of competencies for individuals providing addictions peer support. The work also included exploration of training options to align with the identified peer support competencies.

Summary and Recommendations

A common theme for consideration is the need to make it easier to obtain training and to provide a framework for training that supports individuals' peer support work. Training was identified as the ability to obtain skills and knowledge to effectively provide peer support. It is important because it provides a standardized access to skills and knowledge identify by individuals providing peer support.

The Panel reviewed “*Canadian Mental Health Commission Training Guidelines for Peer Support*”, “*Peer Support Accreditation & Certification Standards*” and the “*DTFP 2013 Peer Support Symposium Results*”.

Core Competencies Peer Support Work in Addictions

The committee identified the following six core competencies:

- Self-Assessment/Self-Evaluation - The ability to complete a self-assessment and/or annual self-evaluation using competencies in order to identify potential areas for training and development.
- Interpersonal skills - The ability to demonstrate intentional listening skills, the ability to engage peers, the ability to demonstrate intentional sharing and the ability to demonstrate how to encourage others to take the necessary steps forward.
- Working with changes and transitions - The ability to demonstrate support for transitions and the ability demonstrate support to overcome transitions.
- Supervision - the ability to work with supervision provided by an organization and/or evaluations provided by a sponsoring agency.
- Personal Development and Learning - the ability to develop and demonstrate a variety of skills for personal development and learning to include but not limited to compassion fatigue, boundary training, confidentiality, role definition, how to be objective, personal safety and nonviolent crisis intervention.
- Access to information tool kit with current information - the ability to access and utilize resources that are provincial, regional based and or interactive material from the Internet.

Figure 1 is a mind map illustrating the six competencies identified by the members of the expert panel.



Figure 2- Six Competencies that can be used to identify training needs

Recommendation(s):

- It is recommended that the current training identified by the 2012 Peer Symposium participants be organized using the identified six competencies.

Training

The Expert Panel explored a variety of training opportunities provided Peer Support Networks in the United States as well as existing training opportunities in Canada. The training ranged from specific courses as identified in March 2013 (Knowledge Exchange Event) and various education opportunities provided through longer term specific Peer Support training programs. The Panel received feedback during the 2014 Knowledge Exchange Event that it is important to align the competencies and the training to the CCSA competencies.

Recommendation(s):

- It is recommended that the Peer Support Network develop an addiction specific core knowledge and skills workshop.

- It is recommended that the Peer Support Network partner with other Peer Support Networks (e.g., HIV, Diabetes, Mental Health) to coordinate peer support training.
- It is recommended, where possible, Addictions Peer Support Training should align and support the development of core competencies.

Knowledge Exchange Event – March, 2014

The following question was addressed at the March consultation to promote feedback and discussion on the above recommendations. The table is a summary of the responses.

1. What topics should be included in a core knowledge and skills workshop(s) for addiction peer support?

Table 3- Attendee Responses to Training Expert Panel Recommendations

<ul style="list-style-type: none"> • Boundaries; e.g. sponsor vs. peer mentor; for sharing lived experience • Concurrent Disorders: the impact of mental illness (co-morbidity) • Supervision • Self-care: awareness of one’s own health status and support to take care • Support to do this fabulous work • Dealing with criticism from peers • Being judged for what you are doing • Formal (Paid \$\$) vs. Informal (Volunteer); delineate levels • Training for the “professional” in dealing with peer support workers • Trauma-informed • Learning about the stages of recovery • Education on drugs of abuse • Listening skills • Discussion on how to make use of other trainings and practices (e.g. MI & CBT) • Learning to de-glorify the drug use –share the healing process • Do no harm (safety) • Understanding stages of change • Scope of Practice • High-Risk policies; i.e. duty to report, violence/harassment, self-harm/suicide • Suicide training • Cultural competency 	<ul style="list-style-type: none"> • Dealing with crisis • Anti-oppression • Physical, emotional, mental, spiritual safety, crisis management • The recovery process • Peer Support – drift Clinical—Recovery • Community Resources • Recognizing many pathways to recovery – how to support regardless of personal differences • Biology of addiction • Learning on how to listen and receive messages: active listening • Knowledge about the SOC model –where person “is at”, readiness to change • Leadership • Conflict of interest/Conflict of commitment • Strengths-based approach • Advocacy knowledge (many disciplines and settings): navigation; skills on how to be an effective advocate • Information about the continuum: e.g. in mental health, medication/treatment is a client choice • Evidence-based practice • Understanding self-disclosure • Triggers and cravings: how to support • Non-judgmental: bias awareness, inclusivity, strength-based focus
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Final Comments

The DTFP-ON projects were evaluated by a team, led by Sanjeev Sridharan, from The Evaluation Centre for Complex Health Interventions. This evaluation included a report on project level contribution stories which summarizes the project level achievements and initial impacts of the projects. The following two sections from that reported are included here as important findings of the Best Practices in Peer Support project.

Acknowledgement of the Need for Addiction Specific Peer Support

As a result of the Best Practices in Peer Support project, the project team has noticed an increase in acknowledgement of the need for an addiction specific peer support network in Ontario. While recognizing that there is a need for integration of Addictions and Mental Health sectors it is essential to note that there are nuances to addiction specific peer support that may not apply to mental health. There are varying philosophies within peer support in Ontario, however, more stakeholders have begun to recognize the need for an addiction specific network and seem more inclined to work in partner.

Quality of Care and Client Outcomes

Evidence shows that offering peer support in substance use programs can have a positive impact on client outcomes (Boisvert et al., 2008). The project team feels strongly that people with lived experience can offer an abundance of knowledge and understanding in a practice setting. Peer work can complement traditional approaches to treatment while also conferring benefits on peer workers. The values of mutuality and experiential knowledge have been identified as aspects that are specific to peer support (Faulkner, Kalathil et al., 2012). The more progress made towards formalizing a peer support network, the more potential for impact on individual, agency, and system levels.

In Conclusion

The recommendations contained in this report will be used as part of the ongoing work of Addictions and Mental Health Ontario to build a sustainable Addictions Peer Support Network in Ontario.

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Appendix 1- Literature Review

Actual Literature Reviewed

After an extensive search for journal articles related to this topic, it was found that the body of literature specifically examining networks of people with substance use is not large. Of the literature that exists, there are three main branches of networks for people with lived experience of substance use. The first branch represents the harm reduction area; the second represents mutual aid related to recovery/ individuals with abstinence goals; the third pertains to networks whose primary focus is mental health but which also offer some services for concurrent disorders.

This document summarizes the key articles for their main findings and identified common themes. These are ordered according to most frequent, with the reference number to the corresponding study in brackets beside the element. This is followed by a full list of documents and notes regarding their key findings.

Elements for success and sustainability

(The percentages in brackets refer to the number of reviewed articles in which an element appeared)

- Partnerships with key stakeholders (54%)
- Governance and a fully developed organizational structure (might include board with oversight of advisory group) (50%)
- Clear feedback process so participants inform direction and practices including evaluation and research that have an adaptive capacity (41%)
- Technology, information dissemination, education (41%)
- Advocacy, voice in planning, policy making (41%)
- Sense of community, self-respect, safety, anonymity (36%)
- Inclusivity, diversity of members (including family) (36%)
- Funding, resources (36%)
- Service provision (training, warm line, drop in centre, needle exchange, hospital visit, etc.) (32%)
- Leadership, champions, (32%)
- Anti-stigma (27%)
- Networking with other networks, being part of a national or international network (as opposed to partnership with key stakeholders) (23%)
- Specialization for substance use (14%)
- Annual event/conference (9%)
- Physical centre/building (9%)
- Clear statement of the values and mission/philosophy and joint definition of “people with lived experience of substance use” (5%)
- Clear and responsive complaint mechanism (5%)

Unsuccessful elements/practices to avoid

- Imposing structure on grassroots organization (5%)
- No “top down” organization (9%)
- Poor organizational structure leads to confusion about decision making (5%)
- Weak local networks cannot be built upon to form stranger larger networks (5%)

Positive advice

- Be patient. There will be failures before success (5%)
- Establish clear definitions for network membership inclusion and exclusion (5%)
- Existing models can be replicated (5%)

Documents Reviewed

Allman et al, (2006): Peer networking for the reduction of drug-related harm. International Journal of Drug Policy

Purpose of Study

To conduct collaborative participatory research on peer networking for the reduction of drug-related harm, involving 900 participants answering a 40 item web based questionnaire.

Key Findings:

- Networks are timely but need funding to develop and grow.
- Government funding is seen as a potential solution, although there was significant distrust of government bodies by some of the respondents.
- There should be dedicated funding to attend workshops and develop training infrastructure.
- Networks are good at disseminating information and an electronic network would reach a broad geographic area.
- Safety and anonymity are critical aspects of a network due to the stigma felt by participants.
- Although there is diversity among drug users, community organization can build collective efficacy; empower their political voice; contribute to local and national policy formation; assist in the structure of interventions, and mitigate the demonstration and ostracism that people who use drugs often experience.
- Networks should build upon other networks: “[t]o get a really good network happening, it was believed, was not so much a question of creating a network but rather discovering the networks that already exist and building on them” (405).

Archibald, M.E. (2006): An Organizational Ecology of National Self-Help/Mutual-Aid Organizations. Nonprofit and Voluntary Sector Quarterly

Purpose of Study

To answer the question “what are the organizational dynamics underlying the institutionalization of self-help/ mutual aid?” The author describes the central patterns of growth, decline, and

persistence of national self-help/mutual-aid organizations, their formal diversification, and the extent to which subpopulations gain market share. In addition to using an organizational–ecological focus to map the trajectory of voluntary organizations, this article builds on resource partitioning theory by applying its central insights to subtypes of organizations.

Key Findings:

- Expansion of self-help/mutual aid is remarkably similar to the trajectories of commercial and bureaucratic populations.
- Few empirical studies address changes in the numbers and types of self-help/mutual-aid organizations except to broadly reflect on the general perception of the remarkable expansion of the field.
- The organizational ecology framework is versatile and can be used to help understand a broad range of very different types of groups, organizations, and social movements.
- Changes in the structure of the population occur because association members come and go, and create other organized groups to fill a variety of niches.
- Self-help/mutual-aid organizations are formal structures sustained by a differentiated, complex organizational structure.
- The group component addresses personal stigmatizing conditions or problems in a public but intimate, face-to-face setting.
- Formal organizations promote better developed support programs; provide stability and predictability; and have a more diverse membership and a stronger leadership structure (Borkman, 1999; Powell, 1987, 1990) than do unaffiliated groups.
- The more stable and predictable the structure, the longer such groups will survive.
- Self-help/mutual-aid organizations almost always attempt to establish a national presence to reach as many potential members as possible and spend time formalizing their programs and structures.
- More formal organizations, as opposed to small informal groups, may be more likely to have evolved a method for incorporating professionals into their structure.

Armitage et al (2010): Recovery Association Project (RAP), Portland, Oregon. Alcoholism Treatment Quarterly

Purpose of Article

To analyze the history and development of the RAP in order to extrapolate key principles.

Key Findings:

- Core values and principles of RAP are derived from the following beliefs:
 - (1) Active citizenship is a stage of recovery, helping to end the social marginalization that is often involved with a history of addiction.
 - (2) Collectively in recovery means that people can do together what they could not do alone.
 - (3) Attainment of self-respect, integrity, and development of one's personal gifts is critical to one's recovery.
- Viewing the need for recovery services from a broader lens, the concept of recovery capital has emerged, defined as individual, relational, and community resources that prevent relapse and support sustained recovery.

- RAP's peer services developed the strengths and unique contributions of people in recovery, with the overarching purpose of building recovery community capacity, through achieving the following goals:
 - (1) Supporting the development of effective citizenship skills through leadership training, thus enhancing the ability of recovering people to “give back” and create valuable social capital to the entire community.
 - (2) Putting a positive public face on recovery and reducing stigma.
 - (3) Providing a range of social support to sustain individual recovery, reduce relapse, and connect participants to a supportive, inclusive recovery community.
 - (4) Building RAP's own capacity to ensure a strong, stable organization with diverse funding and support for long-term sustainability.
- There were key points of tension along the path of applying structure to an organization that was largely grassroots in nature. Sometimes this caused feelings of mistrust between some of the professional staff and some of the peer leaders. Many times, members of the board and other, more “elder” leaders of the organization were involved in mediated discussion to allay fears that the organization was turning into a “top-down” organization. In fact, RAP was attaining structure while maintaining a peer-led organization.
- RAP found that successful strategies for addressing these issues included focusing on RAP's core value of strength-based leadership development and peer recovery values.

Baldacchino et al (2006), The Self-Help Movement in the Addiction Field--Revisited. Journal of Addictions Nursing

Purpose of Article

To examine the nature, ideologies, beliefs, benefits, and limitations of self-help groups and their role in advocacy and in complementing professional help in the addiction field.

Key Findings:

- Section IV of the World Health Organization Declaration of Alma Ata (1978) states that “just as governments must provide adequate health and social measures” the people of any country have “the right and duty to participate individually or collectively in the planning and implementation of their health care”.
- The lack of natural support systems (church, family, and community) in most developed countries, and the socio-cultural isolation in the developing world, means that self-help groups an attractive natural response to these conditions; they serve as extended compassionate families and act as communities that provide mutual support for those who share a particular problem or interest.
- Self-help groups involved in the treatment of addiction use a non-judgmental, caring, and supportive approach with easy access to anyone who desires to be part of the membership.
- The formal treatment system should be ready to fill the community needs that self-help organizations cannot offer, due to lack of finances, management structure, and expertise; the development of working partnerships between the two is ideal, in order to enhance the available community resources.

Brown et al (2010), Determinants of community coalition ability to support evidence-based programs. Journal of Preventative Science

Purpose of Study

Several aspects of coalition functioning significantly predicted support for implementation of high-quality evidence based programs. The discussion examines how coalitions and technical assistance providers can help coalition support such implementation.

Key Findings:

- Coalitions may be most effective when they maintain an efficient focus and task orientation which has been related to member satisfaction and coalition effectiveness.
- Coalition leadership characteristics have been repeatedly shown to influence coalition effectiveness.
- Skilled and capable leadership has been related to membership satisfaction, outcome efficacy, and organizational commitment.
- The quality of relationships and communication both inside the coalition and with the broader community also has important consequences.
- There is evidence that board cohesion influences satisfaction with the coalition, outcome efficacy, and member organizational commitments. Strong inter-organizational collaboration and community relations enhance member satisfaction and participation and may influence coalition support for evidence based practice implementation.
- Coalition leadership that is organized and skilled at facilitating meetings will be better able to create a diligent and efficient coalition culture.

Brown et al (2007), Goal achievement and the accountability of consumer-run organizations. Journal of Behavioural Health Services Resources

Purpose of Study

This study explores how consumer-run organizations can maintain independence while meeting the accountability needs of funding agencies.

Key Findings:

- While consumer-run organizations differ from self-help groups in their organizational structure, their overarching goals remain similar in terms of their focus on mutual support and education.
- Goal setting and tracking play a critical role in strategic planning because the goals guide the focus of the organization and goal tracking informs future strategic planning efforts.
- Although some organizations struggle with goal-tracking, many find it rewarding because it allows them to focus organizational pursuits and use the feedback to make necessary corrections.

Byrne et al (2010), Coexisting or conjoined: The growth of the international drug users' movement through participation with International Harm Reduction Association (IHRA) Conferences. International Journal of Drug Policy

Purpose of Article

To discuss the history and current success of the international drug users movement.

Key Findings:

- According to one Thai drug user activist “Thai drug users have introduced community-driven harm reduction interventions since the 1990s, in spite of the ongoing repressive legal and policy environment” (Suwannawong, 2009). Likewise, in the USA, where federal funding for needle exchange is prohibited, drug users have been central to the development of underground and mobile needle exchanges (see for example the work of the Springfield Users’ Council in Massachusetts). In the still more hostile environment of Russia, where substitution therapy is illegal, drug users have been organizing themselves; in 2001 a group of drug users, who were concerned about problems of drug users in society, formed an organization known as “Kolodez”. During the seven years of its operation, Kolodez fought for improved drug policy in Russia.
- The 6th International Conference in Florence in 1995 marked the low point for the drug users’ movement with the recognition that both the International Drug Users Network (IDUN) and the European Interest Group of Drug Users (EIGDU) had failed. In both cases, this highlighted the difficulty of developing regional and global networks of people who used drugs without strong national networks.
- Although this was the product of many activists’ efforts, the initial process of transforming the International Network of People who Use Drugs (INPUD) into a legal entity was undertaken by a working group which included representatives from Asia, Europe, Latin America, North America and Oceania. The UK’s Department for International Development provided funding for INPUD.
- One major factor that has changed the relationship between IHRA Conferences and the drug users’ movement is the collective growth in experience, which has led to leadership maturation and the ability to sustain a more assertive and measured engagement with the harm reduction movement.
- In addition, the balance between power and participation has shifted to a more mutually acceptable level.

Campbell et al (2003), Emerging New Practices in Organized Peer Support. National Association of State Mental Health Program Directors

Purpose of Report

To examine history and current practices in mental health peer support in the US.

Key Findings:

There have been improvements in self-determination, developing empowering relationships, taking on meaningful roles in society and a decrease in stigma and discrimination.

- The Consumer Organization and Networking Technical Assistance Center (CONTAC) was developed utilizing research on ideal consumer self-help programs, successful consumer-run programs, community support philosophy about service delivery,

descriptions of mature mental health systems, and management and leadership skills. CONTAC has been structured to provide four levels of technical assistance to:

- (1) Peer support groups;
 - (2) Peer outcome orientation;
 - (3) Training for statewide networks;
 - (4) Information sharing.
- Common ingredients of consumer-operated programs were derived from consumer literature on peer support and the work of the Consumer Advisory Panel. These are organized into five domains:
 - (1) Structure;
 - (2) Peer support;
 - (3) Belief systems;
 - (4) Environment;
 - (5) Education/advocacy.

Davidson et al (2010), Enabling or engaging? The role of recovery support services in addiction recovery. Alcoholism Treatment Quarterly

Purpose of Article:

To provide an introduction to the topic, approach, and role of recovery support services in recovery and within a comprehensive network of addiction services and supports.

Key Findings:

- The treatment and recovery communities have become disconnected over the previous decades, and it would be in everyone's best interest for the two communities to be linked back together. Recovery support services may be an especially effective way to accomplish this, by moving the focus and locus of treatment from the institution to the person's natural environment and facilitating a shift from toxic drug dependence to "prodependence on peers".
- The recent advances in this area are emerging from a new generation of grassroots recovery advocacy and support organizations who perceive many treatment programs as more concerned about their own institutional interests than the long-term recovery outcomes of those they serve.

Friedman et al (2007), Harm reduction theory: Users' culture, micro-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups. International Journal of Drug Policy

Purpose of Article

To discuss the user side of harm reduction, focusing to some extent on the early responses to the HIV/AIDS epidemic in each of four sets of localities: New York City, Rotterdam, Buenos Aires, and sites in Central Asia.

Key Findings:

- Those discussing harm reduction programming and strategy must take into account pre-existing forms of activity and organization in which users are involved, in order to consider:
 - (1) Whether their plans will weaken these indigenous responses;

- (2) Ways in which they and already-existing user activities can assist each other.
- Users' responses are a critical part of harm reduction history and theory.
 - Historians and social analysts have critiqued “top-down” analyses of labour and other social movements have been critiqued by historians and social analysts, and research and strategies on harm reduction should similarly be critiqued if they do not deal adequately with users' own collective activities.

Goldstrom et al (2006), National Estimates for Mental Health Mutual Support Groups, Self-Help Organizations, and Consumer-Operated Services. Administration and Policy in Mental Health and Mental Health Services Research

Purpose of Article

To report on a 2002 national survey of mental health mutual support groups and self-help organizations run by and for mental health consumers and/or family members, and consumer-operated services.

Key Findings:

- Inclusion/exclusion criteria for membership need to be established.
- A national campaign to reduce the stigma of seeking care should be developed and implemented.

Humphreys et al (2004), Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. Journal of Substance Abuse Treatment

Purpose of Paper

To summarize key research findings on addiction-related self-help groups and assess their implications for direct service providers, treatment programs, state agencies and policymakers.

Key Findings:

- Australia, Canada, Germany, Poland, and Japan have provided funding for the infrastructure of self-help organizations and have successfully promoted their growth.
- Given the variety of pathways to recovery, clinicians should have a menu of treatment and self-help group options available when planning next steps, in consultation with the client and other stakeholders, and be trained in how to link clients to such groups.
- Self-help supportive infrastructure varies in strength and organization in different communities.
- Resources should be invested in self-help clearinghouses.
- Information on self-help groups should be broadly disseminated.
- Innovative services that promote self-help group involvement should be funded.
- The use of self-help groups as a replacement for treatment should be discouraged; research shows that many clients require the support of both.
- Evaluation research on both 12-step and non 12-step self-help groups should be expanded.
- Opportunities for family members of addicted people to be involved in mutual help organizations should be encouraged.

Kelly JF (2003), Self-help for substance-use disorders: History, effectiveness, knowledge gaps and research opportunities. Clinical Psychology Review

Purpose of Study

Scientific evidence suggests substance-use disorder (SUD)-focused self-help group involvement is a helpful adjunct to SUD treatment, yet significant knowledge gaps remain. The principal aim of this review is to highlight areas of knowledge deficit and their implications for research and practice. To accomplish this, evidence regarding whether self-help group involvement is effective, for whom, and why, is reviewed.

Key Findings:

- Patient motivation fluctuates dynamically in relation to perceived consequences and most patients are unable to maintain high levels of motivation without ongoing support.
- More motivated patients are more likely to seek professional treatment and also follow treatment recommendations to attend self-help groups.
- The likely benefits of self-help involvement include increased coping skills, enhanced self-efficacy, and the maintenance or enhancement of motivation.

Kerr et al (2006), Harm reduction by a "user-run" organization: A case study of the Vancouver Area Network of Drug Users (VANDU). International Journal of Drug Policy

Purpose of Study

To evaluate VANDU.

Key Findings:

- VANDU's constitution articulates two forms of group membership or affiliation, involving both full membership, "reserved for people who report using or formerly using illicit drugs intravenously" and supporting membership, "given to any person who has not formerly used illicit drugs"; while full members can both express views and vote at all meetings, supporting members can express their views but not vote.
- VANDU has repeatedly voiced the concerns of drug users in public and political arenas, garnered political support, and performed a critical educational function by bringing outsiders face to face with the realities of its users.
- VANDU has engaged in activism that has focused public attention on the drug using community and ensured that drug users are more involved in decisions that affect them.

Laverack G., (2006), Improving health outcomes through community empowerment: a review of the literature. Journal of Health, Population and Nutrition

Purpose of Review

To identify material, particularly case studies, that can be included within identified empowerment domains. The paper discusses the results of the literature review and provides examples, from both developed and developing countries, of how each of the empowerment domains has led to an improvement in health outcomes.

Key Findings:

- The literature on community health recognizes that many inequalities in health are a result of power relations that have an effect on the distribution of resources and the development of policy. People attaining the power they need to redress inequalities can bring about social and structural changes, and community empowerment is often the process they use to do this.
- The evidence shows that community action has been able to lead to sustained changes in the social and organizational environment that is linked to improvements in health.
- The study identified nine robust empowerment domains:
 - (1) Participation;
 - (2) Community-based organizations;
 - (3) Local leadership;
 - (4) Resource mobilization;
 - (5) Asking 'why';
 - (6) Assessment of problems;
 - (7) Links with other people and organizations;
 - (8) Role of outside agents;
 - (9) Program management.

Moos, R.H., (2008), Active ingredients of substance use-focused self-help groups

Purpose of Article

To examine the active ingredients of substance use-focused self-help groups by describing four theories defining elements that may contribute to effective psychosocial treatment of substance use disorders.

Cheng et al, (2009), Engaging People with Lived Experience for Better Health Outcomes: Collaboration with Mental Health and Addiction Service Users in Research, Policy, and Treatment A Review of Literature Pertaining to Peer / Consumer Involvement in Mental Health and Addiction Policy. Prepared for the Ontario Minister's Advisory Group

Purpose of Review

To analyze the literature regarding peer / consumer involvement in mental health and addiction policy.

Key Findings:

- “To date, there has been little research that addresses peer/consumer involvement in both the mental health and addiction sectors.”
- Central to the conclusions contained in this paper are the notions of indigenous inclusivity and collaborative autonomy. ‘
- Indigenous inclusivity implies the mandated involvement of people who are indigenous to the specific communities that are being targeted for a given policy, research or treatment intervention.”
- Collaborative autonomy speaks directly to the question of equitable engagement and/or collaboration between service providers and people with lived experience of substance use / mental health issues”.

- Published literature from a variety of sources, including academic, policy and ‘grey’ literature (namely reports published by grassroots agencies employing peer/consumer involvement initiatives) clearly demonstrates the benefits, advantages, and overall importance of engaging PWLE of substance use issues in all aspects of the services and policies that directly affect their everyday lives.”
- peer/consumer-based networking initiatives for the reduction of drug-related harm were seen as “effective, efficient health promoters” thus allowing for the “consolidation and sharing of information, skills and understandings”
- Networks are: autonomous providers of informal, grassroots harm reduction education and services ; service delivery partners with agencies and institutions, albeit in most cases in an underpaid and undervalued capacity; as sources of experiential knowledge and harm reduction education, networking, support and information-sharing; as active and engaged contributors not only in the areas of research, policy making, service delivery and social support, but also importantly in the realm of program development, and; as prominent voices in the ongoing ideologically-charged policy debates surrounding substance use and treatment, the politics of prohibitionism, and the acute lack of humane, ‘patient-centered’ forms of treatment and support.
- In mental health, peer support initiatives can do the following; recovery practice, advocacy, social-recreational activities, public education, Wellness Recovery Action Planning (WRAP) training and other self-care activities, youth awareness, warm line, training for peer workers.
- Internationally, the International Network of People Who Use Drugs (INPUD) is perhaps the first truly global user-run harm reduction advocacy group, based on several core principles, namely: pro drug user rights, pro self-determination, pro harm reduction and safer drug use remaining neutral on an adult’s choice to take drugs or not, anti-prohibitionist, pro equality.
- The Canadian HIV/AIDS Legal Network (2005) argues that greater involvement of people who use illicit drugs is imperative from the perspectives of (1) ethics, (2) human rights, and (3) public health. In accordance with the UN General Assembly’s Declaration of Commitment on HIV/AIDS, “all people should have the right to be involved in decisions affecting their lives” as an ethical principle”.
- Solomon (2004) summarizes the system-wide benefits of peer supports and peer-provided services[in mental health as]: the peer-provided services have the potential to save the mental health system money; reducing hospital use as a result of peer supports and programs saves the system money; the minimal costs of self-help groups is offset by far in savings to the system that is no excuse, however, for not keeping wage parity when a peer is hired into a traditional staff position; peer providers fight stigma by being there; peer providers know how to outreach and link hard-to-reach consumers to the professional services they needs; peer support meet the mental health needs of those in the community ‘.
- The Crack Users’ Project (CUP) is an ongoing peer-driven capacity building ... the objectives of the CUP project were to “increase communication with and among marginalized crack users; build capacity among crack users to develop and implement peer-led, crack-specific harm reduction strategies; and to improve access to physical and mental health services for this group.

- Participants have clearly and repeatedly shared “how much they value having a stable peer attached to the project who can provide advice and information from a perspective of shared and similar experience”.
- The 12-step movement’s central philosophy of anonymity among its members, as well as its overall reluctance and refusal to engage in broader political or social issues are two factors that have effectively served to frustrate research effort... One of the primary strengths of 12-step organizations such as AA and NA is the flexibility of the basic structure of individual groups to adapt to both the ‘local ecology’, and the ‘needs and interests of participating community members’...elements of the 12-step organizational structure serve to facilitate important social benefits exceeding the limited scope of meeting attendance, including post-meeting fellowship, connections with individual sponsors, and involvement in organizing program activities. In general, the wisdom, experiential knowledge and empathy of fellow 12-step program members has been identified as the most important element of social involvement in programs such as AA and NA”.
- The Amistad Peer Center in Portland, Maine has innovatively conducted inreach through its peer supporters directly into the emergency department of the state’s largest psychiatric hospital”.
- Australia employed a Peer Service model that was “identified, planned, operated, administered and evaluated by people with mental health conditions, with fully negotiated input from mainstream mental health sectors and the primary health care sector
- Another way of reframing the overuse of emergency rooms is to divert use through the creative programming of crisis services as discussed by Ashcraft which created a peer run crisis alternative.
- The Auckland Peer Support Network, a support network for peer support workers that meets bimonthly at different locations, providing a forum for peer support workers to engage in information sharing, problem-solving, support and networking.

Power of Peer Support Services in mental health and addictions: Mental Health Commission, New Zealand. (2011).

Purpose of Review

To analyze the literature regarding peer / consumer involvement in mental health and addiction policy.

Key Findings:

- Components of organizational peer support programs
- Clear statement of the values and mission/philosophy and a joint view of recovery
- Fully developed organizational structure with overseeing board or advisory group
- Clear feedback process so people inform direction and practices
- Clear and responsive complaints mechanism
- Partnerships with key stakeholders
- Effective, sustainable relationships with funders and planners

Weeks MR, Convey M, Dickson-Gomez J, Li J, Radda K, Martinez M, et al, Changing drug users' risk environments: Peer health advocates as multi-level community change agents. Am. J Community Psychol 2009; 43(3-4):330-344.

Purpose of Article

To examine the elements of social-level, community empowerment, and participatory models as they pertain to the relevance and sustainability of beneficial intervention effects and efforts by taking advantage of the strength and influence of indigenous social and cultural frameworks and patterns of social interaction as part of the change process. Networks are examined as an approach which represents a significant shift from a focus on individuals and the dynamics of individual-level change to one that situates the individual within the context of an interactive process engaging the whole network group or community.

Key Findings:

- Attention to the community level was built into the PHA training curriculum as a focus on the need for public health advocacy and discussions about issues in the broader community, city, state and nation that affect drug addicts' health, well-being, and quality of life. This was further supported through the ongoing monthly Community Advocacy Group (CAG) meetings. These emphases were primarily chosen to enhance sustainability of the program and its effects by linking the PHAs to the broader community and facilitating their access to and use of community resources
- The monthly CAG meetings were designed to provide an infrastructure and motivation for PHAs to sustain their efforts in community health advocacy, as well as to stay abreast of and engaged in other prevention efforts and actions in the city or region. Emphasis in these meetings was placed on “public health advocacy,” the other role of the PHA.
- Likewise, the program utilized the natural network structure and connections among drug users as channels and support for dissemination of relevant prevention materials. Thus, key community resources and intrinsic characteristics of drug user networks were folded into the design and process of health advocacy and prevention intervention in the RAP program.
- The principle of succession is particularly important in the conceptualization and implementation of the RAP program. Key to sustained effect of any change effort is ongoing presence of the resource that supports that change. In this case, the use of members of the risk community to become change agents within it built on the assumption that as long as they continue to be present in these contexts, they will continue to engage in health advocacy work. In an effort to support this presumption, we included in the training program the slogan, “Once a PHA, always a PHA” to emphasize the transformation of the role of trainees in the context of their network relations and in their communities. We emphasized that even when PHAs stopped all drug use, they could continue to advocate for and take action to promote health in their communities, on behalf of other drug users, or as neighborhood residents. Many embraced this idea and applied it in all aspects of their lives, while others had more limited capacity or cycled in and out of advocacy work, often modulating in relation to the state of their addiction. However, we came to recognize the limitations to long term sustainability of both the PHAs' ability to engage actively in outreach for health promotion and risk or harm reduction, and the resources needed to keep them supplied, informed, and engaged as such. While the interactive feedback supporting PHAs that came from

positive recognition by their peers as a source of information and prevention materials reinforced their motivation to continue this role, neither the feedback nor the motivation appears to continue indefinitely.

- Sustainability also requires long-term institutional commitment and resources to support the continued training and program activities. Without an anchor to a supplier of prevention materials and institutional support for the PHAs, their capacity to sustain their outreach efforts rapidly diminishes. Institutional support includes at minimum the opportunity to resupply, retrain, and reconnect with others like them (especially both role modeling staff and other peer health advocates), and opportunities to engage in broader efforts that allow them to engage as health advocates with non-drug users in broader community contexts. Thus, sustainability incorporates not just the fundamental training and intervention components, but also the dynamic interconnectedness and interrelationships of the PHAs with their community environment on all levels.

White WL. Peer-based Recovery Support Services: The Connecticut Experience. Perspectives on Systems Transformation Connecticut: Great Lakes Addiction Technology Transfer Center; 2006.

Purpose of Article

Interview with the founder of a peer based recovery support service in Connecticut.

Key Findings:

- Funding received from CSAT's Recovery Community Support Program laid a financial foundation that was matched by funding from the Connecticut Department of Mental Health and Addiction Services (DMHAS).
- Close relationship with government addiction agency.
- CCAR was first organized as a pure advocacy organization.
- We started slowly, and as we grew into the delivery of support services, they've become more defined.
- Inclusive "all recovery" meetings.
- Relationship with professional service providers.
- To have a realistic shot at providing support services, they'd need an actual physical location. We put together a loose plan and worked it in Willimantic. The plan follows a theme from the movie *Field of Dreams*, "build it and they will come."
- A lesson learned is that the Center will take on the personality of the lead organizer, and that is a good thing. We call the lead organizer a Senior Peer Services Coordinator, and running a Center is more about community organizing than anything else. I think a lot of Recovery Community Organizations lose the organizing piece; they follow a traditional treatment provider model.

Wituk S, Vu CC, Brown LD, Meissen G. Organizational capacity needs of consumer-run organizations. Adm. Policy Ment. Health 2008 May; 35(3):212-219.

Purpose of Article

The current study utilizes an organizational capacity framework to explore the needs of operating CROs. This framework includes four core capacity areas:

- (1) Technical;
- (2) Management;
- (3) Leadership;
- (4) Adaptive capacity.

An analysis reveals that the greatest organizational needs are related to technical and management capacities.

Key Findings:

- Based on an organization's capacity building needs, technical assistance can be provided to help strengthen nonprofits, including CROs.
- Health professionals and administrators are in an ideal position to support the development of CROs in many ways, ranging from simply providing referrals to becoming an advisor. Greater attention is needed toward fostering these relationships and how best to support them. Such attention will help continue to build and strengthen the mental health movement for years to come.

Wituk SA, Shepherd MD, Warren M, Meissen G. Factors contributing to the survival of self-help groups. Am J Community Psychol 2002 Jun; 30(3):349-366.

Purpose of Study

The purpose of this study was to explore the factors that contribute to self-help group survival by examining their relationship with external sources (i.e., national and local self-help organizations, professionals) and group organizational characteristics (i.e., leadership diversification, recruitment, attendance at group meetings). Representatives from 245 active and 94 recently disbanded self-help groups were included in the analysis. The purpose of this study was to investigate the factors that contribute to self-help group survival by examining their relationships with external sources (i.e., national organizations, local agencies, and professionals) and group organizational characteristics (i.e., leadership diversification, recruitment, and attendance at group meetings).

Key Findings:

- New Jersey Self-Help Clearinghouse, - three factors that contribute to groups' survival (i.e., national affiliation, professional involvement, group concern), other factors may also contribute to the survival of self-help groups.
- as more health and human service professionals begin to refer and interact with self-help groups it is increasingly necessary that they understand how they can increase a group's chances of survival, while allowing it to maintain its own identity, integrity, and independence.
- Powell (1990) suggested that local self-help groups affiliated with national self-help organizations offer members greater benefits because of their highly developed programs, accumulated experience, and the input of a supportive organizational network. In addition, Powell suggested national organizations can promote seasoned members into leadership, insuring local groups that their organization will be maintained for future members. If this is the case, then it seems plausible that groups affiliated and supported by a national self-help organization would be more likely to survive compared with groups without such support.

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- Some groups have strong relationships with agencies and organizations in their local communities.
 - It is not surprising that self-help groups differ in how they are organized, including their diversification of group leadership, recruitment, and maintenance of group members, attendance at group meetings, and length of group existence. Although it has become routine to report at least some of these characteristics in studies of self-help groups, there have been no extensive studies that have explored how these factors contribute to group survival.
 - Leadership burnout can place the group at risk of disbanding if only one leader is primarily responsible for all or a majority of group responsibilities.
 - Such information would be valuable to self-help clearinghouses and advocates, national self-help organizations, and others who interact with self-help groups. This study suggests these organizations and individuals should focus their attention on helping groups attract new members, diversify their leadership, gain resources from other national and local organizations, and support newly developing groups.

Appendix 2: Analysis of Specific Network Websites

Introduction

31 network websites found through the previously conducted review were analyzed. Their structure almost always included the following in the way they were set up:

- Home Page (with pictures)
- Who we are; our purpose
- Guiding principles, aims, structure, position statements
- Staffing
- Internal communication: blog; posts; forum; comments; knowledge exchange
- News: sometimes including a newsletter; local, national and/or international
- How to get involved
- Job postings
- Projects
- Publications
- What's on: sometimes including a calendar of upcoming events
- FAQs
- Links: to literature; articles; media
- Contact us: sometimes containing a brochure
- Privacy statement and disclaimer

Based on this analysis, one can conclude that successful network websites need to be:

- Accessible
- User friendly and easy to navigate
- Addressing gaps
- Disseminating Information
- Transparent
- Meeting needs of membership
- Current
- Sustainable
- Facilitating member communication

Analysis of Content of Network Websites

	Purpose/ Who we are/ Backgr.	Guiding Principles/ Structure/ Values/ Staffing	News – Local/Nat/ Internat.	Internal Comm'cn/ Blog/ Posts/ Comments/ Forum/KE	Projects/ Job postings/ Public'ns/ Resources	What's Going On/ Calendar	How to get involved/ Membership/ FAQ	Links/ Literature/ Videos/ Library	Contact Us (Brochure)
INPUD	x	x	x					x	
Danish DU Union			x			x		x	x
Addiction Recovery Blog	x			x				x	
San Fran. DU Union		x				x	x	x	
UNDUN (DU)	x		x	x	x			x	x
SOLID (DU)	x	x				x			x
VANDU	x		x			x		x	x
BC/Yukon Ass'cn DWS	x	x	x					x	
Toronto DU Union	x			x				x	x
Asian HR Network	x	x						x	x
European HR Network		x	x						x
Canadian HR Network	x			x	x	x		x	x
Arun Exact	x	x				x		x	
Self-Help Connection	x	x			x				x
Schiz. Soc. NS		x		x				x	x
London D&A Network		x	x		x	x	x		x
DPN Canada	x		x				x	x	x
NNAPF	x	x	x				x	x	x

	Purpose (Who we	Guiding Principles/	News – Local/ Nat/	Internal Comm'cn/	Job postings/	What's Going	How to get involved/	Links/ Literature/Vi	Contact Us/ Brochure/N
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	are)/ Backgr.	Structure/ Values/ Staffing	Internat.	Blog/ Posts/ Comments/ Forum/ KE	Public'ns/R esources	On/ Projects/ Calendar	Membership/ FAQ	deos/ Library	ewsletter
LERN	x	x	x	x	x	x	x	x	x
CCMHAR	x	x	x	x	x	x	x	x	x
NNMH	x	x	x	x				x	x
Recovery Network Toronto	x	x		x		x		x	x
OPDI	x	x	x			x		x	x
MHCC	x	x	x		x			x	x
Matthew 25 Aids Svcs.	x				x	x	x	x	x
Aids Network	x	x	x			x	x		x
Ontario HIV Network	x	x		x	x	x	x	x	x
Active Living Alliance	x		x		x	x	x	x	x
Against Women Abuse	x	x	x		x	x		x	x
Toronto ABI Network	x	x	x		x	x	x	x	x
Woman ACT	x	x	x	x	x	x	x	x	

List of Web Addresses of Reviewed Networks

Name of Network and Web Address
International Network of People who use Drugs http://inpuod.wordpress.com/2011/10/07/final-founding-statement-of-euronpuod/
Danish Drug Users Network http://www.netzkraft.net/mitglied.php?teilnehmer=478&lang=espan
Addiction Recovery Blog http://addiction-recovery-blog.com/
San Francisco Drug Users Union http://www.sfdrugusersunion.org/p/drug-user-organising-for-beginners.html
Unified Network of Drug Users Nationally http://www.undun.org/index.htm
Society of Living Illicit Drug Users http://solidvictoria.org/
Vancouver Area Network of Drug Users http://www.vandu.org/
B.C./Yukon Association of Drug War Survivors http://www.drugwarsurvivors.org/index.htm
B.C./Yukon Association of Drug War Survivors http://www.drugwarsurvivors.org/index.htm
Society of Living Illicit Drug Users http://solidvictoria.org/
Toronto Drug Users Union http://tduu.blogspot.com/
Asian Harm Reduction Network http://new.ahrn.net/
European Harm Reduction Network http://www.eurohrn.eu/
Canadian Harm Reduction Network http://canadianharmreduction.com/index.php
EXACT (England) http://recoverytoolkit-westsussex.org.uk/?page_id=320
London Drug and Alcohol Network http://www.ldan.org.uk/
Drug Prevention Network of Canada http://dpmoc.ca/
National Native Addictions Partnership Foundation http://www.nnapf.org/vision-mission-and-mandate
Lived Experience and Recovery (LERN) www.livedexperience.org
National Network for Mental Health (Consumer/Survivors) http://www.nnmh.ca/Home/tabid/380/language/en-CA/Default.aspx
National Consumer Coalition for Canada http://ccamhr.ca/
Recovery Network of Toronto http://recoverynetworktoronto.wordpress.com/
Ontario Peer Development Initiative: our history and the evolution of our mission, vision and values http://www.opdi.org/images/uploads/OurHistory
Mental Health Commission of Canada Peer Project http://www.mentalhealthcommission.ca/English/Pages/PeerProject.aspx
Support, Education and Treatment www.matthew25clinic.org
AIDS Network of HHHNB www.aidsnetwork.ca/education_pemap.php
Ontario HIV Treatment Network http://www.ohntn.on.ca/Pages/About-Us/Default.aspx
London Coordinating Committee to end Woman Abuse http://www.lccewa.ca/who/vision
Active Living Alliance for Canadians with a Disability http://www.ala.ca/Content/Home.asp?langid=1
Self-Help Connection of Nova Scotia http://www.selfhelpconnection.ca/
Schizophrenia Society of Nova Scotia http://ssnsc.blogspot.com/
Woman Abuse Council of Toronto http://www.womanabuse.ca/index.cfm
Toronto ABI Network www.abinetwork.ca/