'Having those conversations': The politics of risk in peer support practice

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ABSTRACT

Peer support is a fast growing type of service provision within the mental health sector. This study draws on interviews with peer supporters and peer support managers to explore the ways that risks of violence, suicide and self-harm are managed within peer support settings in Aotearoa New Zealand. Drawing on Nikolas Rose and other theorists, who define risk thinking as an attempt to 'discipline uncertainty', we argue that the philosophy of peer support is in tension with a 'risk consciousness' because it sees crisis as a learning opportunity. We contend that peer supporters are pulled towards the 'risk consciousness', which pervades the mental health sector, and that they address this by managing risk in various ways. Finally, we show that peer supporters challenge this risk consciousness by working with risk through a philosophy of engagement and relationship. As peer support becomes more integrated into the wider health system, the challenge will be to continue the development of risk practices which work within a strong peer support philosophy.

KEYWORDS: sociology; mental health; peer support; risk; suicide; relationship

INTRODUCTION

Over the past 25 years, risk management has become a central element in community–based mental health services (Godin 2004; Rose 1998; Sawyer 2005; Sawyer et al. 2009). As Godin notes, traditional concerns of psychiatrists, nurses and social workers, around a patient's health and social care needs, have been subordinated to an over-riding imperative to assess and manage the risks they are assumed to pose (Godin 2004:348). Given this trend, it is important to ask how 'risk' concerns are being played out in peer support services; these services are a recent innovation in mental health care in which support is offered to service users by current or former service users.

Peer support has its origins in the self–help and psychiatric survivor movements, within the context of deinstitutionalisation in the 1970s (Campbell 2005; Chamberlin 1978). During the 1990s, it moved into a new phase, in which services were funded within mainstream mental health provision, and provided within a health system context (Bradstreet 2006; O'Hagan 2011). Peer support is a growing sector within

community mental health in a number of countries, such as Canada (O'Hagan et al. 2009), the United States of America (Nelson et al. 2007), New Zealand (Orwin 2008), Scotland (McLean et al. 2009) and Australia (Lawn et al. 2008). It has grown dramatically in New Zealand during the past ten years; indeed, every District Health Board[1] in New Zealand now offers some form of peer support. It has been suggested that peer support might be 'the fastest growing type of service in mental health systems throughout the world over the next 20 years' (O'Hagan et al. 2009:6). As peer support agencies are generally contracted in to provide mental health services in the community, their staff face the intensified risks also faced by other community-based mental health workers who work in unregulated community settings (Sawyer et al. 2009). However, the risk management practices adopted by peer support services are different from those of other mental health services because of the distinctive philosophies and roles of peer support.

In this paper, we will argue that peer support is a liminal occupation. Warner and Gabe (2004:388) define liminality as a state of being 'in-between' two otherwise distinct identities. In the case of peer support, liminality arises from the fact that peer supporters are both inside and outside the experience of 'madness'. They are health workers, located within a health system deeply focused on the identification and management of risk. At the same time, they have been service users and share in the stigma associated with being mental health consumers. While peer support philosophies differ, all are grounded in a recovery philosophy (Anthony 1993; Davidson et al. 2009), and thus emphasise self-determination, mutuality and the honouring of their peers' experiences. In this way, peer supporters occupy a hybrid position in which they identify with the experience of mental disorder while sitting

outside it as providers of services. Inherent in this liminality is a sense of unease.

The liminality inherent in peer support leads to a tension that is experienced in relation to the question of risk. Peer supporters are drawn in two directions at once. They are pulled towards strategies of 'risk management' by wider risk discourses, including clinicians' scepticism about the safety and integrity of peer support. At the same time, they are drawn towards the downplaying or reformulation of risk by virtue of their own experiences and by the philosophy of peer support. We will demonstrate that peer support services deal with this tension in different ways, leading to a continuum of approaches for handling risk among peer support services in Aotearoa New Zealand. We will also suggest that some peer supporters are beginning to develop a specifically 'peer support' way of addressing risk.

METHODOLOGY

The data used in this paper were collected in a qualitative study of peer support services in Aotearoa New Zealand during the first half of 2010. A total of 37 peer supporters and peer support managers took part in group or individual interviews. All of the peer supporters and peer support managers we interviewed held paid positions, with the exception of one manager whose position was unfunded, and two volunteer peer supporters in one of the Kaupapa Māori services. The majority of participants were working part-time. All participants in this study had some form of mental health training. In nine of the 14 services this involved training in a specific peer support model. Participants from other services had completed in-house training, training provided through their District Health Board or the Mental Health Support Worker's Certificate. Many participants who had completed training

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[1]   The District Health Boards are public bodies which own and manage most public hospitals within a region, and fund private and non-government services. There are currently 20 District Health Boards in Aotearoa New Zealand as two of them have recently been amalgamated.

in peer support had also engaged in these other forms of training.

The 14 peer support services offered a variety of types of peer support, including one-on-one peer support, support groups, Kaupapa Māori peer support,[2] intensive peer support, a drop-in centre, advocacy, fieldwork, support to inpatients, a telephone support line, and crisis houses/alternatives to hospitalisation. There were several organisational structures included in this study. Four of the peer support services were based in small consumer-led trusts. Two services were based in a consumer-led business. One service was located with a District Health Board's Specialist Mental Health Services arm. The rest of the services were based within larger mental health trusts offering a variety of services, including consumer-led services. Several of these organisations had offered peer support for up to 12 years, although a period of 4–5 years was more common.

At the beginning of the study, a listing was made of every peer support service in Aotearoa New Zealand funded by a District Health Board, along with some basic information about each of these services. This information was collected, primarily, by contacting the funding and planning officer for mental health in each of the 21 District Health Boards in the country. Purposive sampling was used to select ten of these organisations offering peer support; this amounted to 14 peer support services, as some organisations offered more than one peer support service. Services were sampled to maximise geographical spread; seven organisations were selected in various parts of the North Island and three in the South Island, a division roughly reflecting the spread of population in the country. Sampling also ensured diversity in terms of the type of organisation offering peer support, the

type of service, the model of peer support being employed, and the size of the organisation and service. All 14 services invited to participate agreed to do so.

A mixed methodology was employed, including different data collection strategies for the 12 mainstream services and the two Māori orientated services. We did this because it is important to collect and analyse information about Māori services within a Māori framework (Smith 1999). Thus, in the 12 mainstream services, the primary author visited each service over several days, and spent informal time in the office. Individual interviews were conducted with a peer support manager and one or more peer supporters. In total, 24 peer support staff participated in the individual interviews. Two in-depth interviews were conducted with each participant. The first interview focused on ways of thinking about peer support relationships, while the second interview focused on policy and practice.

In the two Kaupapa Māori services, a tikanga-based methodology was used. Tamehana Consultants, who have expertise in Māori mental health, designed a process that involved two day visits by themselves and our third author to each service. During these visits, unrecorded whakatau and mihi were combined with several recorded group interviews, which included peer support managers, peer supporters, kaumatua, a clinical supervisor and volunteers in the two services.[3] Thirteen participants took part in these group interviews.

During the second interview in the mainstream services, and as part of the conversation in the Kaupapa Māori services, participants were asked how their service dealt with risk. This paper is based on answers to this question, as well as spontaneous discussions of risk-related issues that arose in the course of the interviews.

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[2]   A Kaupapa Māori service is a service based on Māori empowerment and principles.
[3]   A tikanga based practice is a practice based on Māori protocols. A whakatau is a welcome, while mihi are introductions which combine personal introductions with connections on the basis of whakapapa (geneaology) and other connections. A kaumatua is a Māori elder who acts as a guide to the organisation.

The focus of the 'risk' question was specifically on risk of suicide, self-harm or harm to others. Risk of harm *to* consumers from others in the community was not discussed in these interviews, as management of these risks is usually part of case management, a sphere of practice outside the scope of the peer support services in this study.[4]

The interviews were audio-recorded, transcribed verbatim, and coded using the NVIVO qualitative data analysis package across 67 categories. A report is currently being finalised, based on thematic analysis of this data. This paper draws on that thematic analysis. The research was funded by the University of Canterbury's College of Arts, and approved by the Multi-Regional Health and Disability Ethics Committee of Aotearoa New Zealand. All names used are pseudonyms, and identifying details have been changed.

THEORISING RISK IN PEER SUPPORT

Drawing on an approach grounded in Foucauldian governmentality, Nikolas Rose argued that 'risk' has replaced 'dangerousness' as the centrepiece of Western efforts to deal with the uncertainty raised by work in mental health contexts. Risk thinking is heterogenous, but is almost always characterised by an attempt to bring the future into the present and make it calculable:[5]

> We could say that it tries to discipline uncertainty: to discipline it in the sense of making uncertainty the topic of a branch of learning and instruction. And to discipline it in a second sense, by bringing uncertainty under control, making it orderly and docile. Risk thinking tames chance, fate and uncertainty … we can demand that calculations about

tomorrow should and must inform all decisions made today. Risk thinking can become not merely an option but an obligation. (Rose 1998:180–181)

This understanding of risk is a key aspect of what Giddens calls 'high modernity'. Existential uncertainty, or what he calls 'ontological insecurity', is addressed through the use of abstract systems which combine reflexive thinking with a reliance on expertise and technical problem solving (Giddens 1991). Similarly, Bauman (2007) describes the existential uncertainty created by life in this 'liquid' phase of modernity. We cannot do anything about the speed of social change, the increasing inability of politics to restrain the operations of global power, the gradual withdrawal of social safety nets, and the individualisation of responsibility for planning and action. However, we can deflect the ontological fears these social changes raise onto technical processes for managing uncertainty on a personal scale (Bauman 2007:11; Kelly 2000). In particular, this focus for risk management falls upon stigmatised groups and liminal persons, such as refugees.

For this reason mental health consumers occupy a liminal position. They are both 'of the community, needing care, and outside of the community, posing a threat to it' (Warner and Gabe 2004:388). For the purposes of our argument, precaution in the form of risk management leads to an 'othering' of people living with mental illnesses and members of other liminal groups (Warner and Gabe 2004). Mental health legislation and practice in most western countries is pervaded by risk thinking. People with diagnosed mental illnesses are subject to regular risk assessments (Godin 2004), and the risks they pose are 'managed' through a variety of

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[4]   Risk to peer support workers' mental health by job stress was addressed in a separate section of the interviews. Answers to this question are being dealt with in a separate paper; they are not relevant to the risk of suicidal behaviours, self-harm and harm to others, which is the specific focus of this article.

[5]   For instance, see Norko and Baranosli (2005), who have summarised research on the extent to which violence is predictable in the presence or absence of mental illness.

mechanisms, most specifically through a focus on adherence with medication (Sawyer 2008). Consequently, in western mental health practice, a shift has taken place from a therapeutic consciousness to a risk consciousness, centred on assessing and managing 'risk factors' (Sawyer 2005). According to some mental health providers, this has caused a narrowing of services provided to clients, as well as the loss of opportunities for clinicians to listen to clients' own accounts of their experiences, and to engage therapeutically with them (Sawyer 2005).

We contend that this represents a subtle shift towards social exclusion of the 'risk object', which is deeply opposed to the original aims – around community integration – of deinstitutionalisation. The process of 'othering' mental health service users through risk management involves their social exclusion at a conceptual level. To be seen as 'other' is to be treated as a risk object, a collection of risk factors and deficits, rather than a person with a fully valid set of experiences and perceptions (Kelly 2000:465–466). As several participants in our study said, it is to perpetuate a 'them and us' way of thinking.

Thus, we can say that existential uncertainty is steering us towards bringing the future into the calculable present through risk management strategies. The practices this change generates are particularly directed towards liminal 'others' who are socially excluded, such as mental health service users. In mental health practice risk management is now placed at the forefront of everyday consciousness and activities (Godin 2004; Kelly 2000; Langan 2010; Rose 1998; Sawyer 2005, 2008, 2009). In relation to this focus on

risk management, peer supporters are also in a liminal position. On the one hand, they must draw from their own experiences of mental illness to build an empathetic connection with their peer.[6] On the other hand, they are mental health providers, sharing in the trend towards greater risk management within community mental health services. A focus on risk management, with its consequent treatment of mental health consumers as 'risk objects' is in tension with the purpose of peer support, which is to bring the 'othered' mental health consumer fully back into the community.

PEER SUPPORT AND THE DIGNITY OF RISK

Peer support is a relatively new form of mental health provision, which takes place in a variety of organisational and service contexts. Doughty and Tse (2010) note that consumer–operated services were developed for several reasons: it was thought that consumers might better understand issues arising for their peers, that they might encourage participation of consumers in services, and that they could catalyse positive changes in attitudes towards mental illness.[7]

Following a national forum on peer support at which this question was discussed extensively, Te Pou, New Zealand's National Mental Health Workforce Development Agency, developed the following definition of peer support:

> Peer support is person-centred and underpinned by recovery and strength-based philosophies. The life experience of the worker creates common ground from which the trust relationship with the person is formed.

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[6] The term 'peer' is often used by peer supporters to refer to members of their client group. The intention is to reinforce the mutuality of the relationship by avoiding the language of professional services. In this paper, the term 'peer' will be used to refer to mental health consumers with whom peer supporters are working.

[7] Peer support is increasingly being reviewed, although many studies are still part of the 'grey' literature rather than published in international journals. See for example, McLean et al. (2009) and O'Hagan et al. (2009). See Doughty and Tse (2010) for a systematic review of published studies of peer support's effectiveness, and Davidson et al. (2005) for a somewhat older systematic review. See Nelson et al. (2007) for results of a five-year longitudinal study into the effectiveness of peer support in the United States.

Empowerment, empathy, hope and choice along with mutuality are the main drivers in purposeful peer support work. There is great deal of strength gained in knowing someone who has walked where you are walking and who now has a life of their choosing. In this way it is different from support work, it comes from a profoundly different philosophical base. (Te Pou 2009)

In our study, some participants emphasised that peer support was about supporting individuals to overcome their life challenges themselves. Peer supporters were there to walk alongside their peer as s/he made her/his own choices:

… a good relationship is where the peer supporter's not trying to 'fix' the person, or offer help in a way that's disempowering for the person. Everything we do needs to contribute to the person feeling like they have the skills and the abilities to overcome the challenges. (Zoe, manager)

This involved supporting people as they made mistakes, rather than trying to prevent the mistakes. Drawing on the principle of 'dignity of risk', which has been developed in the disability field by Robert Perske and Wolf Wolfensberger (Wehmeyer 1998:7; Wolfensberger 1972), it encapsulates the notion of providing support for people to take risks in remaking their lives:

People fall over a number of times and you're just there; dust them off and keep going. Don't try and prevent them … [This] does [work]. People don't feel pushed, they don't feel forced. They feel respected. They feel they can have their own approach. It provides that dignity word, that respect word. Respect is not preventing people from making mistakes. Respect is letting people find their own way, and follow their own choices, and still be there. (Velda, manager)

As one peer support manager pointed out, this approach can lead to dissonance and potential conflict with mainstream clinical services. Many such services operate through a particular sort of risk consciousness, where great emphasis is placed on managing risky or dangerous thoughts or behaviours (Sawyer 2005):

One team's coming from a very risk averse, medical model approach. And we're coming from an opportunity – risk is opportunity and if you don't take any risk you don't learn anything sort of approach. But the safety's in, I guess safety's not quite the right word. The *container* is the relationship, the peer relationship. (Geoff, manager)

While early indications suggest that peer support is at least equally effective as traditionally provided services across a range of standard outcomes (Davidson et al. 2005; Doughty and Tse 2010), and has additional benefits in relation to community integration and quality of life (Nelson et al. 2007), some clinicians seemed to fear that peer support services would increase risk for their clients. Both crisis houses in our study reported that clinicians had initially been reluctant to refer to them because of potential risks:

Initially we didn't get any referrals through [the crisis team] because of course it wasn't safe. Yeah. People would stop their medication and would commit suicide and we wouldn't know what to do and all that stuff. And everybody who worked there would end up in the unit being unwell as well, because no way service users could provide good support. You know, it's just not safe. So we didn't get any referrals from them. (Velda, manager)

Peer supporters in Aotearoa New Zealand were very sensitive to such attitudes held by clinicians, and placed great importance on building mutual respect with the clinical services. Clinicians' attitudes towards peer support was a theme discussed in almost every interview, and it was spontaneously brought up as one of the main issues facing peer support by more than half our

participants.[8] As peer support has become more deeply embedded in the public health system during the past few years, the importance of gaining respect from clinicians and funders has grown. Funding and successful integration into the health system were seen to depend on it. At the same time, some peer supporters had an evident discomfort with being seen by their peers as a 'professional' like other professionals:

> You don't want to come across as professional, you want to come across as somebody that can be trusted, that can be a buddy or at least be trusted, just somebody to get on with, you know. You don't want to come across as a social worker or a WINZ worker[9] or anything else. That's the exact opposite to what peer supporters should be. (Ross, peer supporter)

Peer support is thus a liminal occupation. Warner and Gabe (2004) describe social work as a liminal profession because it mediates between those who are included as 'social beings' and those who are excluded. Similarly, peer supporters mediate between people living with mental illness and the wider system:

> So peer support means they've got somebody that's outside the system, so they can safely talk about the system to somebody they trust, who knows the system and who also has good experiences of the system. (Deborah, peer supporter)

Peer support is liminal in a second way. Peer supporters are themselves mental health consumers who are, or have been, subjected to stigma and social exclusion; the continuing stigma attached to peer support was mentioned by a number of participants. Thus, peer supporters are health workers, whilst also defined by an identity and philosophy that sits in some tension with the risk-based approaches driving mainstream mental health services.

PEER SUPPORTERS AND THE MANAGEMENT OF RISK

Peer supporters are pulled towards a logic of risk (Rose 1998) for at least three reasons. The first is sheer need. Internationally, most research indicates that the majority of people who die by suicide have some kind of mental disorder at the time of death (Kapur 2009:1). In Aotearoa New Zealand the strongest predictor of suicidal behaviour in adults is the presence of a mental disorder and multiple diagnoses confer greater risk (Beautrais 2003:464). Regardless of how mental health workers respond to risk all have to contend with the real threat of suicidal behaviours. This threat serves to create an anxiety that is perhaps more pronounced in clinicians who are medically trained than in peer supporters. Another focus of need is self-care. Peer supporters are often working on their own in the community, and therefore are at risk of physical or verbal abuse:

> That's the thing about this job. People are unwell; that's what they're there for. And you meet people who are really, really manic and high, and then the good thing about the job too is once you see them when they're well and more stable, how much better they are. But yeah, there is a risk. We're at risk. (Felicity, peer supporter)

The possibility that something can happen is ever present, although actual risks to peer support workers were mentioned in only a few instances by participants.

A second driver towards a logic of risk derives from the wider risk discourses in mental health,

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[8] Stigma and lack of respect from clinicians is still a problem for peer support, although one that is little talked about in the research literature. See Gates and Akabas (2007:297) and Hardiman (2007) for some tentative indications of attitudes towards peer support by clinicians in American settings.

[9] WINZ is Work and Income New Zealand, the agency responsible for distributing benefits to people who are unemployed or on sickness benefit.

and the consequent need to appear credible in the eyes of clinicians and funders. Peer support services are generally required by their funders to have robust and sustainable risk management policies. Finally, it is our argument in this paper that a third driver, which underlies the second, is the existential anxiety that suicide, violence or self-harm can generate.

Peer support services utilised three broad groups of strategies to address and manage risks. The first involved receiving risk assessments from clinical services, or rarely, by producing them directly. The second was enacted by contacting clinical services when a risky situation arose. Finally, safety strategies such as placing a barrier in the office or carrying a mobile phone were sometimes employed. Each set of strategies is discussed and illustrated in turn. We found a continuum of approaches, ranging from those which differed only slightly from mainstream approaches to risk management, to one consumer-led service that used the intentional peer support (IPS) model which has an extremely relational way of handling risk. Approximately half of the services were located in the middle of this continuum.

Many services that engaged with peers and met with them one-on-one over an extended period of time had a policy of requiring risk assessments from the relevant clinical services before peers could travel in peer supporters' cars or receive home visits. There was a spectrum of approaches here, from services which did not use risk assessments at all, to two services which placed great stock in them. These two services were frustrated by the failure of clinical services to keep their risk assessments up to date. For example, a manager in one of these services noted that information regarding an episode in which a peer had attacked somebody with a weapon had come to the attention of the peer support worker, but had not been documented in the peer's risk assessment (Elisabeth, manager).

In many instances, an attempt was made to ensure that risk assessments did not interfere with the development of a good relationship between peer supporter and peer. This stance suggests discomfort with using risk assessment tools, and a tentativeness in embracing the logic of risk. In one service that conducted its own risk assessments, peer supporters reported that the relationship could indeed be affected:

> You're switching back to that oppressor role, that clinician sort of thing. All of a sudden you're turning into a psychiatrist that's telling them, 'Oh well, we're quite concerned that you're going to harm yourself or someone else so we'll be chucking you over here for now'. (Craig, peer supporter)

Here, we see directly the contradictions created by risk assessment for people working in a peer support framework. To deal with this difficulty, many services using risk assessments built a gap between the risk assessment and the peer supporter. In some services, the risk assessment was seen exclusively by the manager, who alerted the peer supporters only if extra safety procedures were needed. In such services, the risk assessments were not kept in the peer's file, and were not accessible for peer supporters to read. For example, in one service based in a large mental health organisation, risk assessments were required in line with wider organisational risk management policy. This requirement was fulfilled, albeit with specific restrictions:

> And I then have that risk assessment in a separate folder in my office. Which is also different, otherwise that risk assessment would be in that person's folder that is accessed by the peer support worker and we don't want that sort of information to be in someone's folder. It's just there because it has to happen. I don't even necessarily read through all of them. I sort of, you know, scan them and put them in the folder, that's it. We've got the risk assessment. (Lydia, manager)

In this quote, we can see the discomfort that the process of risk assessment generated within

this peer support service. The organisational logic of risk management was seen as necessary but, at the same time, at odds with the practice of peer support; while the role of risk assessment was privileged, the requirement for risk assessment was sidelined in practice.

With respect to the second group of strategies, peer supporters made contact with clinicians when a significantly risky situation developed. Thirteen of the 14 services participating in the research noted that this strategy was part of their risk policy. There was great variation, however, in the speed and frequency with which clinicians might be contacted. While some organisations rarely, if ever, felt the need to contact clinical services, others did so on a more regular basis. One peer supporter emphasised that he would contact clinical services as soon as he had any concerns at all:

> I am very clear with my tangata whai ora[10] that I'm working with at that time that this is what is going to happen. If I see or I hear at any time that there is any reason for me to feel that there is a safety issue here for you, me or anybody else then I am going to go to the appropriate agencies to keep you safe, and I won't hesitate. The moment you even say one word like I feel suicidal, I feel like cutting, anything, I will call the crisis team or whoever. Whoever I need to call, I will bring in. (Tane, peer supporter)

This quick recourse to clinical services seemed to be rooted in a desire to avoid anxiety; indeed, this peer supporter emphasised that 'safety first, safety last' guided his actions. However, perceptions of the wider environment also generated such risk averse approaches. Tui, the manager of the service for which Tane worked, described the funding environment as: 'so risk averse that the procedures are so tight to try and cover everybody's butt and that really limits what we

can practice. And it's a pretty risky industry sometimes'.

The consequences of calling clinical services, however, could undermine the peer support relationship. In some cases, the call for help was deemed as not fitting intake criteria by overburdened crisis teams, a problem that several participants mentioned. Alternatively, peers might be subjected to risk management procedures that could be alienating and even traumatising. For example, some peers might be involuntarily admitted into hospital. As clinical services have become more orientated to the assessment and management of risk, mental health clinicians seem to have increasingly limited opportunities to develop therapeutic relationships with their clients (Sawyer, 2005, 2008, 2009). In some cases, peers could feel betrayed when their peer supporters contacted clinical services on their behalf (Rose, peer supporter).

Dealing with risk could also affect the peer relationship more directly. One peer support organisation reported shifting from an engaged, informal relational style to a checklist when issues of risk arose. This involved asking three set questions and, depending on the answers, moving on to contacting clinical services (Caitlin, peer supporter):

> We have, everybody has in their diary, it's almost like instructions that you follow, like a recipe. If you ask this question and if they answer you, ask another question and by the time you get to the end you know what you need to do. And everybody has to keep it in the front of their diaries so they just glance and say, 'ok, I've ticked off all these boxes and I know what I need to do, depending on the answers you get'. (Roberta, peer supporter)

In this structured approach, the philosophy of peer support is suspended. Rather than being left to direct the relationship in his or her own

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[10] Tangata whai ora is a Māori term often used in Aotearoa New Zealand to refer to people living with mental illness. Its literal meaning is 'people seeking wellness'.

way with the possibility of making mistakes, the peer was effectively being managed through a checklist; thus he or she might be said to have become a 'risk object'.

The drivers leading towards risk management strategies sat in tension with a felt need to maintain honesty and mutuality in the peer relationship. This tension led, once again, to a felt ambiguity around the process of calling in clinical services for some peer support services. One service emphasised that they rarely called crisis services, and when they did it was always for a very good reason:

> The approach is if you feel really worried you can ring the crisis team on your own behalf because you can't go home feeling worried. You take the action you need to take to put your mind at rest. (Velda, manager)

In this way, anxiety could be alleviated. When they needed to do this, however, they were adamant that it never happened behind a peer's back. The peer would always be told that clinical services were going to be called, and even invited to make the call themselves. Such transparency in making calls to the Crisis Team, key workers or clinicians was mentioned by almost everybody who talked about the process of calling clinical services. Only one service reported that they sometimes did not tell the peer *who* had called the crisis team or key worker.

The third strategy involved modifying the environment and using teamwork to increase safety. One service had a tall desk installed in the office reception area to act as a psychological barrier on entry to the main part of the office. They also had a policy that the office closed unless at least two peer supporters were present. Another service had installed an alarm button in their small meeting room. They had a policy that peer supporters meeting one-on-one with peers should always sit nearest the door, and the alarm button was discreetly placed in this location. Some services had a policy that, on first meeting with a peer, two peer supporters should be present,

including at least one who was the same gender as the peer. In addition, some recommended that initial meetings take place in a public place. 'Self-care always comes first with us. You know, and you never go into a situation that you feel there's going to be any danger' (Stephanie, peer supporter). It was common practice for peer supporters to carry mobile phones with numbers for the police, the crisis team and other support services entered into the contacts list. The challenge for peer support services was to implement these safety strategies in such a way that the relationship with the peer was not impeded. However, as Stephanie pointed out: if the peer supporter was not comfortable or did not feel safe it would be difficult or impossible to make a connection (Stephanie, peer supporter).

In spite of the drivers pressing towards a more conservative risk management approach, a number of peer support services seemed to be developing a 'peer support' way of handling risk. This started with a refusal to practice within the particular sort of 'risk consciousness' that focused entirely on limiting and preventing potential risks. A number of peer supporters mentioned that they tried 'to get those things in perspective if you like and not to overreact to them' (Matthew, peer supporter). Participants in this study consistently downplayed the risks of violence, self-harm or suicide, and emphasised that they could handle any situations that came up through de-escalation and relationship building:

> We are incredibly lucky. We very very seldom have any kind of conflicts like that. We've had people show up here who say that they have swallowed pills. We have people say they are going to leave and do something to themselves right away; that's pretty regular. But there haven't been – I'm very superstitious and I really want to knock on the table right now – there haven't been incidents that were beyond our ability to manage them, in either programme, so far. And a big part of that is because consumers really act, self-harm, much

less often than they want to. It might be a driving voice all the time, but they succumb to that driving voice much less frequently than the media think, or people think. (Brigid, manager)

This assessment was a direct challenge to the widespread perception in mental health that all service users are a potential risk; they might be 'low risk' but almost nobody has no risk. This emphasis on trusting the peer to manage themselves points to an emerging 'peer support' approach to risk.

Several participants in this study emphasised that a peer support way of dealing with risky situations was not all that different from the way that *any* situation would be addressed by peer supporters. In each case, the focus was simply on 'having those conversations':

I think because a peer support relationship actually is such that people have those honest conversations in a way that makes, that the peer feels that they can have, they don't have to go with a message of: 'I feel suicidal'. I know that peer support workers deal with that and that they have those conversations with people, but it's a conversation that they have, rather than jump on the phone to the clinicians and say, 'so and so is suicidal'. (Lydia, manager)

These conversations involve a direct challenge to a risk consciousness which places safety at the centre of one's concerns, since it is necessary to allow uncomfortable feelings to emerge and be willing to sit with them. While there are clinicians who also do this, risk focused clinical practice makes it difficult to sustain such an approach (Sawyer 2005):

And where I think a big difference is that we see the person and whatever their illness is, is part of them, but it's not who they are. And I think that's a big difference. And I think, because of that we don't feel fear to actually talk to people about things. If someone's sitting with me, telling me that they want to overdose and stuff, it

doesn't freak me out, I'll talk to them about it. I think other people would want to medicate to stop them wanting to feel like that. (Stephanie, peer supporter)

For Shery Mead, the founder of the IPS model, therapeutic relationships and interactions which are framed by negotiation and respect flatten power hierarchies and create space to witness rather than label the experiences of the person in crisis. 'The process of *stepping in* while *stepping back* is at the core of building new responses to crisis' (Mead and Hilton 2003:90). This approach necessarily involves the experience of discomfort. Mead and Hilton argue that 'although most support people don't go into a crisis situation determined to control the other person, their own sense of discomfort may make them become overly directive and controlling' (Mead and Hilton 2003:91). It is important to ensure that peers continue to see themselves as being in control and having strengths:

When relationships are entirely built on assessment of risk, they are by nature controlling and disempowering. … It is crucial that support people maintain a rigorous self-awareness of their own need to 'fix it', 'do it right' or unilaterally determine the outcome. (Mead and Hilton 2003:91)

This peer support model suggests that one copes with crisis only by developing a tolerance for ambiguous states in which nothing is certain and settled.

One participant in this study spoke eloquently about living with that discomfort while she was unwell, and the fact that this gave her a capacity to deal directly with the uncertainty raised by suicidal peers when working as a peer supporter:

I tried to kill myself, very seriously, several times. And it's only by the grace of God that I was found in time. And the people who were most effective in helping me didn't pussyfoot around. It was 'Do you want to kill yourself'? or 'Have you got suicidal thoughts today'? It

was right out there. It was none of this 'Do you think you might be able to keep yourself safe today, Deborah'? Or 'You're not going to do anything silly, are you'? That sort of stuff doesn't work, to my mind. So I talk about it, up front, because what it does is that it then gives the other person permission to talk about it. Because it means that I'm not scared to talk about it. And I'm willing to discuss it in great detail. I can talk about that place of desperation and desolation, because I've been there. (Deborah, peer supporter)

The power of peer support is that a new way of connecting is made possible, through shared experience, in which the peer is not seen as a 'risk object'. Rather than being objectified as a symptomatic person needing management, the peer was seen as a person undergoing a personal crisis which was also a learning opportunity. This reformulation of the meaning of 'risk' integrated the peer fully as one of 'us':

So if we can recognise that he's making that attempt, and talk about it with him, that he's making that attempt to change either cognitive or physical behaviour, and it's scary, it's a risk he's taking, and if we can support him while he's doing that, especially if it doesn't work. In the medical model that doesn't happen. (Deborah, peer supporter)

Stepping in, while stepping back is not an easy option. In her interview, Deborah spoke in a heartfelt way about the extent to which various crisis situations had affected her, about her difficulties in maintaining her own wellbeing and her uncertainty in how she had handled these situations:

I had someone say that they were coming to the office, but they might stop on the bridge and jump over. And I met them on the bridge. I said, 'when you get to the bridge, just stay, because I'll meet you there'. And I ran from here downstairs and met them on the bridge. And we talked about jumping over, and we talked about the consequences of that for her family. And we talked about the things that she wouldn't be able to do in the future that she might want to be able to do. Then I left her. I said, 'I'm going to walk up to [peer support service] now. And I'm going to put the jug on, and hopefully you'll be up for a cup of tea not long after I get there'. (Deborah, peer supporter)

The peer did come up to the office for a cup of tea, but the profound and uncertain effects of such experiences go deep. As Deborah said, 'I don't know what I would have done if she hadn't'.

This reformulation of risk sees risk as being, at least partially, a crisis which is a learning opportunity. This is accompanied by a willingness to allow peers to find their own way through the crisis, while being supported through open conversations and a capacity to tolerate existential uncertainty. This reformulation was not found uniformly across the peer support services participating in this study, however. Two models of peer support practice, IPS and an in-house model that draws substantially from IPS, seemed most associated with these attempts to rethink ways of handling risk.

CONCLUSION

The ontological challenge of what Bauman (2007) calls 'liquid modernity' is in living with uncertainty. One way of dealing with this is to bring the future into the present through risk assessment, calculation and risk management (Kelly 2000; Rose 1998). Mental health services generally have taken this approach, and peer support is no exception. There are very strong drivers pulling peer support services towards operating with a 'safety first' philosophy. However, because peer support philosophy supports self-determination and 'the dignity of risk', these services sit in an uncomfortable relationship with the risk discourses characterising the mental health sector. The participants in our study responded to this tension in varying ways.

Those peer supporters who had completed training in a peer support model such as IPS or a similar approach were most likely to adopt a reformulated approach to risk, which sees crisis as potential opportunity. Their reported practice corresponds with the way that Shery Mead, the founder of IPS, has written about a peer support way of handling crisis (Mead and Hilton 2003). By contrast, those trained through the Mental Health Support Worker's Certificate, and related courses, seemed more likely to adopt 'risk averse' approaches, as this participant noted:

> One of the people who graduated from [the Mental Health Support Worker's Certificate], who works at [a crisis house] has a lower level of confidence at times than anybody else about dealing with certain situations. And I'm wondering if that is because they talk a lot about risk. (Cathy, peer supporter)

Types of training, and the availability of peer support training, seemed to make a difference to the way peer supporters practiced in crisis situations.

There were also differences in the approaches to risk adopted by those trained in different peer support models. Participants trained in a specific year-long accredited qualification in peer support offered in New Zealand tend to be located at the more risk averse end of the continuum. This may be due in part to their employing services' highly structured organisational approach to risk. Those working in the context of District Health Board Specialist Mental Health Services also took a somewhat more conservative approach to risk issues. Their orientation appeared to be a consequence of their organisations' location within mainstream clinical health services. Those services operating with a more radical reformulation of risk tended to be located within small mental health trusts that were consumer-led, or in larger trusts, which afforded peer-led services leeway to develop a strong peer support philosophy, grounded in peer support training, relationship building, mutuality and trust.

The philosophy of peer support is one of empowerment, mutuality and the honouring of the peer's experience. When those experiences include the risk of suicide, self-harm or harm to others, however, peer support finds itself in an ambiguous liminal space. Peer support workers are consumers themselves, dedicated passionately to walking alongside their peers within a shared community. However, peer supporters are also health workers, located within a system that is increasingly driven by a risk consciousness. Our study identified a continuum of approaches to risk management practice within peer support services. Some peer support organisations modified their uptake of mainstream risk management practices. These tended to be either smaller consumer-led trusts with little peer support training, or larger organisations that provided peer support training. Within these, a minority of peer supporters were found to be developing an engaged style of addressing the existential questions associated with risk. These workers sat outside of the risk management approaches seen in most community mental health services. As peer support becomes more integrated into the wider health system, the challenge will be to retain an independence that allows for development and employment of risk practices which operate within a strong peer support philosophy.

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