

Peer Support Pilot Training Workbook

New Zealand Defence Force | DEFENCE HEALTH DIRECTORATE V2 Dec 2024

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# Part One: Introduction

**Whakapuputia mai o manuka, kia kore ai e whati**

***(Cluster the branches of the manuka so they will not break)***

Welcome to the to the NZDF Peer Support team! By volunteering for this role you will be making a difference in our community. This guide and supporting training are designed to ensure that you are well prepared for and supported in this role, and aim to provide:

* clarity around the Peer Support role and operating principles;
* tools and skills for connecting with and supporting others;
* processes and practices that embed the Peer Support role within the matrix of wider NZDF support networks;
* education about issues that you may encounter as a peer supporter and how to manage these;
* wider support available for our people;
* additional support for Peer Supporters; and
* where to go for additional help.

## What is Peer Support?

Peer Support programmes have emerged as standard practice for supporting staff in high-risk organisations where personnel can be routinely exposed to potentially traumatic events, such as emergency services and the military.[[1]](#footnote-1)The rationale for provision of Peer Support programmes often includes the goals of meeting the legal and moral duty to care for employees, as well as addressing multiple barriers to standard care (including stigma, lack of time, poor access to providers, lack of trust, and fear of job repercussions).[[2]](#footnote-2)

Peer Support is the practical, social, and emotional support between people in a community of common interest[[3]](#footnote-3). **Peer Supporters act as a “skilled mate”, a front line support team who can play a role in normalising personal and health difficulties, reducing self-stigma, and connecting service users to their community and support services.** They are often well positioned to be aware when there are significant factors impacting the lives of those around them and recognising when they may not be going well. Peer Supporters often have a range of life experiences that enable them to act as recovery role models to others going through difficult times.

The philosophy of Peer Support is that individuals who may be struggling will usually have the knowledge of what is best for them within themselves and a desire to find a path towards improved health. Peer Support is focused on health and recovery rather than on illness and disability. Key to Peer Support relationships is that they are “based on empathetic understanding and where experiential learning is shared in a non-judgmental and supportive manner”[[4]](#footnote-4).

Within the NZDF, this common experience might be related to service, and to your own health journey or that of a friend or loved one. The specifics of a Peer Support relationship will be a unique experience for each individual. Engaging with a Peer Supporter may be the first step that an individual takes towards recovery, or it may be that you encounter a person who is already on a journey towards wellness. The reduction or elimination of symptoms may be an important goal, but it is only one aspect of the person’s experience.

## The NZDF context

Findings from the 2016 and 2019 NZDF Health and Wellbeing surveys indicated that many people were dealing with a range of psychosocial health issues and around one quarter of respondents screened as having elevated levels of psychological distress. This distress was linked to a range of life stressors spanning work (workload, lack of job satisfaction, exposure to work related traumatic experience) and personal life (relationships, conflict, anger, financial, health issues, loneliness etc). Left unchecked, elevated levels of psychological distress (commonly associated with life’s difficulties) has the potential to develop into more chronic physical or mental health issues.

Common issues that the NZDF community (military, civilian and family members) contact the 0800 NZDF4U wellbeing confidential support service for include stress, relationships, family issues, and mental/psychological health concerns. However, the percentage of those who reach out for support through NZDF4U and internal support services (such as social workers and chaplains) is low in comparison to indications of need based on prevalence.

Many of those seeking help have only reached out once issues have escalated. Many people in uniform (around 1 in 5) indicate they would not seek help for mental health issues in the NZDF owing to concerns about stigma, career impacts and a preference for self-management. Research has also shown that willingness to seek help declines help as people become less well. The most likely place people say they would reach out for help was friends and family.

As a general rule, the early recognition and management of issues will speed recovery. However, while specialist wellbeing support services are available to the NZDF community, those at risk may not always see the need for help nor feel comfortable connecting with these services. This can be due to a number of reasons including perceived stigma, fears about negative career impacts, a lack of awareness or perspective on how support might be helpful, and/or a fear of losing control and fear of the unknown.

Peer Supporters can act as the first-line contact for distressed or troubled personnel in the work environment. Peer Support of a formalised nature helps to ensure that peer supporters have the foundation skills to guide safe peer support practice. This includes learning how to ensure that the critical aspects of hopefulness, recovery-orientation, empowerment, non-judgmental acceptance, and trust are promoted within the peer support relationship. Finally formal training will help ensure that peer supporter have the necessary skills and knowledge to ensure they maintain boundaries and look after their own wellbeing.

The NZDF Peer Support pilot programme was launched in Linton in April 2024. The concept of a tiered model for peer support (see below) is being tested to consider whether it should be rolled out more broadly across the NZDF.

To enable the programme to be evaluated, we will be asking participants in the pilot (you as a Peer Supporter and our community of users) to provide feedback about their experiences, including suggestions for how any aspects of training or practice can be improved. In addition, Peer Supporters play an important role in the success of the pilot by logging their Peer Support interactions in the reporting tool (see page 14).

Tiered model for Peer Support

* The NZDF provides a basic level of peer support training to all NZDF personnel. This focuses on psychoeducation to promote awareness of how to ‘keep an eye out for a mate’ spanning how to recognise common signs of distress, how to ‘check in’ and awareness of the range of support services available.
* The NZDF also provides a higher level of training to those in higher risk situations and roles (emergency services and deployment personnel) to provide immediate incident response support including for critical incidents.
* Trained Peer Supporters sit between these two capabilities, providing an important component of psychological wellbeing for NZDF personnel.

## Values

* **Hope and recovery** – acknowledging the power of hope and the positive impact that comes from a recovery approach.
* **Self-determination** – having confidence that most people intrinsically know which path towards recovery is most suitable for them and their needs, noting that it is the peer’s choice whether to become involved in a peer support relationship.
* **Empathetic and equal relationships** – noting that the peer support relationship and all involved can benefit from the reciprocity and better understanding that comes from this
* **Dignity, respect and social inclusion** – acknowledging the intrinsic worth of all individuals, whatever their background, preferences or situation.
* **Integrity, authenticity and trust** – noting that confidentiality, reliability and ethical behaviour are honoured in all interactions.
* **Health and wellness** – acknowledging all aspects of a healthy and full life.
* **Lifelong learning and personal growth** – acknowledging the value of learning, changing and developing new perspectives for all individuals.

## Principles

Everyone is different, including those that are struggling. Each instance of support is likely to require a somewhat tailored response reflecting their situation, nature and stressors. This can seem a daunting prospect as you look to help. It can be useful to orient to some core operating principles.

**Person-centred**. It’s important that you and the distressed person *work together* and they have the lead on any decision-making. It can be tempting to take on a more active role, such as advice-giving or directing. Sometimes it can even feel like this is what the distressed person wants you to do. However, this can be counterproductive in the long-term as it can diminish the person’s belief in their ability to make choices for themselves, can lead to courses of action the distressed person is not fully invested in, and result in resentment and blame toward you for any unwanted outcomes. Seek to follow their lead, and partner with them on the way forward. Be respectful of cultural differences and needs.

**Connection**. If in doubt, focus on providing a sense of rapport, trust and non-judgemental acceptance. The unconditional support of another human being is the most helpful thing to offer someone that is struggling. Doing this will have a positive effect all by itself, and if it’s not there, whatever else you do is less likely to be helpful.

**Plan together**. Come up with a plan together, and be transparent and explicit about that plan. This might include actions and check-ins. It might also include boundaries, such as when and how you might be available, and who they might get in touch with outside your boundaries.

**Build a Team**. The most robust support involves a range of providers. This might include professionals, peers, whānau, partner and command. Building a team ensures everyone’s efforts are mutually supporting, that everyone is working within their area of expertise, and multiple perspectives applied. Know your personal limits, especially in relation to dealing with crises, and call for assistance (in a collaborative manner) when appropriate. *Never hold it alone*.

**Foster Hope**. The nature of distress means that, when someone is stuck, it’s hard for them to see a way out or a future beyond their distress. Where possible, cultivate the belief that things can get better, even though it may not feel like that to them at the moment. Importantly, this is not about you projecting a “Chin up, tomorrow’s another day” mindless optimism, but rather a commitment to stick with them till things get better, and a patient faith that they will.

**Invest in Yourself**. It’s hard to provide a firm base for others without having a firm base for yourself, so invest in your wellbeing. Reflect on your own stress levels regularly, and be proactive about doing the things that keep you at your best. Invest in your own support network. Be disciplined about your self-care, so you are well placed to support others.

### Rules of engagement

The Peer Supporter role is built on trust. One of the foundations of being able to support others is to have a clear sense of your role and boundaries. Therefore, in order to effectively support both you and the person, it’s important to have guidelines describing how you work together. These ROE’s provide everyone with a clear picture of what they can expect and how you will act as a Peer Supporter. There are four key aspects of the relationship that everyone needs to understand.

**Confidentiality**. When people engage with a Peer Supporter, that conversation is in confidence. This means that, generally, Peer Supporters won’t share the content of that conversation outside the medical sphere without the person’s awareness and consent. This includes conversations with their commander or other related parties, gossip or reporting. If you are the person’s commander, then it is unreasonable to say that the conversation won’t inform your decision-making. In this instance, reassure them that they will have visibility of what and how the information is used, and they will play an active role in any decisions.

The only exceptions are where you are concerned for their safety or someone else’s safety, or there has been a significant breach of the Armed Forces Discipline Act. In such instances the first task is to work with the person to come up with a plan for addressing the concern in a manner with which they agree. However, where this is not possible, safety and military discipline take precedence over confidentiality, and you may need to breach confidence. When you do this, you should minimise the extent of the disclosure where possible. This might be reflected in only disclosing the information necessary to address the concern, and only disclosing it to those that are in a position to address it.

**Consent**. Engagement with a Peer Supporter is entirely voluntary. People only need to engage to the extent they are comfortable. This includes the information they disclose and the actions they take. This principle applies equally to you as a Peer Supporter. Within the limits of the role, there will be variations in individual comfort levels. Some Peer Supporter will be more comfortable with aspects of the role than others. For instance, some may be happy to sit with someone in visible distress, others less so. There may be some topics that feel uncomfortable for you, for instance gender, abortion, or religion. You only need to engage to the extent you are comfortable. If you begin to feel a situation is becoming uncomfortable for you, then you can begin to plan for alternate steps with the person.

**Competence**. It’s important to understand that the Peer Supporter role is comparable to a trusted peer or friend. You are not a trained mental health worker, and it’s not helpful for anyone if there is confusion about that. This is one of the reasons the role focuses on listening and guiding to support, rather than advice-giving, advocacy or a formal support role. If you feel like you are beginning to give advice, take ownership of courses of action, or taking the lead, then it might be a sign that you are nudging up against the boundaries of your competence.

**Safety**. As a Peer Supporter *safety has primacy* in your decision-making. Where you are concerned about the well-being of the distressed person or someone else (such as their children, family or workmates), you should seek guidance and oversight from an appropriately qualified professional. Also remember that, because you are not a mental health professional, you are not expected to make a sophisticated assessment of safety. If you have reasonable grounds for concern, then that is enough. If you decide to take action to ensure safety it is recommended you, where possible, disclose and discuss this with the distressed person, and come up with a plan together.

**If in doubt, seek guidance**. Where a given situation leads to uncertainty about the above, err on the side of caution or seek guidance from a professional. This protects you, the distressed person, and the NZDF. Appropriate professionals might include a medical officer, nursing officer, defence mental health professional, social worker, SAPRA, chaplain or defence psychologist. Seeking guidance might include describing the situation in principle, without any identifying information, and deciding on a course of action together.

## Key skills, abilities, and personal attributes

Life experience

The peer support relationship is based on the connection. This connection can be strengthened from having experience of the NZDF environment and from having navigated personal life challenges. Those with lived experience (whether personal or through having supported a colleague or loved one) are often in a good position to support others who are in the midst of their own challenges. The recovery aspect of a life journey also provides many insights and will help to inform their knowledge as they support others.

Skills, abilities and attributes include:

* a sense of hopefulness and a strong belief in the possibility of recovery
* a personal commitment to self-care and maintaining health and wellbeing through stress management and resiliency strategies and a recognition that each peer whom they support will need to find their own unique approach to self-care
* an ability to detect when their own stressors or triggers may be resulting in unhealthy or unwanted attitudes or behaviours, coupled with a willingness to request assistance and/or take steps to work towards recovery
* an ability to relate to the experience and challenges of the peer as a result of their own life experience

Interpersonal communication

Interpersonal communication is critical to building open, honest, non-judgmental and trusting peer relationships. Skills, abilities and attributes include:

* a personal manner that is warm, empathetic and non-judgmental, demonstrating a genuine interest in their peer and valuing their peer as an equal and a whole person
* communication and listening skills that encourage honesty, openness and clarity for full understanding of the situation being discussed, while honouring personal integrity
* interactions that respect the peer’s right to self-determination and empower the peer to explore options and co-create new ideas on how to proceed, rather than providing advice or having a personal agenda of what should be accomplished
* an ability to know when the time is right to share aspects of their own lived experience in a manner that provides relevant insight and/or hopefulness while keeping the focus on the peer and their situation

Critical thinking

Critical thinking is used when a Peer Supporter engages a peer and tries to understand as clearly as possible the issue that is being discussed. This may include working with a peer to uncover other possible underlying issues when and if the peer is ready to do so.

Skills, abilities and attributes include:

* an ability to encourage open and forthcoming dialogue with a peer using communication styles and skills to improve understanding, and help a peer to discuss other concerns that the peer may initially find difficult to share
* an ability to determine the true needs of the peer, including if the peer only wishes to talk about their stressors or if they are ready to explore options and consider how to initiate changes
* unconditional respect for whatever issue a peer may bring forward, recognizing that it is important to the peer and should not be judged as serious or minor, coupled with an ability to turn a request for advice into an opportunity for the peer to explore options
* an ability to detect when a peer is in or approaching a crisis situation, working with the peer to explore alternative paths if possible, and/or knowing when the situation has escalated to a point where additional resources are required.

Teamwork and collaboration

Teamwork and collaboration is shown when a peer supporter works with a peer to explore the potential benefits of connecting with other community and clinical options. It also includes respecting the limits and boundaries of the peer support role. Peer Supporters understand the benefits that can come from collaborating with others and use resourcefulness and good judgment while doing so.

Skills, abilities and attributes include:

* an ability to learn about other community support systems, understand how they may help, and provide the information as an option for the peer to consider, while respecting the peer’s right to self-determination
* a clear understanding of a peer supporter’s area of responsibility and expertise compared to the responsibility and expertise of others, such as clinical professionals, when collaborating and/or when discussing with the peer the advice of others
* a degree of self-confidence and initiative, coupled with a desire to learn from others, that results in an ability to both give and receive opinions and a commitment to work through whatever challenges might arise.

Ethics and reliability

Personal integrity and an authentic compassion for the peer will ensure that the relationship is grounded in ethical and trustworthy attitudes and actions, including an unwavering support of the personal growth of the peer. Maintain high ethics and personal boundaries in relation to gift giving, inappropriate relations with peers (e.g. romantic or sexual intimacy), and/or other interactions or activities that may result in harm to the peer or to the image of the peer support programme.

Skills, abilities and attributes include:

* high regard for the emotional and physical safety of the peer, ensuring that confidentiality is always protected within legal limits
* a commitment to ensure all interactions with a peer are appropriate (e.g., interactions are empowering and trustworthy and never sexual or romantically intimate), and are intended to protect and promote the safety and recovery of the peer
* unconditional respect for the peer, their efforts and their time by working with them to develop a relationship that is dependable, flexible and considerate of the needs of both the peer and the peer supporter
* a commitment to personal development and learning more about the practice of peer support, taking advantage, whenever possible, of relevant educational and training opportunities
* consistent demonstration of a belief in the guiding values and principles of practice found in these the peer support guidelines, as well as a genuine willingness to follow a Code of Conduct based on these values.

## The NZDF peer support approach: REACT

The REACT model has been selected as a simple to follow guide when providing support to others. See following page for a summary of the model, and Part 4 of the manual for a more in-depth exploration of each aspect.

The nature of engagement will depend on the situation and relationship with parties involved, and the nature of any immediate physical or mental risk if present. Sometimes no further support may be required once links to other support are established, but as a general rule it is important to check back in to see how things are going and whether any additional peer or other support is required.

### Reflection

What are some of the reasons a Peer Support programme might be useful for the NZDF?

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What are some of the risks? For both the NZDF and the Peer Supporter?

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# Part Two: Role and responsibilities

## Role

Peer Supporters serve two key functions:

* to identify and engage those that are struggling before they reach a crisis point; and
* to support those in crisis.

|  |  |
| --- | --- |
| Do… | Do not… |
| * Monitor * Check * Listen * Understand * Identify and address risk * Guide to support * Promote a sense of hope & control | * Counsel * Diagnose * Advocate for * Take over * Parent * Solve things for them * Assume responsibility for someone |

### Triage and referral

Peer Supporters regularly provide an opportunity for triage and referral in relation to psychological wellbeing. Oftentimes Peer Supporters are the first line of contact, particularly following potentially traumatic events. This may provide an early opportunity to assess the urgency of accessing additional support and determine the most appropriate level of support. This might include a GP, an internal or external health professional, hospital admission etc.

### Suicide prevention

Peer Supporters play a vital role in suicide prevention. Peer Supporters receive training in suicide recognition, intervention and prevention. They are situated in a position within the NZDF that enables them to be more able to recognise changes in behaviour and demeanour in their colleagues. This also means that they are more likely to be aware of significant life events that may be confronting their colleagues that may increase suicide risk factors.

### Critical incident management

In many instances, Peer Supporters provide the first line of support following a potential critical incident. This may provide an opportunity for the emotional expression of the recipient, decrease hyper-arousal, provision of psycho-education and referral to additional supports.

### Psycho-education

Peer Supporters may be in a position to provide psycho-education for those they are supporting. This may assist in reducing barriers to accessing support, reducing potential hyper-arousal, and normalisation in relation to their thoughts, feelings and behaviours. Psycho-educational material might include providing brochures, research articles or wellbeing newsletters.

### Positive influence on culture

The Peer Support training provides Peer Supporters with the skills and training to enable those that they are supporting an opportunity to be able to think more flexibly and with more specific detail. It is anticipated that this might enable them greater opportunity to come up with their own solutions to their problems. This, in addition to the championing of self-care and maintaining mental health wellbeing, provides the opportunity for a positive influence on the culture of the organisation.

### Risk identification

Peer Supporters provide an important opportunity to identify psychological risks throughout the state. Verbal and written communication from Peer Supporters provide invaluable information that assists in assessing current levels of risk; identifying gaps in wellbeing strategy and developing mitigation strategies to meet these risks. Given that Peer Supporters are located throughout the state in various positions this allows visibility of these risks across all areas of the organisation that may otherwise not be noticed.

### Reducing barriers to support

In many instances, Peer Supporters provide a critical function in reducing barriers to NZDF personnel accessing the additional support of the NZDF health professionals’ network. This may be through championing and modelling self-care and mental health wellbeing; psycho-education; referral; early contact; and in some instances, going with someone to their first appointment.

### Reducing stigma

Having a Peer Support network comprising of respected peers throughout the organisation and state provides an opportunity to normalise psychological difficulty; normalise emotional expression and normalise accessing support.

## Responsibilities

### Confidentiality

Peer Supporters respect the confidentiality and privacy of the individuals with whom they interact in their role as Peer Supporter. Confidentiality has been shown to be the most significant factor in enabling a helping and supportive relationship to be developed between a Peer Supporter and the person they are supporting.

Breaches of confidentiality are destructive to the individual whose privacy is breached, destructive to the reputation of the Peer Supporter concerned, and to the overall Peer Support programme. Peer Supporters will always seek advice/counsel from their supervisor or programme coordinator when conflict occurs or is likely to occur, or when a doubt arises about confidentiality.

Peer Supporters will only disclose confidential information from peer support interactions:

1. when compelled to by law;
2. in response to a clear and immediate danger to a person or persons e.g. potentially suicidal or homicidal (Note: you must respond immediately to issues of safety);
3. if child abuse of any kind is disclosed; or
4. with the written informed consent of the individual concerned.

Peer Supporters, because of their role within the NZDF workplace, should exercise prudence in respect to:

1. discussing persons, or personal issues within earshot of others;
2. making comments and/or judgements about other people’s behaviour; and
3. making public comment about a person’s behaviour or commenting on hearsay about another person’s behaviour. This is likely to cause concern or anxiety for individual’s involved. This may also diminish the esteem in which Peer Supporters are held.

### Reporting

Keeping a record of all the engagements you have as a Peer Supporter is important for two key reasons:

* it allows the Peer Support Pilot Coordination Team to quantify the outreach that our Peer Supporters are having. This will be an important measure for gauging the impact of the programme and whether there is a case for a wider roll out of the programme.
* it acts as an assurance for you as the Peer Supporter in documenting the assistance you have provided eg. what social services you signposted, whether you have undertaken a risk assessment.

**Please submit a report for each engagement you have had in your Peer Support role within a week of the interaction.** It should only take you a couple of minutes to do this.The identity of the individual you are supporting will remain anonymous, but their gender and rank will be requested (in order to assist with tracking the impact of the programme). You can indicate in the reporting tool whether this is the first or a follow up interaction with an individual.

Use the QR code scanner in your phone to navigate to the reporting tool, or use the link that will be provided via email after the training.



### Supervision

Peer Supporters are required to attend at least 1 one-on-one supervision session each quarter and additional sessions on a case-by-case basis depending on the nature of issues supporters may encounter. Peer Supporters are to ensure, through their direct in line manager, that where supervision is scheduled during usual work hours they are able to be released from operational duties.

Virtual supervision can and should be used in situations where distance makes face-to-face contact difficult or where important and urgent advice may be required.

**Supervision is important because it:**

1. provides a professional, accessible resource to Peer Supporters.
2. provides a confidential environment to discuss cases, thus enabling personal and professional skills development.
3. enables professional monitoring of the ‘health’ of the work environment.
4. ensures that Peer Supporters are themselves not overworked or suffering from fatigue and stress.
5. provides an environment in which Peer Supporters can ‘unload’ safely and with affirmation.
6. provides Peer Supporters with professional guidance.

### Referral

Health professionals - Peer Supporters need to identify instances when a referral pathway to a NZDF health professional is required. Further information will be provided in this guide about when to refer and the range of health support and services that are available in NZDF.

Other helping hand options: The issues that people may reach out to a peer supporter for will be varied and there may not be any immediate health or wellbeing concern (for example, financial concerns or needing time off work to attend to personal matters). There are a range of additional options for support in NZDF including command, Marae staff and Defence Community Facilitators There are also external community organisations that can provide additional information and support.

Peer Support Commitments

**1. Confidentiality**

As a Peer Supporter, I commit to respecting the confidentiality and privacy of those with whom I interact in my role. I understand that I may only disclose confidential information in the following situations:

* when compelled to by law;
* in response to a clear and immediate danger to a person or persons e.g. potentially suicidal or homicidal;
* if child abuse of any kind is disclosed; and/or
* with the informed consent of the individual concerned.

I will seek guidance from my supervisor or programme coordinator should a concern about confidentiality arise.

**2. Scope of role**

I understand the role of a peer supporter is to:

* provide an empathetic, listening ear;
* provide initial support;
* identify colleagues who may be at risk to themselves or others; and
* facilitate pathways to professional help.

I understand that the role of a peer supporter is NOT:

* that of a therapist;
* supporting people on my own; or
* taking on responsibility for the mental health of others.

I understand that my peer supporter commitments are secondary to that of any Command role I hold. When acting in my peer supporter role, I will be transparent about my obligations as chain of command.

**3. Time Commitment**

As a Peer Supporter I will make time available for:

* peers for up to two hours a week;
* recording interactions in the reporting tool a timely manner (within a week of the interaction)
* monthly supervision sessions; and
* refresher sessions as required.

**4. Record keeping**

I will maintain an accurate and timely record of all peer support encounters. I understand this is critically important to being able to measure the success on the pilot programme.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Part Three: Identifiying risk factors

He tina ki runga, he tāmore ki raro

*(In order to flourish above, one must be firmly rooted below)*

### Definitions

Mental health and related terms are often used for differing purposes and with a range of meanings, for instance mental health and mental illness are used interchangeably to refer to impaired wellbeing or diagnosed mental health conditions. For the purposes of this training, we will differentiate some of the terms, in order to make sure we are all clear on their meaning.

Mental Health, as defined by the World Health Organisation is:

“Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.”

This definition makes the point that good mental health is about more than the simple absence of mental illness. It includes the sense that one’s life is connected, purposeful, and rewarding.

Mental Illness, as defined by the International Classification of Diseases (ICD-10) is:

"A clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions."

This definition recognises that the individual is displaying or experiencing a specific set of signs or symptoms, and that this is having an impact on their life.

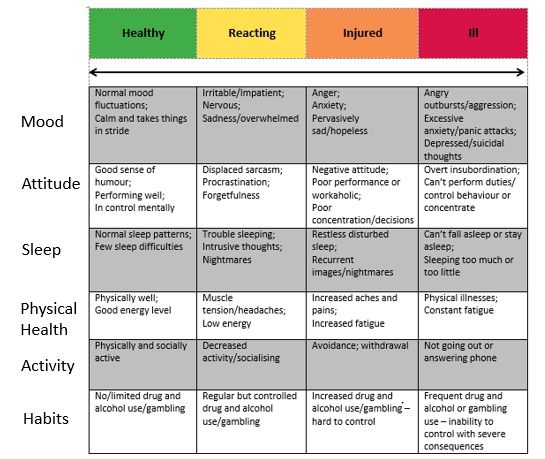
Importantly, someone may be unhappy or struggling in life and not meet the criteria for a mental illness. Similarly, someone might meet the criteria for mental illness, and be able to live a rewarding life. Therefore poor mental health, rather than that mental illness, is the focus of this workshop. Poor mental health is what we are most concerned about in the NZDF, those that struggling, lonely, or deeply unhappy. Mental illness is also the assessment order (AO) of professionals, and the diagnosis and treatment of mental illness is best left to those with training. Poor mental health is something you, as a peer, leader or teammate, can both notice and be helpful with.

For the purpose of this workshop, we are going to focus on supporting those showing signs of poor mental health, and use the term distressed person;

“A person struggling with or experiencing emotional, physical, mental, social and spiritual difficulties, in an unsustainable way and to the extent they are beginning to impact on their functioning in either their work or home life.”

### Mental health continuum

Another way of understanding mental health is on a continuum. As we go through life, we move up and down the mental health continuum, as we and our life changes. Often, we are so busy dealing with life that we don’t notice there has been a change in our mental health. Having a friend or colleague respectfully and compassionately notice stuff out loud can trigger useful reflection. The mental health continuum can be a useful tool for reflection. Anyone that is in the injured or ill spectrum might be thought of as distressed or struggling, and might benefit from action.



Reflection

|  |
| --- |
| When is a time in your life you have been close to green? |
| When is a time in your life you have been close to orange or red? |
| What did you notice in yourself when you started going from okay, to not okay (from yellow to amber)? |
| Where on the continuum are you now?  Healthy  Reacting  Injured  Ill |
| What would be different if you were just a bit to the left? Not all the way, just a bit? |

### Strengths and vulnerabilities

Understanding the strengths and vulnerabilities – aka protective and risk factors – that contribute to wellbeing can help focus attention on those that might be at risk, as well as with planning interventions. Many factors influence a person’s chance of distress. Effective prevention focuses on reducing vulnerabilities, or risk factors, and strengthening protective factors. An awareness of those factors most relevant to the people around you allows you to focus your attention on individuals and groups strategically. Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of distress, i.e. vulnerabilities. Protective factors are characteristics associated with a lower likelihood of distress or that reduce a risk factor’s impact, i.e. strengths. Protective factors may be seen as buffering influences or events. Protective factors are typically the inverse of risk factors, and a given individual at a given time sits at a point on the continuum between the two.

Risk and protective factors can be separated into three broad groups. Individual factors, or those that relate to the individual, including their biology, skills and mindset. Social factors are those that relate to the person’s relationships and connectedness to community. Social support is THE most important factor in wellbeing. Environmental factors include those that relate to their situation and context. Examples include their workload, financial situation and safety.

What are some risk (vulnerabilities) and protective (strengths) factors that might impact on mental health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual** | | **Social** | | **Environmental** | |
| Strengths | Vulnerabilities | Strengths | Vulnerabilities | Strengths | Vulnerabilities |
|  |  |  |  |  |  |

### Stress

Of all the vulnerability factors, stress is one of the most significant. The longer and more intense, the greater the toll it takes.

What is stress?

Stress can be defined as the degree to which we feel overwhelmed or unable to cope in the face of demands. At the most basic level, stress is our body’s response to perceived demands on us. If we feel we are able to meet the demands life is making of us, then we are less inclined to feel stress. If we feel like we are unable to address or control the things that are important to us, then we start to feel stress. How people experience demands varies hugely and differs according to our social and economic circumstances, our history, our training, our situation and our genetic makeup. Aspects of experiences that can amplify stress include experiencing something unexpected, a threat to our health or wellbeing, or a perceived lack of control over a situation.

When we perceive something as stressful, our body releases stress hormones, resulting in the ‘flight or fight’ response and activating our immune system. This response is automatic and is designed to produce a rapid response to a dangerous situation. Sometimes, this stress response can be helpful. “Pressure” can provide us with energy, motivation or drive to take on the challenge in front of us. If the stress comes and goes quickly, our body and mind is then able to recover. However, if stress is ongoing, or chronic, it can have a significant impact on us.

Chronic stress

When the stress response is activated repeatedly, or it persists over time, the effects can result in wear and tear on the body and impair our ability to respond effectively to the demands of life. Rather than helping us, our stress degrades our ability to respond to demands. This ongoing stress is termed chronic, and is often a contributing factor in distress and low levels of mental health.

There are many things that can lead to chronic stress, including events that might be seen as positive, such as buying a home, getting a promotion or raising a family.

Kua pakoa te tai

*(The tide is right out/their strength is all gone)*

Acute Stress

Acute stressors, are events that typically include an immediate threat to physical, emotional, psychological or social wellbeing and might begin a rapid increase in stress or distress. They might include events like grief, job loss, or traumatic experiences. Importantly, while these might play a role in the onset of a pronounced increase in a person’s level of distress, chronic stress often creates a vulnerability. Being aware of both chronic stressors and acute stressors for those around you is an important element of being an effective Peer Supporter.

In the table below, what are some of the situations or experiences that might become chronic stressors? What are some events that might be triggers?

|  |  |
| --- | --- |
| **Chronic Stressors** | **Acute Stressors** |
|  |  |

### Static and variable factors

Some risk and protective factors are static: they don’t change over time. These might include one’s genetic inheritance, family history, or ethnicity. Other risk and protective factors are considered variable and can change over time. Variable risk factors include income level, peer group, social support, and employment status.

As a friend, leader or colleague, you may be in a position to influence variable risk and protective factors. Of the factors below, which might you be able to influence?

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Vulnerabilities** | **Strengths** | **Can you influence? Y/N** |
| Individual | Low Self-esteem | Self-esteem, confidence |  |
| Cognitive/emotional immaturity | Ability to solve problems and manage stress or adversity |  |
| Difficulties in communicating | Is able to communicate difficulties |  |
| Medical illness, substance use | Physical health, fitness |  |
| Social | Loneliness, bereavement | Social support of family & friends |  |
| Difficulties or failure at school | School achievement |  |
| Work stress, unemployment | Satisfaction and success at work |  |
| Neglect, family conflict | Good parenting / family interaction |  |
| Exposure to violence/abuse | Physical security and safety |  |
| Environmental | Low income and poverty | Economic security |  |
| Poor access to basic services | Equality of access to basic services |  |
| Injustice and discrimination | Social justice, tolerance, integration |  |
| Social and gender inequalities | Social and gender equality |  |

### What are the signs of stress?

Emotional changes

When we are stressed we may experience many different feelings, including anxiety, fear, anger, sadness, or frustration. These feelings can sometimes feed on each other and produce physical symptoms, making us feel even worse. For some people, stressful life events can contribute to symptoms of depression.

Work-related stress can also have negative impacts on mental health. Work-related stress accounts for an average of 23.9 days of work lost for every person affected.

Behavioural changes

When we are stressed we may behave differently. For example, we may become withdrawn, indecisive or inflexible. We may not be able to sleep properly. We may be irritable or tearful. There may be a change in your sexual habits. Some people may resort to smoking, consuming more alcohol, or taking drugs. Stress can make us feel angrier or more aggressive than normal. Stress may also affect the way we interact with our close family and friends.

Bodily changes

When stressed, some people start to experience headaches, nausea and indigestion. We may breathe more quickly, perspire more, have palpitations or suffer from various aches and pains. We will quickly return to normal without any negative effects if what is stressing us is short-lived, and many people are able to deal with a certain level of stress without any lasting adverse effects.

If we experience stress repeatedly over a prolonged period, we may notice our sleep and memory are affected, our eating habits may change, or we may feel less inclined to exercise.

Some research has also linked long-term stress to gastrointestinal conditions like Irritable Bowel Syndrome (IBS) or stomach ulcers, as well as conditions like cardiovascular disease.

Who is affected by stress?

All of us can probably recognise at least some of the feelings described above and may have felt stressed and overwhelmed at some time or another. Indeed military training is intentionally designed to be stressful. However, some people seem to be more affected by stress than others, and our susceptibility to stress can change over our lives, or different things are stressful for different people. For instance, some people may find the workplace and their professional lives very comfortable, but parenting is inherently stressful, or vice versa. For some people, getting out of the door on time each morning can be a very stressful experience, whereas others may be able to cope with a great deal of demand.

Some groups of people may be more likely to experience stressful life events and situations than others. For example, people living with high levels of debt or financial insecurity are more likely to experience stress related to money. People from minority ethnic groups or those who are LGBT+ (lesbian, gay, bisexual and transgender) may be more likely to experience stress due to prejudice or discrimination. People with pre-existing or ongoing health problems may be more likely to experience stress related to their health, or stress due to stigma associated with their condition.

Case Study Exercise one

|  |
| --- |
| What Chronic stressors can you identify? |
|  |
| What acute stressors can you identify? |
|  |
| What Protective factors can you identify? |
|  |
| Where on the continuum would you put them? |
| Healthy  Reacting  Injured  Ill |
| What other information might be useful for you to draw on or seek out? |
|  |

## Mental illness in New Zealand

Caveat

Before discussing mental illness in New Zealand it’s important to make a couple of points. This information is to help you get a sense of the breadth and depth of New Zealanders that are struggling. There are a range of disorders, and they fall into the following broad categories;

* Mood
* Anxiety
* Compulsive
* ASD and Developmental Disorders
* Substance Use
* Psychosis
* Trauma

More information on specific disorders can be found on page 154 of Staying at the Top of Your Game. This is provided so that, if a mate or colleague discloses a diagnosis to you, you can get a little more information. However, we won’t be discussing specific disorders on the PEER SUPPORTER course. There are a number of reasons for this. The disorder doesn’t tell you what is going on for the person, and *their* story. Also, the same disorder can look different and need different things for different people, so you still need to get a sense of what would be helpful for them. Disorders also tend to blend in with one another, depression often leads to anxiety and vice-versa, so getting too focused on one can be misguiding. And finally, professionals deal with disorders, but wellbeing sits with everyone. In short, your focus is on what has happened and is happening for them, rather than what is ‘wrong’ with them.

Importantly, acknowledging the “realness” of someone’s distress *is* helpful.

### Statistics

The Mental Health Foundation reports the following statistics on the prevalence of mental illness and poor wellbeing.

The 2017/18 New Zealand Health Survey found that:

* 1 in 6 New Zealand adults had been diagnosed with a common mental disorder at some time in their lives. This includes depression, bipolar disorders and anxiety disorders.
* Nearly 9 percent of adults had experienced psychological distress in the past four weeks.
* Females are more likely to experience a common mental disorder than males, regardless of age.
* Māori and Pacific have higher rates of being diagnosed with mental disorders or experiencing psychological distress than the rest of the population. Mental health service use by Māori is rising.
* People living in the most socio-economically deprived areas were 2.5 times more likely to experience psychological distress as people living in the least deprived areas – after adjusting for age, sex and ethnicity.
* Around 650,000 adult New Zealanders (16.6 percent) have been diagnosed with depression at some stage in their lives.
* Nearly 1 in 4 New Zealand adults (aged 18 and over) experienced ‘poor’ mental wellbeing on the World Health Organisation’s WHO-5 scale.

Depression and anxiety disorders are the most common diagnoses. In the 2011/2012 New Zealand Health Survey, 14.3% of New Zealand adults (more than half a million people) had been diagnosed with depression at some time in their lives, and 6.1% (more than 200,000 people) with anxiety disorders (including generalised anxiety disorder, phobias, post-traumatic stress disorder and obsessive-compulsive disorder). Rates were significantly higher amongst women than men, 17.9% of women have been diagnosed with depression at some time in their lives and 7.7% with anxiety disorder, compared with 10.4% and 4.4% of men, respectively. However, many researchers believe that some common mental health conditions, including depression, can look different in males and that this means mental illness goes undiagnosed and untreated.

According to the Health Loss in New Zealand study, anxiety and depressive disorders are the second leading cause of health loss for New Zealanders, accounting for 5.3% of all health loss, behind only coronary heart disease (9.3%). For women, they were the leading cause (~7%). Approximately 1 in 8 (12.6%) New Zealanders were prescribed antidepressants in the last year[[5]](#footnote-5). One in 36 New Zealander’s have been prescribed an anti-psychotic in the last year[[6]](#footnote-6).

## Stereotyping, stigma, and discrimination

Research suggests that about 40% of those meeting the criteria for a mental disorder are not getting any treatment for it, and one of the reasons for this is the stigma associated with mental illness. Understanding the role of stigma as a barrier to help-seeking, and working to minimise these barriers, is one of the most useful contributions we can make to good mental health in our community.

There are a number of steps in the creation of stigma. The first step is stereotyping. This is when people make assumptions about someone based on a group they belong to, or a label that is attached to them. These assumptions can relate to their character, abilities, likely behaviour or values. These assumptions are passed on through our culture, conversations and the behaviours we see around us. Everyone is prone to use stereotypes sometimes. We evolved them to help us make sense of our social world. The important thing is to notice them and be able to decide whether they are useful, fair and accurate right now. This is particularly important when it comes to mental health and distress.

Stigma happens when a particular worth or value is attached to these assumptions, specifically a negative one. This might be a mark of shame, disgrace or disapproval attached to a person, often based on the stereotype. People with mental health or addiction experiences often suffer as the result of the negative beliefs of others, as well as their own beliefs about mental health and mental illness. This is often experienced as labelling or branding, and contributes to negative feelings such as shame, unworthiness, rejection and loneliness. Some people who experience mental health problems do not seek help for fear of it attracting negative judgements.

As an example, in the 2016 national health survey New Zealanders felt more comfortable about having a neighbour with a different ethnicity to themselves (88.5 percent felt comfortable or very comfortable) than they did about having a neighbour who had a mental illness, and only just over half of New Zealanders (54.8 percent) felt comfortable or very comfortable about having a neighbour with a mental illness.

Stigma in military populations has a range of definitions, but Acosta et al. (2014) provided a comprehensive one; “*a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or people with mental health disorders. This process happens through an interaction between a service member and the key contexts in which the service member resides*”.

Discrimination is the systematic, different, or unfair treatment of people, because of a group they belong to. Essentially, discrimination is behaviour that says to people that are struggling that, “we don’t want you here”, “you’re not as good as us”, “you’re not one of us” and “you are not important and you don’t belong”.

So let’s apply this to an experience you might be familiar with.

When you tell people that ***you are in the military***, what;

|  |  |  |  |
| --- | --- | --- | --- |
| Assumptions do they make about you? | Value judgements do they make? | Behaviours do they tend toward? | Do you feel? |
|  |  |  |  |

The experience of stigma and discrimination is one of the biggest barriers to recovery that people face. Stigma and discrimination stops people from:

* feeling a part of their community
* feeling good about themselves and believing in their personal power to recover
* seeking treatment
* maintaining wellness
* participating in work, education and social activities
* accepting support, awhi and tautoko from loved ones
* participating in and contributing to their local communities.

Stigma and discrimination are common experiences for people that experience mental health difficulties. Research has found that the experience of stigma and discrimination occurs not only with the public or broader society, but also come from families and whānau, loved ones and people working in services. Stigma exists when people are recognised as different, and then labelled and identified as such. Invariably this process is linked to beliefs about what is normal and “okay”. In a survey conducted in New Zealand in 2004 by the Mental Health Foundation over 84 per cent of people with lived experience of mental illness reported they had experienced discrimination, and research on NZDF personnel suggests similar experiences. As a result, peers and commanders have two key tasks. Firstly, that they do not contribute to experiences of stigma discrimination, and secondly that they challenge stigma and counter the effects and impacts of discrimination.

Once people have been identified as being “other” or “different”, they are often collectively and individually subjected to labelling, negative stereotyping, prejudices, isolation, ridicule, loss of status, loss of dignity and, in some instances, loss of basic human rights. Discrimination is a term that is often used to describe these acts, which can be conducted by people or institutions and society. Part of your role as a Peer Supporter is to:

* understand the negative impact of stigma on each individual (as this will differ), and work with that person to reduce this impact
* identify practices within NZDF that might be stigmatising or discriminatory
* identify and correct any thoughts, beliefs or behaviours that they have that may contribute to stigma and discrimination
* challenge stigmatising attitudes and behaviours when they are encountered.

### Self-stigma

Research shows that one of the most damaging forms of stigma is self-stigma. This is when someone that might be suffering from mental illness believes the negative assumptions and value judgements relating to mental illness. Unfortunately, research suggests that - because of the way distress heightens our sensitivity to threat – distressed people are more likely to believe in stigma and prejudice than those that are doing well. Self-stigma has a number of unfortunate consequences, as distressed people may be;

* More likely to feel shame and beat themselves up for their mental illness
* Less likely to seek help
* Interpret non-judgemental comments as judgemental or stigmatising

Let’s look at some of your stigma beliefs. Go through the survey on the next page, and see what you notice as you answer the questions.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mental Health Beliefs[[7]](#footnote-7)**  How true do you think the following statements are… | not at all | a little bit | somewhat | quite a bit | very much |
| 1. I would be taken less seriously if I had mental health problems | 1 | 2 | 3 | 4 | 5 |
| 2. If I had mental health problems, I would not seek professional help because treatment does not work. | 1 | 2 | 3 | 4 | 5 |
| 3. If I had mental health problems, I would not seek treatment because it would take time away from serving my unit. | 1 | 2 | 3 | 4 | 5 |
| 4. If I had mental health problems, I would be uncomfortable seeking professional help because people might find out about it. | 1 | 2 | 3 | 4 | 5 |
| 5. If I had a mental health problem, other service members would not be very tolerant of my problems. | 1 | 2 | 3 | 4 | 5 |
| 6. If I had mental health problems, it would be viewed as a sign of personal failure. | 1 | 2 | 3 | 4 | 5 |
| 7. If I were suffering from mental health problems, I would feel responsible for my problems. | 1 | 2 | 3 | 4 | 5 |
| 8. I would not be respected if I talked about my worries, fears, and problems. | 1 | 2 | 3 | 4 | 5 |
| 9. If I sought mental health treatment, I would be seen as weak. | 1 | 2 | 3 | 4 | 5 |
| 10. If I were having mental health problems, I would feel that I was a burden on my family or friends. | 1 | 2 | 3 | 4 | 5 |
| 11. I would be given less responsibility if my chain of command knew I was seeking professional help for mental health problems. | 1 | 2 | 3 | 4 | 5 |
| 12. If I had mental health problems, members of my unit would have less confidence in me. | 1 | 2 | 3 | 4 | 5 |
| 13. If I were getting help from a mental health provider, my peers would think less of me. | 1 | 2 | 3 | 4 | 5 |
| 14. If I were diagnosed with a mental health problem, I would feel stigmatized. | 1 | 2 | 3 | 4 | 5 |
| 15. If I had mental health problems, people would feel awkward and tense when around me. | 1 | 2 | 3 | 4 | 5 |
| 16. It is possible for people with mental health problems to recover. | 5 | 4 | 3 | 2 | 1 |
| 17. If I had mental health problems, it would be easy for me to find the time to see a professional for those problems | 5 | 4 | 3 | 2 | 1 |
| 18. People that I am close to would support me in seeking mental health treatment. | 5 | 4 | 3 | 2 | 1 |
| 19. If I had mental health problems, I would be comfortable talking about them with a counsellor or professional. | 5 | 4 | 3 | 2 | 1 |
| 20. If friends learned that I received treatment for mental health problems, they would be supportive and understanding. | 5 | 4 | 3 | 2 | 1 |
| 21. If I had mental health problems, I would receive good professional care from the military. | 5 | 4 | 3 | 2 | 1 |

|  |
| --- |
| What did you notice as you answered the questions? What stood out to you, or surprised you? |
|  |

Stigmatising beliefs tend to fall into four categories;

**Individual beliefs about mental health and illness**. These include how they are caused and what they say about the person, shame and thoughts of not being “good enough”, and general beliefs about being able to control thoughts and feelings.

**Beliefs about how those that are struggling will be seen and treated by others**. These might include losing the respect of others, being isolated or marginalised, concerns about career, or negative judgements of others.

**Beliefs related to treatment**. These include the perceived confidentiality of the process (i.e. a concern that peers or commanders might become aware without their consent), the difficulty of accessing treatment, that treatment is unlikely to make much difference for them, and preferences for non-professional care such as self-help and peer support.

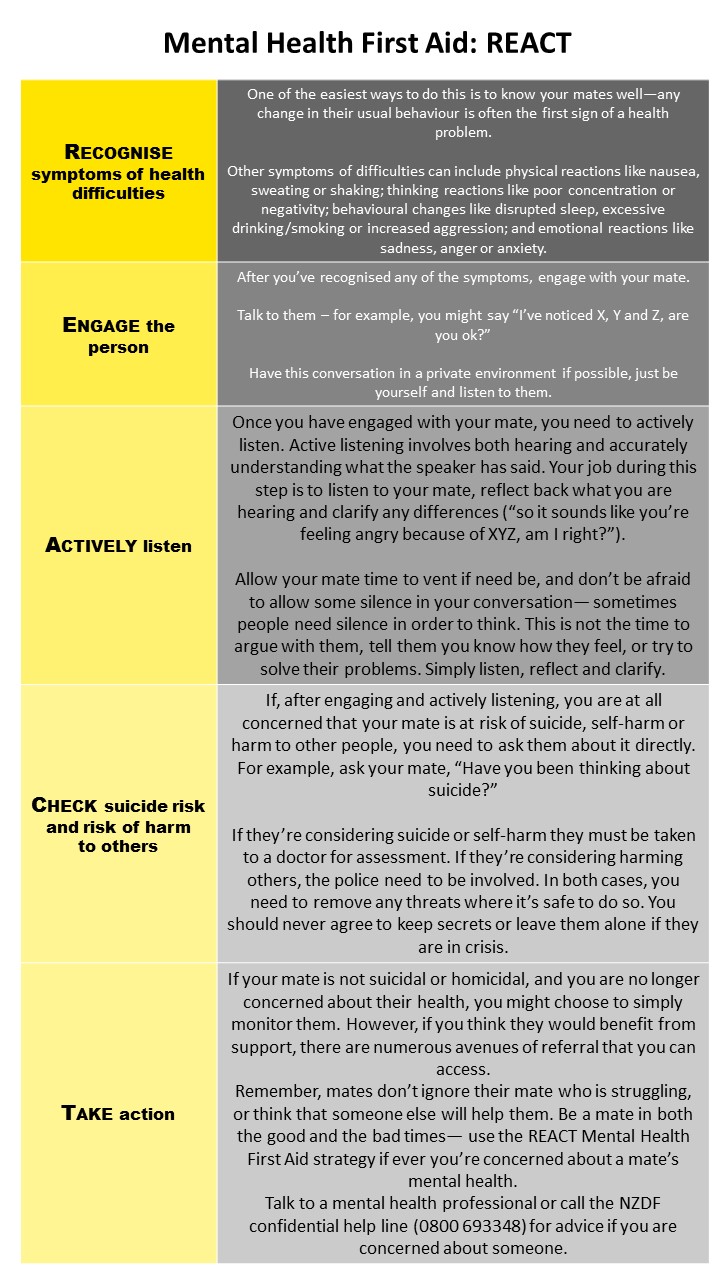
**Beliefs related to military norms**. These beliefs relate to a service member’s idea of what it means to be a war fighter, and might include a rigid sense of stoicism, self-reliance, and emotional detachment. It also includes the desire to be a contributing member of a unit, and to not be seen as a burden.

As a Peer Supporter, listening for and challenging these beliefs is an important part of your role. Therefore, key messages to reinforce include;

* It’s okay to not be okay. No matter who you are, life can take a toll and get on top of us at times. Plenty of high performers have struggled.
* The people around you, including your whānau and your team, want to see you happy and well. They are more concerned to support you than to judge you. And maybe those that do judge are not people that you ought to be too worried about.
* It may well feel like nothing seems likely to help, but it is worth exploring options with professionals. There is a lot of science behind both “talking therapies” and medications.
* War fighters are inherently part of a team and an organisation. Making use of both the team and the organisational resources, to be the best war fighter you can be, is the right thing to do. For you, your whānau and your team.

|  |
| --- |
| Based on discussions and reflections so far, what is one stigmatising belief that it’s important to you to challenge when you hear it in yourself or others, and what is your counter belief? What message are you going to remind yourself and others of? |
| Belief:  Counter message: |

# Part Four: Peer Support tools



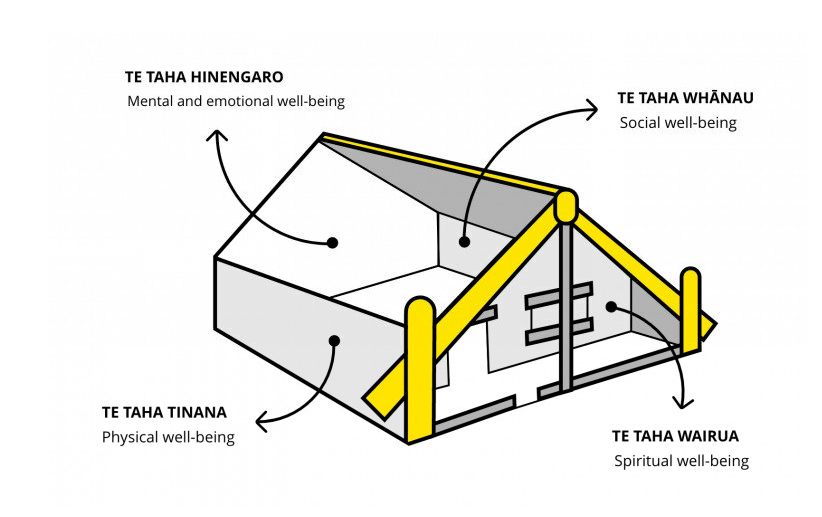
## REACT: Recognise

The first and most important step in supporting someone in distress is to notice. No matter how helpful you have the potential to be, if you don’t realise someone is struggling, then it is much harder to be useful.

Unfortunately, it can be difficult to recognise when someone is struggling.

|  |
| --- |
| What gets in the ways of noticing when people are struggling? |
|  |

### Te Whāre Tapa Whā



There are a range of models for understanding mental health and wellbeing in NZ. The model we are going to base the rest of this training around is the Te Whāre Tapa Whā model, which encompasses all of the elements of a person’s mental health. This model, initially proposed in 1984 by Sir Mason Durie, a prominent Māori psychiatrist, suggests that a person’s wellbeing is a function of their wellbeing across four areas of their life, all of which are connected, like the walls of a Whārenui (meeting house). The Whārenui’s connection with the whenua (land) forms the foundation for the other four dimensions.

* **taha tinana (physical wellbeing)**. Taha tinana is about how your body grows, feels and moves, how we care for it, and what we put into it. Nourishing and strengthening our physical wellbeing helps us to cope with the ups and downs and life. Changes in our physical health can have a direct impact on other aspects of our health, such as our mental and emotional health. Some key behaviours related to taha tinana are physical activity, healthy eating, sleep and smoking.
* **taha hinengaro (mental wellbeing)**. Taha hinengaro is a person’s thoughts, feelings, mind, conscience, and heart. It’s about how we feel, as well as how we communicate and think. Taking care of taha hinengaro is important for everyone, regardless of whether or not we’ve experienced mental illness or distress. When taha hinengaro is strong, people are able to gain perspective on their thoughts and feelings, remain hopeful in the face of distress, and make choices that reflect what matters to them. Behaviours relevant to taha hinengaro include being able to express our thoughts and feelings, making choices that reflect a balance of short and long term interests, allowing distressing thoughts and feelings without being overwhelmed by them, and being able notice when stress was becoming unhelpful and take effective action to manage it.
* **taha wairua (spiritual wellbeing).** Our spiritual essence is our life force, or mauri. This is the essence of who and what matters to you. Different people have different perspectives of wairua. For some, wairua is linked to religion or faith, and for others it is about a connection to something divine in each of us. For others, it encompasses the values, ethical & moral standards and the passions that drive the things in life that matter to each person. It also links to identity, such as one’s cultural identity or one’s professional identity, including our identity as a member of the NZDF, service, trade and unit. Behaviours that relate to taha wairua are things like going to church, being passionate about one’s work, acting according to the principles that are important to us, and maintaining a connection to family and the place we came from.
* **taha whānau (family or social wellbeing).** Taha whānau is about where we feel we belong, who matters to us in our life, who we spend our time with, and who we choose to love. Whānau is not just our immediate family, it includes the networks, extended relationships, and groups we belong to, as well as our friends, hoamahi (colleagues), and community. Everyone has a place and a role to fulfil within their whānau, and whānau contributes to individual wellbeing and identity. Connection and belonging are fundamental to human wellbeing. Behaviours that relate to taha whanau include how openly we engage in relationships with friends and family, our connectedness to our work colleagues and how we show up in romantic relationships.

When someone is struggling, there will often be indicators of this in different components of their Te Whāre Tapa Whā. Below are some of the common ones:

|  |  |  |
| --- | --- | --- |
| Life | **Te Taha Whanau or Social**  Withdrawal or social isolation  Seeking reassurance  Shyness  Outbursts and pushing people away  Manipulation  Loneliness  Risky relationship/sexual behaviour  Blaming others  Unresponsive or indifferent  Doesn’t recognise behaviour is inappropriate  Lacks insight into other’s reactions | **Te Taha Hinengaro or Mental & Emotional**  Sadness  Anxiety  Anger & Irritability  Worry & Catastrophising  Rumination on the past  Numbness, flatness, detachment  Difficulty concentrating  Intrusive thoughts or memories  Poor motivation  Self-absorbance  Low self-worth  Excessive fear about certain situations  Being ‘on edge’ and restless  Thinking illogical or inflexible |
| Work | Avoiding meetings and social events  Checking in a lot  Seeking a lot of feedback  Gossiping | Making mistakes  Slow or impulsive decision-making  Not understanding instructions  Lower outputs  Inappropriate or extreme response to constructive criticism |
| Life | **Te Taha Wairua or Spirituality, Meaning, Identity & Values**  Disengagement from passions  Disengagement from culture  Crisis of faith  Unethical behaviour  Disillusioned  Purposelessness  Deterioration in hygiene/presentation  Risk taking behaviour | **Te Taha Tinana or Physical**  Hyperactive or elevated  Poor sleep  Alcohol use  Caffeine use  Energy levels up or down  Skin complaints  Appetite or diet changes  Fatigue & Lethargy  Physical illness |
| Work | Poor motivation  Toxic Cynicism | Injuries  Use of sick leave |

### Top 10 Combat Indicators of Distress

There can be a range of signs of distress in any given person, and how it looks can vary according to history, culture, context and health. The list of indicators can be long; however, below are the top 10 signs that someone is struggling. The common factor across all of these is that they are an outcome of distress, they can feel like they are helping the person by making their life simpler or reducing their stress levels, and they also cause more problems;

|  |
| --- |
| * Withdrawal from friends, whānau or other social connections * Irritability, agitation and anger * Mood swings, or feeling like emotions are “close to the surface” and need constant monitoring and containment to stay managed * Feeling low, sad or tearful * Feeling flat, numb, or detached, including feeling unable to be tearful despite the urge and desire to * Impulsive or risky behaviour, this might include gambling, risky sexual behaviour, purchases or major life decisions * Sleep problems, including difficulty getting to sleep and waking in the night * Difficulty concentrating, easily distracted or disconnected thoughts, or confusion * Persistent worries that get in the way of life, these might be focused on particular aspects of their life, or more generalised, and may include self-critical or guilty thoughts. * Drinking, including drinking non-intoxicating amounts, consistently (e.g. 3+ beers every day) * Change in energy levels – either up or down * Inability to enjoy things they normally enjoy; this might look like disengaging from the activities or pursuits that are important to them, perhaps in order to “simplify” their lives |

### Your Te Whāre Tapa Whā Combat Indicators

Everyone’s Combat Indicators are different, so knowing yours is a good place to start.

Based on the conversations and material so far, what are some the things that show up for you when you are beginning to struggle and go from yellow to orange?

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
|  |  |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
|  |  |

### When to act

It is normal for people to experience some stress at times, and this is not a reason to worry or intervene. However it can be difficult to know whether someone is experiencing “normal” stress, or something that merits a more proactive response. Are they “reacting” (yellow) or “injured” (orange)? Here are some rules of thumb that might be helpful;

**It’s a Change**

Is it different or new for them? In order to know this, we need to have a good baseline to assess against, this is why it is important to get to know the people around you.

**It’s Pervasive**

Are you seeing indicators across different elements of their Te Whāre Tapa Whā. If so, this warrants more concern. If you are seeing only physical changes or only social behaviours, then this is less concerning. However, you should still pay attention as the different elements can quickly begin to impact one another, and some aspects of a person’s life are less evident than others. For example, you may not have an accurate sense of what is going on for them at home. Be aware that changes might take different forms across different areas of their Te Whāre tapa whā.

People can get into particular difficulty situations when their indicators start to feed on each other. For instance, they worry a lot, so they can’t sleep, so they don’t have the energy to catch up with their mates and they are grumpy with their loved ones, so they ruminate on their loneliness, which further interferes with their sleep, and so on...

**It’s Consistent**

We all have days when we are bit snappier than we would like, or we opt out of social activities, or we get disillusioned with our passions. That is normal. However, if you start to see these things persisting over time, then you might want to take action. Often we can wait too long before checking in on someone, so a good rule of thumb is **two weeks**. This might not seem like long, but it is better to check in too early than too late. Part of the reason for this is that some mental illnesses require a consistent change in state for a period of two weeks, though this does not mean that someone is mentally ill, it’s just useful to know.

**It’s Impacting on their Functioning**

If a change is significant, and it is either very apparent or notably impairing a person’s ability to function (at work or at home), then this would also warrant more immediate or deliberate action. It’s worth remembering that people will typically work hard to be at their best at work, and there is research suggesting that military personnel are particularly inclined to do this, so if you are seeing impacts at work, then there is a good chance things are not optimal at home.

Case Study Exercise two

What indicators can you recognise?

Consider: How might culture influence how indicators appears in different individuals?

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
|  |  |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
|  |  |
| Would you act? Why? What would you do? | |

## REACT: Engage

He toa taumata rau

*(Bravery has many resting places)*

### What gets in the way?

It’s not uncommon to have a concern or feeling that someone is not okay, and wonder whether we ought to talk to them about it. However, internal or external barriers often stop us. Internal barriers are the thoughts, feelings, beliefs or other internal experiences that prevent you from doing something. There might also be external barriers, including aspects of the context, the rules in your context, your time and resources, or things that are in your environment.

What might be some barriers that are relevant to you and your workplace?

|  |  |
| --- | --- |
| **Internal Barriers** | **External Barriers** |
|  |  |

Values Reflection

Whāia e koe te iti kahurangi. Ki te tuohu me he maunga teitei

*(Seek the treasures of your heart, if you bow, let it be to a lofty mountain)*

The internal and external barriers are many, including awkwardness, busyness and uncertainty. One way to overcome internal and external barriers is to have a clear sense of what matters to you in these situations, and what you would hope to bring to them. This can provide the impetus to push through the barriers, and have the conversation.

What personal value, characteristic or quality do you want to bring to these conversations?



Write for 10 mins about a value you would like to bring to your role as a PEER SUPPORTER. If this is difficult to connect to at the moment, then anchor your thoughts on another role that is important to you, perhaps as a friend, whanau member, or commander. Focus your writing on a value *you* want to live by and that *you* have felt connected to, even if only fleetingly, not what others have *told* you that you should. This will be different and personal for everyone, and will be informed by your knowledge of yourself and what matters to you.

These should be qualities of action and being that are intrinsically important to you. This is between you and you. It’s not about seeking approval or following a set of rules. You are not trying to avoid guilt or tell a self-justifying story. If you notice yourself beginning to tense up or feel a sense of anxiety around these expectations, that’s okay, write that down too. These feelings are a reminder that this really does matter to you.

As you write, consider some of the following questions;

* What do I care about?
* When in my life has this value been important?
* When have I not lived this value and what has it cost me?
* What have I seen in my life when others pursue this value? Or not?
* What are the qualities of my actions when I am acting in alignment with this this value?
* What does your internal critic tell you that stops you?
* How has it felt when I have lived this value?
* What do I do when I act according to this value?
* What does this behaviour look like for others? How do others feel when I act this way?

Keep writing for the whole time. If you run out of things to write, repeat what you have already written until something new shows up.

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This is a form of active reflection that focusses on how you want to be, rather than traditional goalsetting. It might feel a bit “fluffy”, however there is good evidence that doing this, and reviewing the reflection regularly, can have a real impact on performance. For instance, one study had university students do a similar exercise with regard to the values they wanted to bring to their study. Students in the condition that reflected on their values for 15mins at the beginning of the school year did 5% better on their grades than the comparison group that had set goals.

As we go through the rest of the training, bring this value to mind as you prepare for the activities and roleplays.

### Preparation and Considerations

He manako te kōura e kore ai

*(The wish for fish will bring none)*

Pick a time and place that is private and away from the rest of the team or other workmates. Consider the prospect that the conversation might prompt tears, and look to a location that will be supportive. Make sure you have put aside enough time for the conversation, and consider signalling how much time you have at the outset of the conversation, for instance “I’ve put aside an hour for our conversation today, as I want to make sure we have enough time to do it properly.” Also make sure that the distressed person has enough time for the conversation, and that they haven’t got anything critical they are rushing into next.

You might prepare for the conversation by pausing and reviewing your reflections on the person, perhaps drawing on the te whāre tapa whā model, in relation to them.

### Soften your Landing

It can also be advisable to centre yourself with some tactical breathing before you enter into the conversation, particularly if you are busy and stressed yourself (which we often are).

### Opening the Conversation

“A person’s success in life can usually be measured by the number of uncomfortable conversations that he or she is willing to have.” - Tim Ferris

|  |
| --- |
| **What are some good ways to broach the topic of Wellbeing?** |
|  |

Opening the conversation can be the hardest part, so having some go-to phrases that fit for you and sound okay coming out of your mouth, can be worthwhile. Here are some examples;

|  |
| --- |
| * How are you feeling? * I’ve noticed …. and I was wondering ….? * Are you OK? Really? * I’d like to hear about what is going on for you at the moment? * What’s happening for you at the moment? ­ * I’ve noticed you haven’t been going out lately, is there anything you’d like to talk about? * You’ve seemed withdrawn/… lately, is everything okay? * How are you doing? Really? * Is there anything making things hard for you at the moment? * You don’t seem yourself lately, what’s going on? * How are you tracking at the moment? * Everyone in the team has been under pressure lately, and it’s showing up for each of us in different ways, so I wanted to get a sense of how it’s going for you? * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## REACT: Actively listen

Active listening is a form of listening that enhances your ability to understand and relate to the other party in your conversation. It encompasses listening to the other person in a deep and empathetic way, with the hope of understanding their experiences, perspective and feelings. This results in the other person feeling heard and valued. Active listening is the foundation of strong and trusting relationships, and a necessary ingredient of an effective conversation when someone feels distressed, vulnerable or ashamed.

Importantly, active listening is inherently helpful when someone is distressed. Feeling a sense of connection and support activates physiological and neurological systems associated with calming and emotion regulation, such as the parasympathetic nervous system.

Think of a time when you were struggling or going through a tough time, and someone tried to offer support or be helpful. What was helpful and what wasn’t?

|  |  |
| --- | --- |
| **Things that were helpful** | **Things that were unhelpful** |
|  |  |

### Non-Verbal Listening Behaviours

He iti te mokoroa nāna te kahikatea i kakati

(Even the small can make a big impact on the big)

Active listening includes both non-verbal and verbal behaviours. Non-verbal behaviours relate to the things you do with your body to convey you are present and focused. We convey a surprising amount of information through our body language, in fact some experts suggest over half of our communication is non-verbal. We commonly do things with our body out of habit or without awareness that others will unconsciously interpret as being unreceptive, even when we really ARE listening. Egan (1986) describes the **SOLER** model as one framework for understanding non-verbal listening skills.

**Square Body Orientation or Sit Alongside**. Face the person or side alongside them. You may start off at a bit of an angle, though notice as you build rapport you will tend to twist toward one another. Make sure that you aren’t facing your computer or other distraction. When you get into the problem solving phase of the conversation you might sit alongside them and look at the plan together.

**Open Body Language**. Sit in a relaxed, open posture. This includes avoiding crossing your arms or legs. It can be helpful to remove any barriers such as tables or desks where possible. In moments when particularly personal or sensitive things come up, it can be a useful signal to put down any pads or paper that you might have. It can be useful to have your palms or wrists upwards, rather than your knuckles, perhaps having your hands rested in your lap.

**Leaning Forward**. As a culture, New Zealanders have some of the biggest personal bubbles in the world, so you don’t want to get too “in someone’s bubble” too early. However, when someone discloses something personal or vulnerable, it can be useful to lean forward a little to convey that you are attentive and wanting to hear more. Also be aware that leaning back after a comment can be perceived as you being unwilling to hear, or uncomfortable with, what someone has said.

**Eye Contact**. Eye contact is particularly important in western culture, and is one of the key ways we convey that we are present and listening. Nodding in affirmation of points can avoid the possibly intimidating sense of sustained eye contact. Importantly, eye contact can be different across cultures, with Maori and Pacific Island cultures more commonly seeing the person of lesser social status looking down as an indication of respect. Often they can be seen nodding in rhythm with the speaker if so.

**Relaxed** **Posture**. When people are talking about something personal or vulnerable, they are very alert to signs of discomfort or nervousness. Be aware of any nervous habits you might have, such as pen-clicking or fidgeting, and try to keep these minimal in sensitive conversations. Try to find a headspace and mindset that allows you to relax and be calm. This might include settling yourself with some breathing or focusing exercises, such as tactical breathing, just before the conversation.

This doesn’t mean that you need to adopt the same or a rigid posture when talking to someone in distress; rather, be aware of what you might unwittingly be conveying with your body language.

It can be useful to notice if you and the other person appear to have a similar posture, or are in a similar rhythm. This is termed “mirroring” and is a sign that you have a good rapport, and might be able to ask a more probing question. Similarly, if you have a good rhythm and you suddenly loose it, then it can be worth noticing this out loud, and inquiring about it. It might signal that something you did or said felt uncomfortable for the other person.

### Verbal Listening Behaviours

Verbal active listening skills include that things you might say. These can be remembered with the acronym, VOICEing.

**Verbal Attending**. This includes all those little sounds you might make in rhythm with someone when they are talking to you, including sounds like “Aha, hmmm, I see…” All these convey interest and encourage the person to continue.

**Open Questions**. Illicit an answer longer than a word or two. Often, these will invite a description, exploration or expansion on a topic and begin with “Tell me about…”, “What are your thoughts on…” or “How…”.

Open questions will often begin with a “W”, such as what or when. Importantly, avoid starting questions with why. People typically hear “why” questions as a request to justify your thoughts, perceptions or actions, and will shut down or get defensive. If you want to ask a “why” question, pause and rephrase it, perhaps with a request to “tell me more about how…”.

**“I” Statements**. Be cautious about making assertions or assumptions about other people’s experiences, instead focus on your own observations and thoughts, and describe them as such. Useful phrases can be “I’ve noticed…” and “I’m wondering…” These might then be followed by queries about whether they share those thoughts, feelings or wonderings.

**Check Understanding**. This includes clarifying questions, such as “Can you tell me more about…” as well as paraphrasing key points, or repeating back points to convey that they have been heard. This also includes checking the emotional content of their story. This might include being curious about what they were feeling “and how did you feeling when that happened?” or hypothesising about what they might have felt (being careful not to project an emotion on them), such as “it sounds like you felt overwhelmed, how did it feel for you then?” Synthesising and reflecting emotions allows people to integrate them and move on. If someone appears stuck on a topic or to be going in circles on something, then focusing on labelling the emotion that they are trying to describe can help them to get perspective on it.

**Ending & Summarising**. Can be useful to draw together various threads or points, and can also help if people appear stuck in a loop or to have difficulty organising their thoughts.

Other tips include;

**Make use of silence**. We often get uncomfortable with silence, and instinctively fill it. If you notice a moment of silence, experiment with letting it play out, particularly if it feels like the distressed person is experiencing a lot of emotion. This can allow time for this emotion to rise and fall, and they will find the words to talk to their experience. It also conveys that you are comfortable with emotion.

### Emotion Labels

In order to reflect and validate, we need an emotional vocabulary. Being able to label and describe emotions helps us to organise them, and get perspective on them. The more layered and granular our vocab, the more succinctly we can reflect and validate emotion. However, many of us struggle to identify, label and describe what we are feeling, particularly when we are feeling more than one emotion at the same time. This is a skill that can be practiced and improved.

“But emotions can’t be ignored, no matter how unjust or ungrateful they seem.” - Anne Frank

Let’s see how you might do this, below is a list of emotions.

Think of a recent time you were upset or feeling strong emotions, describe it and tick all the emotions you were feeling;

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Situation**: | | | | |
| **Enjoyment** | **Sadness** | **Fear** | **Anger** | **Disgust** |
| happiness  love  relief  contentment  amusement  joy  pride  excitement  peace  satisfaction  compassion | lonely  heartbroken  gloomy  disappointed  hopeless  grieved  unhappy  lost  troubled  resigned  miserable | worried  doubtful  nervous  anxious  terrified  panicked  horrified  desperate  confused  stressed  overwhelmed | annoyed  frustrated  peeved  contrary  bitter  infuriated  irritated  mad  cheated  vengeful  insulted | dislike  revulsion  loathing  disapproving  offended  horrified  uncomfortable  nauseated  disturbed  withdrawal  aversion |
| **What do you notice about your thoughts and feelings as you label emotions?** | | | | |

Practice task

|  |
| --- |
| **Who might you deliberately practice your active listening skills on in the next day or two, and how might you do it?** |
|  |

### Active Listening Tips

Resist the righting reflex

When someone is distressed, our first instinct is to try to help. Sometimes this can lead us to do or say things that seem like they should and could be helpful. This might look like;

* Giving advice and suggestions.
* Reassuring them that it’s not so bad.
* Give information.
* Providing reasons they should not be upset.
* Distracting them with other things to focus on which aren’t so bad.
* Encouraging them to “shake it off” or “buck”.

While many of these responses can be helpful in time, when someone is upset, their emotions can get in the way of hearing these messages. In many cases they have already tried these approaches and they have not helped. Offering advice can shut down the conversation and result in the person feeling disconnected and isolated.

If you notice the urge to fix something, sit back, breath out, and connect with values that matter to you.

Validation

Validation is conveying acceptance of another person’s emotional experience and the sense that it is “okay to feel the way you feel”. This is distinct from responding to another person’s feelings with judgement, rejection or dismissal – which would be termed invalidation, and leads people to withdraw, close down or feel ashamed. Importantly, this does not mean that you agree with the other person, or the righteousness of their thoughts and feelings, but that you understand their feelings and can see how that feeling makes sense for them. This won’t make the emotion go away, but it will make it easier to talk about and begin to process.

Often, we can invalidate people’s emotions in an effort to be helpful. This can come in the form of efforts to minimise, reassure, change their perspective to a more helpful one, or challenge thoughts that appear to be hurtful for them. For instance, if someone is upset after a relationship breakup, we might say some of the following;

* *“You’re better off without them”*
* *“You were only together a short while”*
* *“Now you are free to focus on other things”*
* *“You’re a great catch, you’ll find another someone special”*

All of these come from a desire to help, however the implicit message of all of them is   
“you shouldn’t feel that way.” Because feelings don’t always make sense, and the person does feel that way, they feel foolish and alone. When you next feel the urge to reassure or minimise, Russ Harris, an Australian therapist, suggests you try imagining what would come out of your mouth if the next sentence began with “who wouldn’t feel that way…”

* *“Who wouldn’t feel that way… I know how much you liked him/her.”*
* *“Who wouldn’t feel that way… I could see how hard you worked on that relationship.”*
* *“Who wouldn’t feel that way… it was clear how special that relationship was.”*
* *“Who wouldn’t feel that way… breakups effing suck!”*

Other useful validation phrases are;

* *“That makes perfect sense.”*
* *“I can see how you felt that way.”*
* *“That’s sounds like a really difficult situation.”*
* *“It must be really hard to be carrying all this stuff with you.”*
* *“It sounds like you are working really hard to manage this.”*
* *“Sounds like this is really stressful, no wonder you feel overwhelmed.”*

If you try to problem-solve without validating the emotion, you may find you don’t get anywhere - as the emotion interferes with the perspective taking required to problem-solve. Validation allows the emotion to settle and organise, so you can then problem-solve. Consequently, one of the key rules of thumb when dealing with a distressed person is “validate, then problem-solve.”

If you get uncomfortable, don’t stop, but **S.T.O.P.**

When we are talking to people about topics that are distressing, awkward or upsetting, we can be uncertain about what the right thing to do is. STOPping can be a useful technique in such circumstances. STOPping refers to the steps below;

1. **Slow down**. Many of us, particularly European New Zealanders, can be tempted to fill a silence with more words. Sometimes these swamp the other party, or deny them the opportunity to feel less overwhelmed so that they can continue. Slowing down creates space for them to settle and talk.
2. **Take a breath**. Taking a breath helps insert some time and space for both of you to settle into the moment. You may also notice that, when conversations are tense or uncomfortable, your breath becomes halting, or even stops. This can actually add to our sense of anxiety, so taking a breath can also help us to relax physiologically.
3. **Observe and open up to the discomfort**. Notice what you are feeling, and maybe label it – is it anxiety, embarrassment, guilt, sadness? Remind yourself that those are all very normal emotions to feel when sitting with someone that is distressed, and they reflect your humanity and compassion.
4. **Proceed according to your values**. What value or personal quality do I want to bring to this moment? Is it my compassion? My warmth? My patience? A sense of awhi? A sense of being understood?

Observe & Describe

Observe and describe is a technique that can be useful when it feels like there is something going on that is unclear or “getting in the way”. This technique involves taking a curious observers perspective on both the situation and your reactions to it, including thoughts and feelings, and saying those out loud. Importantly, this is not about making those someone else’s responsibility. It begins with observing;

* Noticing what is going on around you, what are you noticing in the other person?
* Notice your own thoughts and feelings.
* Notice your own posture, and what your body wants to do.
* Defer reacting to any thoughts, instead, just let them come and go.
* Don’t push anything away, but don’t grab onto any thoughts.

Describing looks like;

* Stating out loud the thoughts or feeling you are noticing in yourself, and querying whether the other person is having similar thoughts to those.
* Describing what you are wondering about.
* Describing changes in the behaviour of the other person, and being curious if they have noticed them, and had any thoughts about them?.

Pulling on a thread

Pulling on a thread involves following a line of inquiry. As the person offers up more information, you ask about an aspect of what they have just offered. Ideally, you pick out the key element of what they have just offered or said, and invite them to tell you more about that. Rather than getting a full picture, as in a Deep Dive, you are going down a bit and seeing where it takes you.

|  |
| --- |
| **Pulling on a Thread Questions** |
| What is XXX (stress/worry) like for you?  How has that affected you?  What else?  Can you tell me a bit more about that?  Can we just pause and unpack that a little?  What difference did/would that make?  Flesh that out for me?  What was that like for you?  What does that mean for you?  What was your reaction to that?  What impact did that have on you? |

#### Useful Questions & Phrases

You might also think about asking questions from the different aspects of the Te Whare Tapa Whā model:

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
| How are your relationships at work at the moment?  How are things with your family/whānau at the moment?  Who in the team do you feel like you can trust at the moment?  Who else can you talk to about this?  Who else can you lean on? | How has that impacted on you?  What goes through your mind when you are feeling this way?  On a scale of 1-10, 10 being the worst you have ever felt, how are you feeling now? Over the last couple of weeks?  How are you feeling about things now?  How are your anxiety levels at the moment? |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
| What are the things you are passionate about at work at the moment?  What are the things outside of work that you are passionate about?  What do you feel you are strong in at the moment?  What are the things in your life that are particularly important to you at the moment?  What is helpful for you at the moment? | How’s your health, more broadly?  What are you doing to look after yourself at the moment?  Any health difficulties at the moment?  Any pain or old injuries?  How’s your sleep? What’s difficult about it?  How’s your diet and appetite?  How’re your energy levels more broadly? |

|  |
| --- |
| What are some good questions, phrases and framings that you might use when actively listening? |
|  |

Case study Exercise three

As a group, decide where and how you would approach the conversation, and set the scene.

Everyone will have a turn to be a listener, observer and case study.

* Two mins as a group to decide how you would set it up.
* Pick a tool or technique to try,
* Review your values reflection exercise.
* Five mins to role play.
* Two mins to debrief.
* Switch around & repeat.
* Switch around & repeat.

When you assume the role of a concerned colleague remember to;

* Focus on active listening,
* Resist the urge to advise, problem-solve, or solutionise,
* Consider picking one listening technique to try,
* Identify a couple of questions or phrases that you might go to if you aren’t sure.

Reflection

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| --- |
| What reflections or learning did you get from the role play? |
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## REACT: Check on risk

In some cases a distressed person may have experienced, or be experiencing, suicidal thoughts and/or urges. This can be unsettling for them, those around them, and you as a support person. Common reasons people consider or attempt suicide are;

1. A desire to escape overwhelming emotions and thoughts. They are seeking relief from a deep emotional pain, and they feel like there are no other options for escape. They feel there is nothing they can do to get some control and that they are a burden to others, or will not be missed by anyone.
2. An attempt to communicate how they are feeling to another person that is important to them. Sometimes hoping that this will change the way the other person feels about or responds to them.

It can be useful to remember that many suicidal people have very mixed feelings about ending their lives, and, consciously or subconsciously, will give off signals warning of their intentions. Mental health conditions, particularly mood conditions such as depression and bipolar disorder, are some of the strongest predictors of suicidal thoughts and behaviour. If you are aware that someone is struggling with a mental health condition, then it may pay to be aware of possible suicide risk indicators, and what you might do if you become concerned.

### Signs of risk

The New Zealand Ministry of Health describes the following indicators of suicide risk, when someone;

* tells you that they want to die or kill themselves
* accesses things they could use to hurt themselves
* reads or writes about suicide online, or post photos or videos about suicide
* becomes obsessed with death
* becomes isolated or withdrawn from family, whānau and friends
* doesn't seem to be coping with any problems they may be having
* has changes in mood – becoming depressed, angry or enraged
* hurts themselves
* feels worthless, guilty, or ashamed
* has no hope for the future
* uses drugs or alcohol to cope with difficult feelings or thoughts
* loses or gain a lot of weight, or has unusual eating patterns
* sleeps a lot more than usual, or stop getting enough sleep
* seems to have lost interest in life, or things they used to enjoy
* gives away possessions, pay back debts or 'tie up loose ends'
* stops taking their medication
* suddenly seems calm or happy after they have been depressed or suicidal.

The more you see of these, the greater your concern should be.

Many of the above signs are also signs of mental illness. More broadly there are some types of thought and outlook that may signal particular risk. Specifically, this includes a combination of emotional pain, hopelessness, helplessness and worthlessness. It is a deep and abiding pain, hurt or anguish, sometimes termed “Psychache” that feels persistant and inescapable. Hopelessness is reflected in thoughts suggesting there is no change coming, or no future where things will be different. Helplessness is the belief that there is nothing that can be done to ease one’s distress. And worthlessness or disconnection is the belief or sense of being alone, thoughts might sound like “I don’t matter to anyone” or “I am a burden to the people I love”. Theory suggests that these factors can leave people feeling like suicide is the only option that offers respite.

There are also a range of events, thoughts or experiences that trigger or exacerbate these feelings and thus escalate risk, and warrant you asking after the person.

|  |  |  |
| --- | --- | --- |
| Reports of low mood | Legal problems | Suicide in social network |
| Loss of a loved one | Child custody issues | Intense anger |
| Substance misuse | Chronic pain | Trauma (other) |
| Insomnia | Sexual/physical abuse | Expressing hopelessness |
| Feels a burden on others | Family breakdown | Reporting helplessness |
| Relationship problem | Financial difficulties | Emotional abuse |
| Conflicted sexual identity | Significant career setback | ???? |

### Alcohol and Suicide Risk

One of biggest risk factors for suicide is substance use, particularly alcohol. For example, in 2017 over half of the completed suicides in New Zealand (57%) had alcohol or traces of alcohol in their system[[8]](#footnote-8). Alcohol impairs judgement, reduces impulse control and can contribute to the relationship conflict that is a common trigger for suicidal acts. If someone is at risk and you know they are drinking heavily, or are likely to do so, then you should be additionally vigilant.

### What to do if you are concerned

If you believe someone is at risk of suicide, there are three recommended steps. There are part of the **ACE** model, developed by the US Army. The steps are **Ask**, **Care** and **Escort**.

### Ask

The first step is to ask whether they have had any thoughts of suicide. As noted in the myths and facts section, there is no evidence that this increases the likelihood of their attempting suicide. In fact, people will often be relieved that someone has asked about it. Suicidal thoughts are more common than many of us realise, and having someone ask about them in a frank manner can be both reassuring and a relief for the person.

When you ask the question, it is best to be direct and explicit, referring to the thoughts and actions directly. Resist the urge to ask in an indirect or leading way, such as “You aren’t thinking of doing anything stupid are you?” or “Are you thinking of hurting yourself?” There are two risks with these types of approaches, the first is that they give the other person the chance to answer honestly, while still concealing they are suicidal. For instance, it’s may not seem like a stupid act to them, or it may seem like a way of relieving hurt and pain. Secondly, and more importantly, asking indirectly conveys you are – on some level – uncomfortable with the topic. By asking about it directly and concretely, you communicate that you are willing to talk about it. It can be useful to make such thoughts normal or understandable as part of your introduction of the topic. For example;

* *“I can see how hard/sad/painful things are for you right now, and so I want to check in on something. I know that, sometimes, when people feel stuck and unhappy, they have thoughts of suicide. Have you had any thoughts like that?”*

If the person indicates they have been having thoughts, then you need to ask about whether they have had any intention of acting on those thoughts. If so, then ask whether they have any plans as to how they might do it, and if so, how far they had got with those plans. Had they started to put things into action, for instance acquiring information or means, or rehearsing? Gather all this information in the course of the conversation. This allows you to get an understanding of the immediate risk.

It can be helpful to have some specific questions to ask if this is a new area for you. If you think this might be the case, then the questions below may be useful. These questions are known as the Columbia Suicide Severity Rating Scale, or CSSRS. These are not intended as the only way to get a sense of the risk, but research on a range of populations suggests that these questions can be asked across a variety of contexts, and can provide a useful framework for a conversation about suicide risk.

1. *Have you ever wished you were dead? Or wished you could go to sleep and never wake up?* If yes, go to Qu 2.
2. *Have things been so bad lately that you have had any thoughts of actually killing yourself?* If yes, as all remaining questions. If no, got to Qu. 6.
3. *Have you been thinking about how you might do this?*
4. *Have you had these thoughts and had some intent to act on them?*
5. *Have you started to work out, or worked out, the details of how to kill yourself?*
6. *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

If you get a yes to **any** of these questions, then you should guide the person to a health or mental health professional.

### Care

Once again, the most useful thing you can do is listen openly. You don't need to have all the answers. The best thing you can do is to be with them and really listen. Feeling connected and accepted is one of the most protective experiences for those experiencing suicidal thoughts, so if you can do that then you will be making a difference. It can be difficult and uncomfortable for a person to tell you they are feeling suicidal. Thank them for telling you and let them know there is help available. Be gentle and compassionate. Even if it’s hard to understand why they are feeling this way, try to accept that they are. Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before and what they did to cope or get through it. They might already know what could help them. If they seem unwilling to talk, don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them (or who is closer to them).

|  |  |
| --- | --- |
| Do’s | Don’ts |
| * Stay with the person until help arrives. Never leave someone experiencing suicidal thoughts alone. * Try to stay calm and hopeful that things can get better, but don’t gloss over their distress. * Remove any weapons, drugs or other means of self-injury from the vicinity if possible. * If you’re on the phone with someone who you believe is in immediate danger, try to keep him or her on the line while you or someone else calls 111. Ask if there’s someone nearby who could offer support, and keep talking until help arrives. * If the person is unwilling to accept help, contact command or the police. | * Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends. * Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe. * Tell them they shouldn’t feel the way they do, or argue with how they feel. * Tell them off. * Deride them. |

Care For Self

An important part of responding to suicide risk is to care for yourself. These can be very stressful experiences, particularly if you are supporting someone in an ongoing way. Therefore, it is important to invest in your own wellbeing. This might take a number of forms.

**Recovery immediately after the event.** This might include an “informal debrief” (respecting the person’s privacy and dignity) with a trusted friend, partner, colleague or leader. It might also include discussing events with a professional. This can be useful for getting perspective on your own experiences, feeling more confident and competent about similar situations in the future, and understanding boundaries and where your role begins and ends.

**Routinely investing in your wellbeing.** This ensures you have a solid foundation for yourself, so if your stress or anxiety levels go up, you have some “buffer” to absorb stress. Making sure that you are disciplined about your wellbeing ensures that you have a firm base from which to support others. This includes making sure you are taking breaks regularly, both within the day and across the year. It also means keeping an eye on your health behaviours, such as exercise, diet and drinking. Finally, and perhaps most importantly, invest in a social support network for yourself. Have some friends, mentors or whānau that you can talk to about what’s going on for you, because having these conversations yourself will help when you need to have them with others.

**Consider talking to a professional**. Sometimes, particularly if you are regularly having these kinds of conversations, it can begin to take a toll on you. This might because of the emotional labour, i.e. the need to manage your emotions, or it might be because the experiences of others resonate with your own experiences or beliefs. You may also notice yourself thinking on conversations, or wondering about whether you could/should be doing thing differently. Talking to a professional can help you get perspective, and potentially provide you with skills that are useful.

### Escort to Help

When thinking about risk to self or others, it is important that you bring others on board. This generally results in a better outcome for you, the person and those around them.

|  |
| --- |
| If you are concerned about someone, who are some people you can go to or call? |
|  |

Ki te otahi te kakaho ka whati, Ki te kapuia e kore e whati

*(Alone we can be broken. Standing together, we are invincible)*

This leads us to the final step in our REACT model…

## REACT: Take action

### Encouraging help-seeking

Barriers and stigma are some of the biggest impediments to mental health in the NZDF. We know that a reasonable proportion of those that are distressed or struggling do not seek help. Research suggests this is for one of four reasons;

**Not being Aware of the problems they are having and can get help for**. Often people attribute their current problems to stress, their situation or their own weakness. Having a friend notice out loud how they are tracking, and suggest that the might be people that can help them deal with that better, can be a useful contribution. Also, if you are talking about mental health generally, making people aware of some of the common signs of mental illness and burnout, across all the aspects of their life, can be helpful.

**Not able to Access help**. Getting mental health support can be surprisingly difficult. This includes knowing who to go to, getting time off to go, and feeling able to take the time. One of the great things about the NZDF is that we have a number of pathways into support, and the freedom to access medical appointments. The pathways to support include MOs, social workers, defence psychologists and chaplains.

**Not able to Afford help**. Mental health treatment is not cheap, and cost is a barrier for many New Zealanders. For serving members of the NZDF, it is free. NZDF4U will provide three free sessions to civilian employees. Family members are eligible for sessions where the issue is related to a person’s service. When talking about helpseeking with people, it can be useful to remind them of these low cost provisions.

**Too Ashamed to**. The last, and perhaps most significant barrier to disclosure is stigma, so remember the key messages that;

* People won’t be judged for helpseeking
* Their career will be supported
* Treatment can help

### Take to Support

Here are just some of the people that might be able to offer support when someone is struggling.

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
| Whanau  Social Workers  Civilian mates  Unit mates  Commanders  Family therapists  Iwi  Mentor  Civilian Clubs  ??? | NZDF4U  Clinical Psychologists  Counsellors  Community mental Health  Self-help groups (e.g. AA)  Specialist support groups  Lifeline & Youthline  Specialist services (anxiety groups)  Online groups  ??? |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
| Defence Chaplains  Kaumatua  Transition Coaches  Culturally relevant groups & leaders  Support groups  Career Coaches  Leader Development  Church  ??? | MO/GP  Medic  Nurse  PTI  Financial adviser  Physio  Dietician  A&E  ??? |

For a fuller list of resources see pp.116-120 of Staying at the Top of Your Game (available at health.nzdf.mil.nz).

Case Study Exercise Four

Imagine that you had sat down with your case study person and come up with a plan that was tailored to that person; their needs, strengths and situation. What might that plan look like? Think of one or two things that might be relevant to each of the elements of their te whāre tapa whā. Also think about who might be able to help with that.

List what you might have come up with together and who you might draw on as part of that, and make it as specific to that person as you can.

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
|  |  |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
|  |  |

## Mental health crisis intervention

Sometimes a service member may experience a critical failure in their ability to deal with the world, leading them to appear dysregulated or erratic. Such crises might include “*intense feelings of personal distress (e.g. anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g. neglect of personal hygiene, unusual behaviour) or catastrophic life events (e.g. disruptions in personal relationships, support systems, or living arrangements,; loss of autonomy or personal rights; victimization or natural disasters)*”[[9]](#footnote-9). Crises are often characterised by a sense of losing control of events, feelings and thoughts, and they might include agitation, anger & aggression, catatonia (inability to move/being frozen), panic, self-harm or perceived loss of touch with reality.

While major crises are more commonly seen in those with severe forms of mental illness, no-one is immune. Crises more commonly present in young people, and NZDF recruits people at a relatively young age. It’s possible that a service member’s difficulties and distress may not have manifested by the time they enlist. Everyone’s story and distress is different, so the most effective responses are tailored to the person and situation. Also, crises can present at any stage in life, and can be triggered by all manner of stressors, including common human experiences such as raising a family, employment disruption, and heavy work pressures.

Once again, the core principles offer good guidance to managing crises.

In addition to these it can be useful to consider the following:

Remain Calm

When confronted with someone in crisis, it can feel overwhelming. You may find yourself experiencing feelings of powerlessness, frustration, confusion, fear or concern. These are all normal and understandable, and it is important that you seek to maintain a balanced and composed interpersonal style, even if you are not feeling it. It may be useful to apply some of the military mental skills you have found useful in other contexts, such as tactical breathing.

Communicate Appropriately

Be respectful and protect their dignity. Talk with the person in a quiet but clear and concise manner, and be prepared to repeat yourself or rephrase things. It can help to talk slowly and to pace your speech. If you are misinterpreted or have difficulty tracking responses, be patient and seek to clarify. Avoid accusations, making fun of the person, arguing, or dismissing their concerns/distress.

Check for Substance Use

Sometimes substance use may be playing a role in crises and might be exacerbating distress or contributing to disconnection from reality. It can be useful to gently inquire about substance use if you think that this might be relevant, as this might help you better understand what may be contributing to their behaviour. It may also inform judgements about risk to self from overdose.

Be mindful of possible trauma history

Be mindful that the distressed person’s reactions and perceptions may link to their history, and make sense in the context of that. For example, physical touch might have a range of associations and memories that are intensely distressing for them, so be gentle and understanding of intense reactions, and respect their perspective.

“Watchful waiting”

When someone is in crisis, the intensity will often peak and pass. Creating a safe and supported space for this can be a useful step in managing a crisis. As long as any threat to self or others is mitigated, then patience and time are your allies. In many cases, staying aware and present as the distress rises and falls allows space for the development of a collaborative plan when things have begun to settle.

Prioritise providing a sense of control

The trigger for a crisis can often be a perceived loss of control, and a person’s actions reflect attempts to regain control. Give them choices throughout, both big and small. This might include allowing them to make sub-optimal (but safe) choices, even when you would assess those choices as less effective. In the long-term, this is more likely to lead to positive outcomes, and avoid both disempowering the person and you becoming responsible for any negative outcomes.

Let the person move around as long as this does not involve a threat to their safety or others; restraining people can aggravate distress.

Make safe

Often a crisis is triggered by a sense of not being safe (even if this perception is not objectively true), so one of the goals in navigating through crises is to cultivate a sense of safety. The agitated behaviour sometimes associated with a crisis can reflect the person’s attempts to make themselves safe. Framing agitation or anger as fear and anxiety driven, and identifying and addressing those fears and anxieties with the person can be helpful.

Keep them connected and supported

Where possible, minimise a sense of isolation and restriction. As you navigate the crisis, work with the individual to identify people and places that they feel are supportive and safe, and aim to have these incorporated into the support plan.

Listen to concerns and greiveances

Unfortunately people in distress are more likely to be victims of further violence and mistreatment. This may be because their difficulties lead them into risky situations, or sometimes because predatory individuals identify them as either isolated or less credible and target them. Therefore complaints or accusations are sometimes ignored or dismissed. Treat accusations and grievances as credible, and provide info on any investigations or follow-up.

### Build a Menu of Options

When thinking about an action plan, it’s important not to move to decision-making too early, and spend a bit of time just laying out the options. This serves three purposes. It ensures you have a full survey of the options before you settle on the ones to pursue. It also builds hope that there might be a number of ways to make things better. Finally, it promotes choice, which increases buy in.

When building a ‘menu,’ it can be useful to explore the things they have thought of and dismissed, the things they have tried, and the things that have been helpful in the past. Sometimes it can be helpful to write these down.

* *What’s working for you now, that we might want to protect?*
* *What have you tried already?*
* *What have you thought might make a difference, but not actioned?*
* *What has worked in the past?*
* *What are some other areas of your life it might be worth thinking about?*
* *Would it be useful for me to offer some ideas?*
* *Which of these feels like the most useful or workable?*
* *Which feels like something you can do? How doable on a scale of 1-10?*
* *Who can help in those areas?*

### How To Make Suggestions

You may have ideas about actions that might be useful, and it can be compelling to suggest these – particularly if you think that they might be helpful! However, there is a strong body of research suggesting the urge to give advice can often be counterproductive, particularly when a topic is sensitive or has shame attached to it. Research on helping people change, specifically in an area known as motivational interviewing, persuasively demonstrates that jumping in with advice the wrong way can shut the conversation down, or lead to people feeling like they are following your instructions rather than making their own choices. This can impact on their long-term outcomes and your relationship with them. In addition, offering advice the wrong way or too soon can make it *less* likely people will listen, even if it might be useful to them.

However, often your advice may have some value, so here are some things to think about when giving advice.

### Ask for permission to give advice

A simple way to soften the landing of advice giving is to ask for permission to offer it. This helps to soften the landing of advice, and conveys that it is an offering, rather than an instruction. Here are a couple of ways you might preface advice;

* *Would it be useful to talk through some things I’ve seen help other people?*
* *Would now be a good moment to offer a couple of thoughts that have occurred to me as we’ve been talking?*
* *It sounds like you feel a bit stuck, would it help if I offered some thoughts that occur to me, as a start point?*

### Explore-offer-explore

The explore-offer-explore technique is one of the best ways to approach suggestions. Again, advice giving can land badly, and close off connections. So, once you have built up a menu of options and got it on the table (explore), and asked permission to give advice and given it (offer), then move to exploring once again by asking about what they think now, having it all out on the table?

### We believe what we hear ourselves say

Whilst giving advice and direction can be unhelpful, it can still be useful to focus attention on helpful or hopeful thoughts, ideas and COAs. The simplest way to do this is to get CURIOUS and ask more questions about them when they come up. These questions might include;

* *What difference might that make?*
* *What would that do?*
* *How would that help?*
* *What are some of the reasons that’s a good idea?*
* *How important is it to make this change? What makes it important?*
* *How would you start with that?*

The more people talk about an idea, the more real it becomes to them and the deeper the thought gets embedded. Prompting people to explain, describe, and reflect on hopeful or helpful thoughts is one of the most effective ways to promote more lasting change.

Brainstorm and Explore

What are some tools, resources or people a distressed person might look to in each of the following areas?

|  |  |
| --- | --- |
| **Social** | **Mental & Emotional** |
|  |  |
| **Spirituality, Meaning, Identity & Values** | **Physical** |
|  |  |

For further ideas check out the relevant sections of SATOYG.

The Defence Health Website, Pūtahi Hauora, also hosts a wealth of wellbeing information, including self-assessments.

Planning To Make a Change

This worksheet provides a structure for planning through the obstacles that get between you and your goals, and mentally rehearsing moving through those barriers. Evidence shows that taking a few minutes to go through this process when considering and setting goals markedly improves your odds of achieving them.

Wish: Describe the goal you are hoping to achieve? Make this as succinct (4-6 words), concrete and SMART as you can. Make it a meaningful stretch goal, but achievable (80% likelihood).

|  |
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|  |

Outcome: Describe the best result if you achieve your goal. What difference will that make for you? Hold that image for a few moments, fill out the detail. How will you feel?

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Obstacles: What are the things in your environment that might get in the way of you achieving that goal? What are the internal things that might get in the way (anxieties, thoughts, doubts)? Take a moment to really imagine it.

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Plan: If those obstacles come up, what could you do to help you move through them? Put the obstacle and action in the statement below. Mentally rehearse that obstacle coming up, doing the action and moving through to your goal.

|  |  |
| --- | --- |
| If… [obstacle], | then I will [effective action]. |
| If… | then I will… |
| If… | then I will… |
| If… | then I will… |

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|  |  |
| --- | --- |
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| If… | then I will… |
| If… | then I will… |
| If… | then I will… |

## Boundaries

Importance of boundaries

Healthy boundaries play a critical role in ensuring effective, ethical, and sustainable interactions, especially in support settings. Here are the top five reasons why boundaries are important:

**1. Protection for Both Parties**

Boundaries safeguard the emotional and psychological wellbeing of both the supporter and the supported. They prevent the supporter from experiencing burnout and compassion fatigue by delineating the limits of their responsibility. Similarly, they protect the person receiving support from becoming overly dependent or being exposed to potential bias or judgment.

**2. Maintains Professionalism**

Clear boundaries are essential for maintaining a professional relationship, which is crucial in contexts where support could otherwise blur into personal territory. Professionalism underpinned by boundaries fosters a safe and respectful environment, ensuring that the relationship remains focused on the intended support and guidance.

**3. Prevents Misunderstandings**

Boundaries set clear expectations for what the relationship will entail, including the roles, responsibilities, and limitations of each party. This clarity is vital in preventing misunderstandings and conflicts that can arise from assumptions or unspoken expectations, thereby preserving the integrity and effectiveness of the support relationship.

**4. Supports Emotional Health**

Emotional health is supported through the establishment of boundaries by recognizing and respecting the emotional needs and limits of both parties. Boundaries help individuals to understand and articulate their own needs, fostering emotional resilience and preventing the potential for emotional distress or enmeshment in the challenges of others.

**5. Fosters Trust**

Trust is foundational to any support relationship, and boundaries are key to building and maintaining this trust. When boundaries are clearly communicated and respected, it reassures both parties that the relationship will be handled with care, respect, and confidentiality. Trust, once established, facilitates open communication and a more effective support process.

**6. Encourages Autonomy**

Boundaries encourage individuals to take responsibility for their own actions and growth. In a supportive relationship, this means encouraging the person being supported to develop coping strategies and solutions, fostering independence and self-reliance rather than dependency.

Navigating boundaries

Some of the key aspects of establishing and navigating boundaries are:

* Intent: Ensuring the action is aimed at supporting the peer’s wellbeing within boundaries;
* Perception: Considering how the action might be perceived by the peer and others;
* Context: Evaluating the situation's context, including the setting, the nature of the support relationship, and any specific policies or guidelines;
* Communication: Clearly communicating the purpose of the action and setting boundaries as needed to avoid misunderstandings; and
* Consultation: When in doubt, seeking advice from a supervisor can help clarify the best course of action.

### Reflection:

* What are some of your limits or boundaries?
* What is your experience with setting limits with people? How did you learn to do it?
* Is it sometimes hard to keep others from violating your boundaries? Why do you think that is?

What boundary violation combat indicators do you think you most need to be aware of?

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# Conclusion

This manual provides an outline of the structure, operating guidelines and supporting tools and resources to support the roll out of the Peer Support programme.

You have been selected as a peer supporter because you have the pre-requisite attributes that will enable you to be successful in the peer supporter role. Many of you are already informally acting in this role and now you have an extra toolkit to help you. Back yourself, support each other, practice self-care, maintain your boundaries and remember that support is always available and encouraged if you need it. If you are not sure, consult with the Peer Support coordination team.

Peer support will make a real difference in the lives of those you support. Thank you for taking on this important role in supporting others… you will be awesome!

# Annex A Mental Health in the NZDF FAQ

1. **What support services do you have at NZDF for people with mental illness?**

We have a wide range of support services to support people with their mental wellbeing. This includes psychologists, our confidential helpline, Social Workers, Chaplains, Community Facilitators and more [SAPRAs, AHAs, Health Centres]

1. **What does NZDF do to find out how personnel are doing?**

We periodically check in our people which gives us insight into how our people are going across a range of areas, including mental health. This helps us identify priority areas for our work to focus on. NZDF people – check your emails this week to have your say!

1. **Does having mental illness stop me from being in the NZDF?**

No it doesn’t. But it is important that we manage our mental health and seek help early. Seeking help early is essential for managing our mental health so we stay operationally ready

1. **Does being in the NZDF make you more at risk of mental health problems?**

Not necessarily. We actually have similar rates of mental ill-health as the every-day New Zealander. But the nature of the work we do and the military lifestyle can place unique demands on our people, so it’s important that we look after our mates and ask for help early.

1. **If I have a mental health issue or ask for help, will it end my career?**

In most cases, it might mean in the short term NZDF needs to support you into a role to help you get back on top of your game. Remember earlier recognition of issues and asking for a helping hand will usually prevent problems getting worse and speed your recovery.

1. **I’m not that comfortable about asking for help, what are my options?**

There is a range of support available both internally and externally. If you are concerned about getting help internally, you can contact our external confidential helpline. Remember that everyone goes through tough times and reaching out for help early can help you get back on track sooner.

1. **What can I do if I am worried about someone? Where can I go for advice?**

A great place to start is by talking to a trusted friend, manager or health professional. It helps to discuss the situation with someone who can help you to support this person. You can contact our confidential helpline, 0800NZDF4U or speak to a chaplain or social worker. If you feel comfortable asking, reach out and ask the person directly how they’re going. If you are ever worried about their immediate safety call 111.

# Annex B External Resources and Contact Numbers

#### National helplines

Need to talk? Free call or text 1737 any time for support from a trained counsellor

Lifeline – 0800 543 354 (0800 lifeline) or free text 4357 (help)

Suicide crisis helpline – 0508 828 865 (0508 tautoko)

Healthline – 0800 611 116

Samaritans – 0800 726 666

#### Helplines for young people

Youthline – free call 0800 376 633, free text 234, email talk@youthline.co.nz or web chat from 7pm–10pm

Thelowdown.co.nz – or email team@thelowdown.co.nz or free text 5626

#### Sexuality or gender identity helpline

Outline nz – 0800 688 5463 (outline) provides confidential telephone support, available evenings from 6pm–9pm.

Online chat support with rainbow youth - is available for anyone aged 13-27 who is looking for guidance, support, or advice around sexuality, gender identity, and intersex status. 2-4pm monday - friday, anonymously & confidentially

#### Help for parents, family and friends

Edanz – improving outcomes for people with eating disorders and their families. Freephone 0800 2 edanz or 0800 233 269, or in auckland 09 522 2679. Or email info@ed.org.nz.

Parent help – 0800 568 856 for parents/whānau seeking support, advice and practical strategies on all parenting concerns. Anonymous, non-judgemental and confidential.

Family services 211 helpline – 0800 211 211 for help finding (and direct transfer to) community based health and social support services in your area.

Skylight – skylight’s specialised services support children, young people, and their whānau, to navigate through times of trauma, loss and grief. We aim to provide the right help, at the right time, in the right way.

Supporting families in mental illness – for families and whānau supporting a loved one who has a mental illness. Auckland 0800 732 825. Find other regions' contact details here.

#### Specialist helplines

Depression and anxiety helpline – 0800 111 757 or free text 4202 (to talk to a trained counsellor about how you are feeling or to ask any questions)

Www.depression.org.nz – includes the journal online support tool

Sparx.org.nz – online e-therapy tool provided by the university of auckland that helps young people learn skills to deal with feeling down, depressed or stressed

Alcohol and drug helpline – 0800 787 797 or online chat

Are you ok – 0800 456 450 family violence helpline

Anxiety phone line – 0800 269 4389 (0800 anxiety)

Gambling helpline – 0800 654 655

Moneytalks – 0800 345 123. A free and confidential helpline for people experiencing financial hardship. Moneytalks can provide advice on budgeting, bills, debt, loss of income etc. To individuals, family and whānau. Visit www.moneytalks.co.nz, email help@moneytalks.co.nz or txt 4029.

Quit line – 0800 778 778 smoking cessation help

Rape crisis – 0800 883 300 (for support after rape or sexual assault)

Shine – 0508 744 633 confidential domestic abuse helpline

Women's refuge crisisline – 0800 733 843 (0800 refuge) (for women living with violence, or in fear, in their relationship or family) NZDF Resources

**Healthify|He Puna Waiora** provides tips for prevention, self-care, and treatment for an A–Z of health conditions: [www.healthify.nz/health-a-z](http://www.healthify.nz/health-a-z/).

#### District Health Board Mental Health Crisis Response Teams

|  |  |  |
| --- | --- | --- |
| **Northland** | Topuni to North Cape | **Whangarei** 0800 223 371 |
| **Waitemata** | Wellsford to North Shore | **West Auckland and North Shore** 09 487 1414 **After Hours** 09 486 8900 (ask for North Crisis team) |
| **Auckland** | Auckland City | **Central Auckland** 0800 800 717 |
| **Counties Manukau** | South Auckland to Te Kauwhata | **South Auckland** 09 261 3700 |
| **Waikato** | Coromandel, Hamilton to National Park | **Hamilton** 0800 505 050 |
| **Bay of Plenty** | Tauranga, Whakatane to Te Kaha | **Tauranga** 0800 800 508 **Whakatane** 0800 774 545 |
| **Tairawhiti** | Hicks Bay to Gisborne | **Gisborne** 0800 243 500 |
| **Lakes** | Rotorua, Taupo, Turangi | **Lakes** 0800 166 167 |
| **Hawke’s Bay** | Wairoa, Napier, Hastings, Waipukurau | **Napier, Hastings** 0800 112 334 |
| **Taranaki** | New Plymouth to Waverly | **New Plymouth** 0508 277 478 |
| **Whanganui** | Ohakune, Whanganui to Bulls | **Whanganui** 0800 653 358 |
| **Mid Central** | Palmerston North to Waikanae | **Mid Central** 0800 653 357 |
| **Wairarapa** | Masterton to Martinborough | **Te Haika** 0800 745 477 |
| **Hutt Valley** | Lower and Upper Hutt | **Te Haika** 0800 745 477 |
| **Capital & Coast** | Kapiti to Wellington | **Te Haika** 0800 745 477 |
| **Nelson Marlborough** | Top of South Island to Hanmer Springs | **Nelson** 03 546 1421 **After Hours** 03 546 1800 **Marlborough** 03 520 9907 **After Hours** 03 520 9999 **Golden Bay** 03 525 7647 |
| **Canterbury** | Kaikoura to Ashburton | **Ashburton** 0800 222 955 **Christchurch** 0800 920 092 |
| **West Coast** | West Coast, South Island | **Greymouth** 0800 757 678 |
| **South Canterbury** | Timaru, Mt Cook, Tekapo, Temuka, Waimate, Timaru | 0800 277 997 |
| **Southern Dunedin** | Milford Sound south to Stewart Island | 0800 467 846 Press 1 for **Southland** Press 2 for **Otago** |

# Annex C NZDF Tools and Resources

**Websites**

**Pūtahi Hauora**, the Defence Health website also offers a wide range of health and wellbeing guidance, including quick and anonymous self-checks on your currents levels of [resilience](http://www.health.nzdf.mil.nz/take-action/self-check/resilience-self-assessment), [anxiety](http://www.health.nzdf.mil.nz/take-action/self-check/resilience-self-check/) and [depression](http://www.health.nzdf.mil.nz/take-action/self-check/depression-self-assessment/), along with tips for improving these: health.nzdf.mil.nz.

**Force 4 Families:** Support and information available to Defence family /whānau. Includes information about being new to Defence, moving and being posting, deployment support, support for parenting and extended whānau, managing your finances, safety and wellness, benefits of belonging to our wider Defence family such as discounts: force4families.mil.nz.

**Force Financial Hub** provides information and helpful resources regarding your financial wellbeing: [www.force4families.mil.nz/force-financial-hub](http://www.force4families.mil.nz/force-financial-hub).

**Guides**

You can download the following guides from the Human Resources Toolkit on the ILP and Pūtahi Hauora, or request a printed booklet from your ***Defence Health Centre***:

* *Tāngata Whaiora: Defence Health Services Handbook for Members of the New Zealand Armed Forces*
* *Ko te Toi Ora: Staying at the Top of Your Game – A Guide for Maintaining Health for the Defence Community*
* *NZDF Exercise Guide during and after Pregnancy*
* *Parental Planning: A guide for all members of the New Zealand Defence Force*
* *A Practical Guide to Transitioning from Military to Civilian Life*

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2. Creamer, M. et al (2012) Guidelines for Peer Support in High-Risk Organisations. Journal of Traumatic Stress April 2012, 25, 134–141. <https://www.kcl.ac.uk/kcmhr/publications/assetfiles/interventions/Creamer2012-PeerSupport.pdf> [↑](#footnote-ref-2)
3. Kyte, A.,Pereira, J. (2018).[1GettingStarted](file:///C:\Users\Clare\Documents\Work\Peer%20Support\NZ%20Proposal\1GettingStarted.pdf) [↑](#footnote-ref-3)
4. Ibid [↑](#footnote-ref-4)
5. Wilkinson & Mulder (2018) *Antidepressant prescribing in New Zealand between 2008 and 2015*. New Zealand Medical Journal, 131, 1430, 52-59 [↑](#footnote-ref-5)
6. Wilkinson & Mulder (2018) *Antipsychotic prescribing in New Zealand between 2008 and 2015*. New Zealand Medical Journal, 131, 1430, 61-67 [↑](#footnote-ref-6)
7. Acosta, Joie D., Wenjing Huang, Maria Orlando Edelen, Jennifer L. Cerully, Sarah Soliman, and Anita Chandra, Measuring Barriers to Mental Health Care in the Military: The RAND Barriers and Facilitators to Care Item Banks. Santa Monica, CA: RAND Corporation, 2018. [↑](#footnote-ref-7)
8. OIA to Coroners office by Action Point. Actionpoint.org.nz/deaths-from-alcohol [↑](#footnote-ref-8)
9. (Substance Abuse and Mental Health Services Administration, 2009) [↑](#footnote-ref-9)