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# Progressing recovery-oriented care in psychiatric inpatient units

## Occupational therapy's role in supporting a stronger peer workforce

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### Abstract

**Purpose** – Initiated by the service user movement, recovery-oriented practices are one of the keystones of modern mental health care. Over the past two decades, substantial gains have been made with introducing recovery-oriented practice in many areas of mental health practice, but there remain areas where progress is delayed, notably, the psychiatric inpatient environment. The peer support workforce can play a pivotal role in progressing recovery-oriented practices. The purpose of this paper is to provide a pragmatic consideration of how occupational therapists can influence mental health systems to work proactively with a peer workforce.

**Design/methodology/approach** – The authors reviewed current literature and considered practical approaches to building a peer workforce in collaboration with occupational therapists.

**Findings** – It is suggested that the peer support workforce should be consciously enhanced in the inpatient setting to support culture change as a matter of priority. Occupational therapists working on inpatient units should play a key role in promoting and supporting the growth in the peer support workforce. Doing so will enrich the Occupational Therapy profession as well as improving service user outcomes.

**Originality/value** – This paper seeks to provide a pragmatic consideration of how occupational therapists can influence mental health systems to work proactively with a peer workforce.

**Keywords** Recovery, Mental illness, Peer Workforce, Psychiatric hospitalisation

**Paper type** Viewpoint



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## Introduction

Since the first published literature over 20 years ago, the recovery paradigm has evolved and grown. Recovery-orientated practice is now seen as one of the core tenets of good mental health service delivery (Slade *et al.*, 2014). At the core of the recovery paradigm is the preservation of an individual's hope and right to self-determination. Recovery-orientated practice is creating real change in health providers' attitudes (Slade *et al.*, 2014). Despite this, there remain areas of mental health care where progress in recovery-oriented reforms has been harder to achieve.

The inpatient environment is one such setting. Peer workers are individuals with a lived experience of mental illness who identify themselves as such and who use their lived experience to support their peers during recovery (Tse *et al.*, 2013; Vilic *et al.*, 2016). Peer workers can play a pivotal role in progressing recovery-oriented practice reform. This is recognised in the Fourth National Mental Health Plan (Commonwealth of Australia, 2009) with peer workforce identified as key areas of three of the five priority areas and as part of the vision for mental health care reform in Ireland [Department of Health (Ireland), 2006]. Being an occupational therapist does not inherently make a practitioner recovery-oriented. The underlying philosophies of the profession, however, do provide a solid platform for occupational therapists working on inpatient units to form a natural alliance with peer support workers to help advocate and support recovery-oriented practice reforms (Lloyd *et al.*, 2004).

While occupational therapists have been actively engaged in research on and with peer workers, there is minimal published literature addressing how the peer workforce and Occupational Therapy can work in collaboration in the clinical setting to achieve better mental health care. This article seeks to encourage occupational therapists to be active advocates in research and clinical practice for the development of a strong peer workforce working in collaboration with occupational therapists.

## Recovery in mental health

The ideas behind recovery practices emerged out of the service user, or survivor, movement and, thus, outside the traditional mental health arena. The service user movement emphasises that mental illness must be understood from the perspective of those directly affected and draws on the recovery values of hope and use of knowledge gained from lived experience to help each other (Deegan, 1992). As such, it seems logical that those with a lived experience are the most appropriate people to facilitate culture change towards a recovery-orientated approach. Recovery refers to wellness as a work-in-progress rather than one side of a binary structure of exclusive states of health, which is the absence or presence of illness. In the UK, recovery outcomes are described as:

> A greater ability to manage one's own life, stronger social relationships, a greater sense of purpose, the skills needed for living and working, improved chances in education, better employment rates and a suitable and stable place to live (Her Majestry's Government, 2011, p. 6).

The recovery paradigm represents sets of values and principles, informing changes to practices and healthcare systems, based on accumulated research and debates from more than two decades (Slade *et al.*, 2014). In Australia, recovery is defined as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues' (Commonwealth of Australia, 2013, p. 2). It seems most now agree what recovery-orientated services look like. The question remains 'how best to shift traditional approaches in well-established institutions like inpatient psychiatric units further towards recovery-orientated practice?'

Lawn *et al.* (2008), in reviewing the impact of peer workers as part of an early discharge support service, found that where adequate supports were available, overall staff, service users, carers and peer workers themselves reported positive experiences with the peer worker role. Peer worker roles have the potential to impact the experience of service users accessing psychiatric inpatient units and help drive the culture of inpatient units towards a true recovery framework.

## The inpatient context

Inpatient mental health units are undoubtedly one of the most challenging environments in which to introduce recovery-oriented practice. The processes of managing a busy acute mental health ward can involve the use of compulsory hospitalisation and result in a perceived, and at times real, lack of choices about medication, freedom to leave the ward and even simply meal choices can cause frustrations for the service user (Walsh & Boyle, 2009). While there are positive examples, overall a negative picture of the inpatient unit is portrayed with boredom on the units, poor communication with staff, lack of information and perceived valuing of hospital routines over service user needs being evident (Hyde *et al.*, 2014; Walsh & Boyle, 2009). In addition, they may have little knowledge about what is available in the community, as there is little encouragement for service users to re-engage with neighbours and others in the community with similar interests (Cleary *et al.*, 2013; Walsh & Boyle, 2009).

The dominance of the biomedical and legal models of care continues to be pervasive (Hyde *et al.*, 2014). Medication is the main form of treatment given to people on inpatient wards, and participants in Hughes *et al.* (2009) study reviewing involuntary inpatient care expressed strongly negative views about how this treatment was administered. Walsh and Boyle (2009) also revealed consensus amongst study participants with the way medication was administered in the inpatient setting. Interestingly, a significant number of participants in Walsh and Boyle (2009) did report finding medication helpful as a treatment. There is a continuing emphasis on custodial measures, such as the use of seclusion and the use of medication that are both characteristics of a biomedical model. Seclusion and restraint practices, used to manage people who are a risk to themselves or others, remain commonly used to help maintain short-term safety despite the current knowledge that these practices are known to be traumatic to the individual experiencing them (Muskett, 2014). This is despite well-established evidence that alternative approaches to seclusion such as the use of sensory approaches are more effective in creating a place of safety that is less harmful in the long term to the individual (Ashcraft *et al.*, 2012; Lloyd *et al.*, 2014). Coercion has been reported by inpatients as being extremely distressing and impacts negatively on people's sense of self-efficacy and self-worth as well as perpetuating cycles of conflict (Hughes *et al.*, 2009). Attempts have been made to improve the clinical interventions in individual inpatient psychiatric environments with some success. Overall, however, the picture remains one where progress to more recovery-oriented systems is slow at best.

## Peer workers on an inpatient unit

Davidson *et al.* (2012) report that increasing/introducing a peer workforce in a mental health setting is complicated but can support significant cultural change. The introduction of peer workers into the acute inpatient psychiatric setting can be a powerful tool in moving these settings closer to true recovery-orientated systems. By working closely with peer workers, occupational therapists may find allies in establishing inpatient units that are health promoting venues that uphold the tenets of recovery-oriented practice. Occupational therapists have long promoted the development of the recovery approach for people with a

mental illness (Lloyd *et al.*, 2004) and have advocated for the active participation of service users.

Peer workers have assisted in developing an environment of hope, a sense of self and belonging and determination to recovery (Davidson *et al.*, 2012; Vilic *et al.*, 2016). They provide social and emotional support coupled with instrumental support to others sharing a similar mental health condition to bring about a desired social or personal change (Landers & Zhou, 2011). The peer worker can share their knowledge from a lived experience with both service users and staff. It is a twofold effect that, in turn, reduces stigma and provides the opportunity for the person to commence their individual recovery journey.

Peer workers can provide input to the day-to-day operations of a ward through group work, individual sessions and/or participating in ward meetings (handover, case review). Inpatient groups facilitated by peer workers focus on discussing recovery and how to manage early warning signs and offering referrals to community-based clinical and peer support workers after discharge (Vilic *et al.*, 2016). Alternatively, individual sessions may occur allowing discussions between two people with lived experience around strategies that may help service users to manage symptoms. Peer workers are able to draw on their personal experiences, sharing strategies of what they have utilised/use that may assist service users on the inpatient ward. Sledge *et al.* (2011) found peer support to be effective in reducing readmissions of people with multiple psychiatric hospitalisations. Likewise, Lawn *et al.* (2008) found that peer workers' role in supporting early discharge facilitated reducing readmission rates. This demonstrates the value of peer support programmes in assisting service users to identify resources and supports to accomplish recovery goals and with assisting systems to engage with service users.

A less tangible benefit of a strong peer workforce can be the impact this has on the culture of a service. An example of this is the work by Foxlewin (2012) in influencing seclusion and restraint practices. To be successful, it is clear that a healthy peer model requires strong leadership, supervision and support (Davidson *et al.*, 2012; Vilic *et al.*, 2016). Gillard *et al.* (2015) acknowledge that there are many barriers when introducing peer workers into established structured environments (such as inpatient units); however, when supported by the organisation and introduced as equal members of the team culture, change can be sustained. Strategies on the ground need to be put in place that address the role of the peer worker, the unique needs of the worker and overall workplace environment to enable peer workers to provide meaningful psychosocial, emotional and practical support to inpatients (Moran *et al.*, 2013). Training is required for peer worker supervisors to ensure that they understand the policies and practices with respect to confidentiality, role definition/scope and are equipped to set them in place and enforce them amongst their staff (Gates & Akabas, 2007; Vilic *et al.*, 2016). It is absolutely necessary that regular supervision be provided to peer staff to ensure they are receiving the support and accommodation that they need to best meet their job requirements (Gates & Akabas, 2007), and a senior peer worker or external peer supervisor is appointed to provide professional supervision (Vilic *et al.*, 2016). It is important that peer worker roles are clear, and they are able to optimise their expertise.

## Occupational therapy and peer workers

Occupational therapists working on inpatient units usually are in sole positions and have a role where they may be responsible for the group programme (Duffy & Nolan, 2005; Lloyd & Williams, 2010). In addition, a part of their role may include assessing people's activities of daily living and making recommendations about discharge (Lloyd & Williams, 2010).

Nowadays, with the advent of peer workers on inpatient units, there is an opportunity for occupational therapists to rethink their role and to work out ways of working closely with peer workers.

Peer workers are a unique professional group which in many ways is continuing to clarify and define their role (Kemp & Hendersen, 2012). Occupational therapists working with peer workers need to be mindful that as a professional group, peer workers require support and a willingness to understand their unique role (Kemp & Hendersen, 2012). The relationship between the peer worker and the occupational therapist starts with how they work together on a day-to-day basis. The inpatient unit can be an unfriendly place to a newcomer. It is a place where there is much action happening, and yet at the same time, it can be quiet and appear as if nothing is happening. It is a place of contradictions. The occupational therapist has the opportunity to start working on establishing a collegial relationship with the peer worker as a colleague and partner in recovery-based interventions. This may extend from talking to the peer worker, maybe sharing office space together, seeing service users jointly and collaborating (both as lead and supporting facilitator) on the group programme together. Lloyd and Williams (2010) suggested that there were four key elements of practice undertaken by occupational therapists working on inpatient units. In regards to the day-to-day clinical work, occupational therapists may consider working in partnership with peer workers in these practice areas:

- Assessment – Occupational therapists should actively pursue opportunities to work collaboratively with peer workers in the assessment processes (mostly informal assessment rather than the use of specific Occupational Therapy assessment tools) to identify the service user's strengths and assets. Involving the peer worker in this process may provide a much more realistic view of the service user and highlight alternative information more freely shared with the peer worker, enhancing the occupational therapist's ability to understand and accurately assess the skills, abilities, concerns and hope for the future.
- Individual work – When meeting with service users for individual work, the occupational therapist could ask the service user if they would like to see the peer worker as well. This would give a much more rounded approach, and the service user would feel that their concerns were being heard.
- Group programme – It may be a good time for the occupational therapist to think about the groups that he/she has been running and see if there is some way to work more closely with the peer worker. Where appropriate, the occupational therapist should support the peer support worker to take the lead facilitator role. These groups could include such things as managing your illness, lifestyle, hope and recovery (Vilic *et al.*, 2016).
- Discharge planning – In talking with the service user about discharge, the occupational therapist could involve the peer worker. This may include jointly running a discharge preparation group to seeing the person individually (Table I).

At a broader level, occupational therapists have an opportunity to advocate for system change to support the introduction of peer workers. This can be achieved in organisations in a number of ways:

- Language – Language in the work place has a significant impact on staff culture and attitudes. Occupational therapists can support a positive culture identifying positive language (person first language, strengths based).

- Supervision – It is commonplace at present for supervision of peer workers to sit with a member of the allied health team. Occupational therapists need to resist the system push to provide supervision to peers and be a clear voice advocating for the requirement to ensure adequate professional supervision is available by a senior peer worker.
- Workforce development – Developing a clear role description and workforce development plans that are sensitive to the needs of the professional roles are essential components in the creation of new positions. It should be no different when considering the peer workforce. This cannot occur without the involvement of senior peer workers in this process. Occupational therapists can be advocates within their work system to ensure that peer worker roles are not established and built without the leadership of a senior peer worker.
- Research – Simpson (2010) suggested that greater involvement in research that focuses on the role of occupational therapists, their impact on service user experiences and outcomes and the interrelationships with the functions and responsibilities of other staff was essential. Importantly, this would give us opportunities for greater collaboration and a firm background of involvement with service users on the inpatient unit.

## Conclusion

While there have been considerable advances made in inpatient psychiatric care, it is recognised that it remains a challenging environment in which to introduce recovery-oriented practice. However, peer workers are an essential component of comprehensive mental healthcare. Recovery-oriented practices are about evolving a culture of values and principles that support environments and behaviours where service users feel a sense of control, choice and hope in their future. Occupational therapists working on inpatient units are ideally positioned to play a key role in driving the push for recovery-oriented practice. This article contributes to the developing debate on recovery-oriented practices in the inpatient environment by suggesting that the employment of peer workers is both a positive step towards creating recovery-oriented inpatient services in mental healthcare on inpatient psychiatric units and presents an opportunity for the profession of Occupational Therapy to help facilitate culture change in establishing peer workers as a mainstay of inpatient care.

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| Service delivery | Engage peer workers in joint working to enhance:<br>Assessments<br>Individual work (both Occupational Therapy led and referring for peer worker led)<br>Group programmes (as lead and support facilitator as appropriate)<br>Discharge planning/facilitation process |
| Peer support | Seek opportunities to engage peer workers as equal colleagues of the multi-disciplinary team<br>Ensure peer workers have office space available with other allied health team members<br>Be sensitive to the language in the workplace |
| System level | Advocate for appropriate supervision for peer workers<br>Advocate for clear role descriptions and development plans that are driven by senior peer workers |

**Table I.**
Summary: occupational therapists' possible role supporting peer workers

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