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The growing pains of peer support

We live in distinctly adolescent times for peer support. As a concept, it has grown beyond infancy, gradually moving from the periphery to occupy an ever more prominent place in mental health policy and practice across the western world. In this issue, several authors have described the ubiquity of peer support in the USA, Australia and the UK (Rogers, 2017; Gillard et al., 2017; Bellamy et al., 2017; Jackson and Fong, 2017). The past decade has seen the development of accredited and specialist training courses, widespread creation of paid roles and the expansion of community peer support initiatives (Crepaz-Keay, 2017). Under the umbrella of recovery, peer support has been identified alongside the development of recovery colleges as one of the key indicators of recovery-focussed change in UK mental health services (Shepherd et al., 2014).

Peer support has reached a point in its development which is hard to quickly surmise, given that the intense growth has brought with it controversy, and drawn attention to areas where further growth is needed, both in terms of research evidence (Bellamy et al., 2017) and changes in traditional mental health provision (Irwin, 2017). Its growth has taken place in ever more complex cultures of austerity and division, but nonetheless, peer support is a movement spilling out in all directions. Like a teenager, peer support occupies an uncomfortable “in-between” identity, one that is crowded with contradiction, ambivalence, and a desire to be accepted.

My own experiences with peer support track a somewhat similar process of growth. Seven years ago, facing unemployment, I was looking through the NHS jobs website when I came across six “peer support worker” posts. The advert read: “The role of peer support worker has been developed specifically for people who have lived experience of mental distress. Through sharing wisdom from their own experiences, Peer Support Workers will inspire hope and belief that recovery is possible in others”. As I read, I felt a rush of excitement ripple through me; there were people out there who saw my experiences as a source of wisdom, there was a way that they might become something more to me than a source of shame and failure.

I look back with breathless disbelief that fate acted as it did and I was offered a peer support worker job, given that I did not know what “mutuality” meant. I skim read “Recovery and social inclusion” (Repper and Perkins, 2009) and sort of got it, and sort of did not. And nonetheless I was offered a job as a peer support worker and began my second childhood, being raised in peer support, in the culture of the NHS. During this time, my understanding of peer support expanded from the singular experience I began with, to begin to appreciate the emotional, political and economic complexities that such a seemingly simple concept contains. I have worked, trained and researched in different peer support contexts, listened and read hungrily on topics of recovery, anti-psychiatry, trauma and inequality. I have learnt that peer support is not the simple solution I once thought it to be, but a philosophy with deep roots, trying to find space within the chaotic communities and mental health systems which we inhabit.

I can now look out on the ever expanding landscape of peer support and simultaneously find hope and despair. Collectively, the picture that is painted by the articles in this special issue is one of complexity, of head and heart, of success and trouble, of rampant progress and sad withdrawal. Although not explicitly, the debates in peer support have centred on some particularly teenage questions, questions that have been thoughtfully considered from different standpoints by the authors in this special issue.

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How can I be popular?

While peer support has undoubtedly grown in popularity in recent years, with the widespread creation of peer worker roles across western mental health services, popularity on an international level does not necessarily translate to popularity within staff teams for individual peer workers. Peer workers continue to struggle to feel valued and appear credible when they are employed within traditional mental health services (e.g. Vandewalle et al., 2016; Mancini and Lawson, 2009).

The calls for higher quality research evidence may go some way to increase the popularity of peer support. Bellamy et al. (2017) provide a helpful overview of the existing research into the effectiveness of peer support. Currently, evidence is of a low quality and provides mixed results, often finding that peer support produces similar outcomes to traditional mental health services in terms of reducing hospitalisation, and slightly better outcomes in relation to increasing hope and empowerment. These fairly unremarkable findings may in part be due to the continuing focus on the outcomes prescribed by traditional mental health service provision. In peer support and recovery, “outcomes” are personally defined; indeed the outcome of peer support may simply be the peer support relationship itself. There is some difficulty in providing evidence for peer support without transforming it into a one-sided intervention to suit the needs of RCT protocols. From a philosophical perspective, this can be seen as an example of the medical/positivist paradigm privileging its own way of understanding the world, inappropriately applying its own standards to the evaluation of another paradigm. If we understand peer support to be part of a new paradigm, it must be judged within its own context using standards that are defined by this.

The process of bringing peer support into mainstream mental health provision has often resulted in some level of compromise; peer support is transfigured into a one-sided intervention, with quantifiable outcomes. This is a dilemma faced by so many teenagers; is it more important to be accepted, even if it means compromising one’s integrity? Such a dilemma invites another teenage question pertinent to peer support.

Why cannot you just accept me for who I am?

I recognised myself in Carlina Whitmore’s (2017) article, as she describes feeling unsure of herself as a Peer Worker, feeling like “the token mad woman”. I too remember wanting to “blend in fine”. Like Carlina, I slowly learnt that honesty, even when it is difficult, is what peer support rests on. In fact, it is what my own recovery rests on. Carlina describes navigating, and ultimately finding her place as a peer worker within mental health services. She suggests that honesty, even when it is difficult, is what has made her the peer worker that she is. For others, honesty even when it is difficult is what has caused them to withdraw from peer working within mainstream services. Sue Irwin (2017) has offered a first-person perspective on the issue of peer support in traditional contexts, describing the reasons why, ultimately, she could not continue to work as a Peer Support Worker in an NHS system. These two articles illustrate the diversity of experiences among peer support workers who question, react to and accept their working contexts to myriad different degrees.

There is no small element of rebellion and disagreement within peer support about the contexts that it takes place in and what this means for its identity. Many believe that peer support in mainstream mental health services is being co-opted (Brown and Stastry, 2016, that there is little chance of true mutuality surviving in medical, expert based systems (Filson and Mead, 2016; Scott, 2011). Mead and Filson (2017) explain, “as peer support is mainstreamed into traditional mental health services, it faces a dilemma: uphold the principles and values of peer support such as mutuality and shared power, or comply with job descriptions that can include the use of force”. In their article, they describe how Intentional Peer Support can be offered within any context and how this differs from traditional mental health approaches. This is helpful because many peers are faced with such a challenge and must find ways of both upholding the principles of peer support, and complying with their job descriptions. By becoming part of mental health services, which continue to use practices which are at odds with its philosophy, peer support walks a delicate tightrope between being part of the solution and becoming part of the problem.

Jackson and Fong (2017) have provided a hopeful example of wide scale adoption of peer support across their organisation, Flourish Australia. They illustrate the importance and power of
wholehearted strategic support for new ways of working, which has translated into tangible HR policies and recruitment processes that have underpinned the wholesale adoption of peer working. The approach of Flourish Australia is exceptional in a landscape where the values of peer support continue to be misunderstood and undersupported (Gillard et al., 2015). Many peer workers, including myself, remain working within mental health systems as part of a “survivor mission” (Deegan, 2002). I stay because this is the system that I found myself in, this is the system that many people are forced into and that they see as their only hope. And if we do not try to change it, if we give up hope then what?

In many ways, community initiatives seem like a better fit with the mutual philosophy of peer support. Community-based peer support removes focus from fixing broken individuals, to place it on what affects our collective mental health (Crepaz-Keay, 2017). Locating peer support within communities acknowledges the inequalities that exist within them, and provides a means of repairing divides as well as supporting individuals. This shift addresses one of the common criticisms of recovery, that it depoliticises individual experience by removing it from its social context. In community-based peer support, peer workers can develop an awareness of inequality and poverty and how these directly affect health.

Crepaz-Keay’s (2017) article draws attention to the wide spectrum of peer support that exists outside of mental health services, and the importance of this. Several authors in this issue have contemplated the varied offerings that we consider to be peer support. The context and the content of peer support encompasses huge variety; peer support can take place within traditional mental health services, within peer-run initiatives, and within community contexts, by paid and unpaid, trained and untrained peer workers. With such variety, how can we be sure of our shared understanding of peer support? Does everything that is offered under the guise of peer support bear any similarity to what you or I understand peer support to be? The multiplicity of peer support approaches gives rise to the final teenage question, one that, in my experience, extends into adulthood.

Who am I?

There is a growing need to understand and protect the identity of peer support as it is colonised, embraced and co-opted in different mental health contexts. A helpful starting point is the conception of a clear values base that underpins peer support. There have been many incarnations of different values and principles which define peer support. Gillard et al. (2017) describe the process of developing fidelity criteria using existing literature and national expert panels in the UK. The resulting values include themes of mutuality, strengths focus, using experience and the importance of trusting relationships. These values, once clearly established, can be used as a means of understanding what kind of environment provides the most fertile ground for peer support. Related to this is the call for a better understanding of the mechanisms that underpin peer support (Rogers, 2017). Understanding these mechanisms will go some way to answering the question of what peer support is, and what makes it unique.

Perhaps an equally important question to “who am I?” is “what should I strive to be?” This is not a teenage question but one that we continue to revisit throughout recovery, and throughout life. Should peer support strive to be an approach that is integrated into services, should it strive for social change, community cohesion, the demise of psychiatry? As adulthood draws closer, peer support will face new challenges; will this adolescent movement rise up and rebel, or will it conform?

For what it is worth, what I believe peer support to be is part of a new paradigm, a different way of understanding human growth, a relational way of holding “recovery” between people, a human process worth fighting for, that demands attention, that needs space. I believe it to be at odds with current ways of understanding mental “illness” and I believe that we must acknowledge that clearly, so that we can mainstream mutuality in a way that does not change the meaning of the word, or ignore the difficulties involved in doing this. To me, becoming an adult means acknowledging the fallibility of the system that raised me, and finding my own way of living, and values to live by, not merely for the sake of teenage rebellion, but for the sake of a meaningful life.
References


Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves into mainstream mental health services

Steve Gillard, Rhiannon Foster, Sarah Gibson, Lucy Goldsmith, Jacqueline Marks and Sarah White

Abstract

Purpose – Peer support is increasingly being introduced into mainstream mental health services internationally. The distinctiveness of peer support, compared to other mental health support, has been linked to values underpinning peer support. Evidence suggests that there are challenges to maintaining those values in the context of highly standardised organisational environments. The purpose of this paper is to describe a “principles-based” approach to developing and evaluating a new peer worker role in mental health services.

Design/methodology/approach – A set of peer support values was generated through systematic review of research about one-to-one peer support, and a second set produced by a UK National Expert Panel of people sharing, leading or researching peer support from a lived experience perspective. Value sets were integrated by the research team – including researchers working from a lived experience perspective – to produce a principles framework for developing and evaluating new peer worker roles.

Findings – Five principles referred in detail to: relationships based on shared lived experience; reciprocity and mutuality; validating experiential knowledge; leadership, choice and control; discovering strengths and making connections. Supporting the diversity of lived experience that people bring to peer support applied across principles.

Research limitations/implications – The principles framework underpinned development of a handbook for a new peer worker role, and informed a fidelity index designed to measure the extent to which peer support values are maintained in practice. Given the diversity of peer support, the authors caution against prescriptive frameworks that might “codify” peer support and note that lived experience should be central to shaping and leading evaluation of peer support.

Originality/value – This paper adds to the literature on peer support in mental health by describing a systematic approach to understanding how principles and values underpin peer worker roles in the context of mental health services. This paper informs an innovative, principles-based approach to developing a handbook and fidelity index for a randomised controlled trial. Lived experiences of mental distress brought to the research by members of the research team and the expert advisors shaped the way this research was undertaken.

Keywords Mental health services, Lived experience, Peer support, Experiential knowledge, Fidelity, Randomized controlled trials

Paper type Research paper

Background

An established sociological literature on role change in the workforce suggests that there are innovation and early implementation stages at which system-wide role adoption remains in doubt (Bernard, 1976). The introduction of peer workers into mental health services as an organised approach to providing mental health care – in the UK and many other countries – seems to be past those tenuous early stages. Arguably, in the UK at least, we are beyond the
so called “tipping point” whereby a new role becomes generally accepted as a fixture in the workforce (Turner, 1990). Most National Health Service (NHS) Mental Health Trusts and large not-for-profit mental health care providers in the UK now employ at least some peer workers in an ever wider range of service delivery contexts. Strategy and commissioning guidance internationally are actively encouraging the development and introduction of peer workers into mental health services (e.g. JCPMH, 2012a, b; MHC Canada, 2012; MHC New Zealand, 2012; NICE, 2016), while funding arrangements in the USA and Australia provide a powerful incentive where eligibility of peer support services for state funding is linked to nationally accredited training (Kaufman et al., 2012; ISC, 2013). However, the sociological literature referred to above tells us that role adoption, in itself, is not a guarantee of sustainability of a role as it was originally envisaged; that there are ongoing risks to the distinctiveness of a new role if favourable conditions are not met (Turner, 1990). Just because mental health care organisations employ people called peer workers, it does not inevitably follow that those workers continue to provide support in a way that is different from the support provided by other mental health workers. The aim of this paper is to explore the challenge of ensuring the distinctiveness of peer support as peer worker roles are mainstreamed into mental health services.

There is a strong argument that the distinctiveness of peer support is attributable to a values base that has its origins in the naturally occurring, real-world interactions between people supporting each other with their emotional distress (Mead and MacNeil, 2006), a long way from the formal delivery of mental health services. Indeed for many people peer support exists as something very separate from, or even in resistance to mental health services where a set of medically defined, expert-to-patient values prevail that are anathema to the authentic peer support relationship (Faulkner and Bassett, 2012). Attempts have been made to define value sets that underpin peer support. For example, O’Hagan et al. (2009) identify three primary values: equal power relationships – a commitment to consumer/survivor choice and control over peer support at individual and organisational levels; identification with each other – a sense of mutuality, camaraderie and acceptance between peers, reciprocal roles of helping and learning, and minimal distinction between “staff and clients”; holistic understanding of madness – emphasising the whole of life, strengths rather than illness focussed, and confirming the validity of personal experience.

It has been suggested that when peer support is intentionally provided, in any context, there is work to be done to maintain those values (Mead et al., 2001; O’Hagan et al., 2009). There is an additional challenge when this takes place within a highly standardised organisational culture (Stewart et al., 2008) such as the NHS. Furthermore, it has been questioned whether the values that “make peer support different” can survive in mental health services at all if a peer-led ethos is not also retained (Faulkner and Kalathil, 2012). In attempting to address this challenge, some organisational initiatives have been at pains to articulate the values base underpinning the peer support. For example, US-based Intentional Peer Support offers itself as “unique from traditional human services” through its partnership approach (both parties are “invited to learn and grow”, rather than one helping the other), its creative rather than problem-based approach and its focus on relationship and community rather than individual change alone (Mead and Filson, 2017). In New Zealand, the delivery of some state-funded peer support has been shaped by Maori understandings of connection and relationship grounded in “things that are intrinsically shared” between people (Scott et al., 2011).

It is interesting to note that, while there are numerous qualitative and observational studies that attest to the benefits of peer support (Repper and Carter, 2011), more formal research (randomised controlled trials and systematic reviews) do not indicate improved outcomes when peer support is compared to other forms of mental health support (Pitt et al., 2013; Lloyd-Evans et al., 2014). Arguably trials are not measuring the outcomes that people experience as benefits of peer support – for example, a trial might focus on service delivery and productivity outcomes – and so benefits experienced by participants go largely unmeasured. However, where trials have attempted to measure and compare experiential outcomes (e.g. empowerment: Ochocka et al., 2006; Rogers et al., 2007) significant differences are not shown. Additionally, it is noted that trial methodology – especially the random allocation of people to receive peer support or not – can undermine the relationship at the heart of peer support (Corrigan and Salzer, 2003). To date,
only a single cluster randomised controlled trial has been reported, comparing veterans’ mental health services including peer workers as part of the staff team with those without (Chinman et al., 2015). This study showed a greater improvement in patient activation – measuring, for example, the extent to which patients know what their medication is for (Green et al., 2010) – in those services with peer workers compared to those without. Authors note that it was difficult to attribute that difference to the peer component, with peers performing the same duties as other members of the team (Chinman et al., 2015). The reviews cited above also note a lack of reporting of what peers do, how that is distinctive from what other mental health workers do and how that might bring about change (Pitt et al., 2013; Lloyd-Evans et al., 2014). It is possible that these studies are telling us that not enough attention is being paid to what peers are expected to do in their work, and therefore whether it is peer support that is being delivered and evaluated.

Challenges to offering values-based peer support in mental health services

Existing research is indicative of a number of challenges to delivering values-based peer support in formal mental health services, especially where this takes the form of one-to-one peer worker roles:

1. Simply employing someone, as a member of staff, to a peer worker role – a badge and a job title – can create difference and power imbalance in the peer-to-peer relationship (Gillard et al., 2014). The word “peer” in the job title necessarily discloses that an individual has used mental health services and/or experienced mental distress. While this makes a strong statement about the validity of lived experience, it also removes choice and control from the individual (Moran et al., 2013; Dyble et al., 2014) and as such can act as a barrier to taking on the role.

2. Providing a standardised peer support training has the potential to formalise, or professionalise peer support (Faulkner and Bassett, 2012), and the “conundrum” of being asked to “work and train at being authentic” has been noted (Scott, 2011). Mandating peers to “tell their recovery story” as a way of delivering “recovery focused care” arguably conflicts with the relationship building process while imposing an understanding of mental health on an individual that might not chime with their own lived experience. The authors found that, in delivering their own largely self-directed, experience-based peer support training, trainee peer workers nonetheless began adopting some of the language used in the training, perhaps to demonstrate that they had “learnt well” on the course.

3. Inflexibilities in organisational cultures impose constraints on peer worker roles, even where the values of peer support are supported throughout the organisation. Scott and Doughty (2012) noted tensions – in some state-funded services in New Zealand – between the collaborative values underpinning peer support and the clinical need for auditable notes that could be accessed by the wider staff team.

4. There is an inherent tension in allocating people to peer support based on perceived clinical need, in comparison to the choice and control that people ordinarily exercise in forming relationships in the world outside of mental health services (O’Hagan et al., 2009).

5. A lack of shared expectation about the peer worker role – especially in how lived experience is used – can result in peers feeling unsupported in using their lived experience, potentially eroding peer support values and defaulting to a generic support worker role (Gillard et al., 2015). It has been noted in the sociological literature cited above that if workers in a new role are not enabled to bring a distinctive knowledge set to their work then the added value of their work is lost (Turner, 1990).

Peer support roles are now being introduced into a wide variety of mental health service settings, including specialist mental health services, with peer workers being ascribed a range of functions. In addition to the challenges listed above, it does not necessarily follow that the aims, function, training and so on that might apply to peer support in general adult mental health services are equally helpful as an approach to peer support in, for example, forensic mental health services (Shaw, 2014). In addition, there are cultural and identity contexts where, due to language
differences or stigma related to explicitly labelling services as “mental health”, peer support is offered without being named as such (e.g. people working from an experiential perspective might simply be referred to as a “project worker”). While the service or project might be designed to support people with their mental health, people meet on the basis of a group activity (e.g. cooking, walking or making music), or a shared life experience (e.g. social isolation, parenting or being an asylum seeker) or identity (e.g. ethnicity or sexual identity). Defining who is a peer to whom in such settings, and what form peer support might take, is not something that can necessarily be transplanted from a statutory mental health care setting into the community sector (Kalathil, 2009; Gillard et al., 2014).

Principles in reflective practice and the evaluation of peer support

All this raises an important question: if peer workers are going to be introduced into mainstream mental health services anyway, irrespective of whether we think that is desirable or not, is it not morally important to somehow ensure that peer support is delivered in a way which is potentially as beneficial as possible for those involved (i.e. that it is a values-based, rather than nominal peer support that is being offered)? If there is a broad consensus that what is distinctive about peer support is embodied in a set of values, perhaps the answer lies in somehow monitoring or evaluating the extent to which those values survive into mainstream practice. This paper will explore this question in relation to some existing experiments, and a new project that sets out to integrate a principles-based approach into developing and evaluating peer support.

In the USA, a fidelity measure was developed as part of an evaluation of eight consumer-led mental health services. While the structure and aims for the projects were very different, a high degree of shared philosophy was noted. A fidelity measure was developed to explore the relationship between “common ingredients” of projects and outcomes, and to inform funding and development of future projects (Johnsen et al., 2005). In Denmark, the National Social Services Department, in a programme to introduce peer support into mental health services through health, social care and grassroots partnerships, first developed a values framework through an extensive consultation process with stakeholders to the programme. The framework was used to guide the development of local models of peer support in three pilot regions, and as a basis for reflective learning prior to national roll out of the programme (http://socialstyrelsen.dk/projekter-og-initiativer/handicap/peer-stotte-initiativet). In the UK a large programme led by the not-for-profit organisations Mind, Bipolar UK and Depression Alliance supported the development of new grassroots peer support initiatives in nearly 50 community sector organisations. Evaluation of the programme worked with stakeholders to develop a “values and principles framework” for evaluating peer support projects. Mindful that peer support can mean different in different community contexts, the framework sought to articulate values and principles that might underpin all peer support, and those that are specific to particular communities or service delivery contexts. The framework was also developed as a “legacy tool” to support reflective learning and capacity building in peer support in community-sector projects (http://mcpin.org/evaluation-of-mind-peer-support-programme).

A principles-based approach to developing and evaluating a new peer worker role

A UK National Institute for Health Research-funded programme, ENRICH, seeks to develop, pilot and trial a new peer worker role supporting discharge from inpatient to community mental health care. In response to the challenges set out above, the ENRICH team developed a peer support principles framework. This framework was designed to inform development of both the ENRICH peer support for discharge handbook, and a principles-based fidelity index. The fidelity index was designed to assess the extent to which peer support values explain any differences in outcomes observed in the trial. In contrast to the frameworks referred to above, which were largely focussed at the service or group level, the ENRICH framework was specifically designed to inform the development and evaluation of one-to-one peer worker roles in mainstream mental health care.
Method

The development of the ENRICH peer support principles framework addressed a simple question:

What are the principles that should inform the development and evaluation of one-to-one peer support in mental health services in order that the values underpinning the distinctiveness of peer support are maintained in practice?

The development process took place in three stages. First, a systematic review of one-to-one peer support in adult mental health services (reported elsewhere) extracted data from studies on the values and principles underpinning peer support. The review included reports of evaluations published outside of the peer-reviewed academic literature (the grey literature) as these were often produced by peer-led teams or organisations. This ensured that experiential knowledge informed development of the principles framework, alongside formal academic knowledge. It is interesting to note that a much higher proportion of data relating to principles and values came from the grey literature than did from the academic literature (12 of the 95 studies included in the review were from the grey literature). Data were coded – given succinct labels – and grouped into categories that were meaningfully similar (i.e. sets of similar principles). Those codes and categories are presented in Figure 1 with the principles identified from the grey literature highlighted, and frequencies indicated where individual codes appeared in more than one source in the data.

Second, a National Expert Panel (NEP) was convened of ten people all of who had lived experience of sharing peer support, developing and leading peer support projects in either the not-for-profit or statutory mental health sector, or of doing research about peer support from a lived experience perspective in the UK. In a first task each panel members was given five blank cards and asked, individually, to address the question above, noting one principle on each card. In the second task the panel were asked, together, to sort the cards into groups of meaningfully similar principles. Notes of the discussion were made whereby the panel clarified the meaning in each others’ cards, gave reasons for groupings, and defined and labelled groups of principles. The output of the NEP is given in Figure 2.

Finally, the two sets of outputs were mapped onto each other and an iterative process of labelling a composite set of principles and producing a short definition for each principle was undertaken, circulating drafts between the team and, by e-mail, with the members of the NEP until the content was agreed on. Nearly half of the ENRICH research team bring explicit, lived experience of using mental health services and/or of mental distress to their work, either in their roles as researchers, peer workers or as leaders of peer support projects, ensuring that experiential knowledge shaped this process alongside academic and clinical expertise (Gillard et al., 2012).

Results

The final version of the ENRICH peer support principles, stating that mental health services, training programmes, practice guidelines or interventions that are based on or include peer support should, in their development, delivery and evaluation, is as follows:

1. Support the building of safe and trusting relationships based on shared lived experience as fundamental to peer support:

   Where that lived experience is appropriate to the service or community context in which peer support is given and received, reflecting and respecting the full diversity of lived experience that people bring.

   Through the offer of human kindness, compassion, time and space to share experiences of mental distress & difficulty and to build connections through shared language, learning and understanding.

2. Ensure that the values of mutuality and reciprocity underpin peer support relationships:

   Mutuality in this context includes the qualities of empathy and mutual respect, a fundamental sense of equal value, and a connection to communities defined by the diversity of culture and experience.

   Reciprocity in this context includes willingness to both give and receive support, of listening and sharing, and of learning from difference.
3. Promote the validation and application of experiential knowledge in the provision of peer support:

Where validation means recognising, acknowledging and placing value on peers’ personal lived experience as useful and powerful sources of knowledge and strength.

Especially where that knowledge provides an alternative to, or complements other forms of knowledge about mental health (e.g. medical or psychological knowledge, recovery models etc.).

Paying attention to the diversity of peers’ lived experience as grounded in particular cultural contexts and ways of making sense and meaning.
4. Enable peers to exercise leadership, choice and control over the way in which peer support is given and received:

To exercise leadership in peer support at an organisational level (especially where there are organisational constraints and control over how peer support is put into practice).

To bring power to peer support roles within teams (enabling peers to use their lived experience in a safe and supported way).

To retain choice and control over how lived experience is shared at an individual level and within relationships (including self-determination and negotiation in the sharing of lived experience).

5. Empower peers to discover and make use of their own strengths, and to build and strengthen connections to their peers and wider communities:

To enable peers, in a non-directive, non-prescriptive way, to discover, develop and make use of their own strengths, skills and strategies, and to build and strengthen positive connections with their peers, networks and wider communities.
This principles framework is represented diagrammatically in Figure 3.

This framework has been used to inform development of the ENRICH peer support for discharge approach – the ENRICH handbook – in particular guiding the writing of the training that peer workers will receive, and the supervision and support they are offered at individual, team and organisational levels. Testing of the ENRICH principles-based fidelity index is currently underway, while in-depth qualitative interviews with peer workers, the people they support, their team leaders and the other staff they work alongside will also explore the extent to which the principles were reflected in the peer support in practice. It is envisaged that the framework and index will be useful in supporting the development and evaluation of other one-to-one peer worker roles in mental health services, while also going some way towards addressing those criticisms of existing trials that fail to properly describe and evaluate what might be distinctive about peer support (Pitt et al., 2013).

Conclusions

Reflection on the ENRICH project and those other experiments suggests that there is potential of a principles-based approach to reflect practice and evaluation to ensure that the distinctive values underpinning peer support are not eroded as peer support is mainstreamed into mental health services. Such an approach might take place in a number of stages:

1. There should be a clear understanding of the values underpinning any peer support project, including values that might apply more generally across different approaches to peer support, and values that are specific to a particular service delivery setting or local community.

2. There should be principles established that seek to protect those values as peer support is implemented into practice in mainstream mental health services.

3. Those principles should guide development and delivery of all aspects of implementation, from developing a role description, producing a training programme and providing supervision and support for peers at an individual, team and organisational level.

4. Peer support services should be evaluated and audited against those principles as a way of checking that the values underpinning peer support are being preserved and protected as peer support is implemented into practice.

5. Reflective learning, guidance and further development should follow evaluation to support the delivery of peer support that remains distinctive from other forms of mental health support.

The key learning from this paper is that commitment to reflective practice and evaluation of peer support is likely to play an important role in sustaining the values-based distinctiveness of peer support in a mental health service delivery context. Cycles of reflective learning should be

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**Figure 3** The ENRICH peer support principles

The development, delivery and evaluation of peer support services should:

1. Support the building of safe, trusting relationships based on shared lived experience

2. Ensure that the values of mutuality and reciprocity underpin peer support relationships

3. Promote the validation and application of experiential knowledge in the provision of peer support

4. Enable peers to exercise leadership, choice and control over the way in which peer support is given and received

5. Empower peers to discover and make use of their own strengths, and to build and strengthen connections to their peers and wider communities

In delivering on all these principles, peer support should respect and support the full diversity of experiences, language, culture, identity and background that people bring, enabling peers to build connections and relationships, and access resources and strengths found in the range of communities with which they identify and belong.
introduced to ensure that the values underpinning peer support are protected, i.e. peer workers are properly supported to use their experiential knowledge in the role. This reflective learning encompasses both formal evaluation (e.g. the use of principles-based fidelity measures) and the use of self-assessed organisational learning tools.

Given the wide diversity of approaches to peer support noted above – and that peer support can mean very different things to people in different service delivery and community contexts – it seems unlikely and probably undesirable that there is any one-size-fits-all set of values and principles underpinning all peer support. As such “off the shelf” approaches to peer support should be treated with some caution, except perhaps where these integrate flexibility for local peer and community expertise and knowledge to shape the peer support. Imposing a peer support “model”, however carefully developed, risks sending a message that peer support is something to be learnt, rather than being grounded in the experiential knowledge of peers. A didactic approach to techniques – for example, a requirement to follow a prescriptive self-management manual – potentially sends a message that the codified knowledge in the manual takes priority over lived experience. Similarly, a formalised language of peer support might distance people for who mental health and peer support are understood and described differently – for example, in culturally specific contexts – possibly undermining the sense of mutuality and relationship building at the heart of peer support.

A final note of caution should be sounded. Given the centrality of lived experience to all value sets underpinning peer support, people working from a lived experience perspective should shape and lead this reflective learning process. Experiential knowledge must be central to research about peer support so that the academic and clinical assumptions embedded in conventional ways of doing mental health research do not constrain and reconstruct the evaluation of lived experience. Likewise, reflective self-assessment of peer support projects should not become a clinical or bureaucratic exercise. These should be inclusive, shared learning experiences, validating the experiential knowledge of people sharing peer support. Reflective practice and evaluation of peer support should not fall into the trap of codifying and regulating lived experience, and therefore imposing an orthodoxy or organisational constraint on what peer support can be as it moves into the mental health service mainstream.

Dedication

This paper and the ENRICH peer support principles are dedicated to the late Ruth Chandler. As a member of the ENRICH team Ruth chaired the meetings of our NEP we describe above, was a vital source of inspiration and leadership for the programme as a whole and will be hugely missed as a leading light in the UK mental health survivor movement.

References


NICE (2016), Nice Guideline 53: Transition Between Inpatient Mental Health Settings and Community or Care Home Settings, National Institute for Health and Care Excellence, Manchester.


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Abstract
Purpose – The purpose of this paper is to demonstrate how mutuality and shared power in relationship can avoid coercion and force in mental health treatment.
Design/methodology/approach – This is not a research design. It is rather an opinion piece with extensive examples of the approach.
Findings – The authors have found that using these processes can enable connection; the key to relationship building.
Originality/value – This paper is totally original and stands to offer the field, a new perspective.
Keywords Mutuality, Coercion, Forced treatment, Mutuality, Shared power, Alternatives to force, Shared power
Paper type Conceptual paper

Introduction
Forced intervention is a fear-based response to a person in crisis. Its aim is to control and contain. Force, by definition, is a violation of human rights and personal/bodily integrity and has become society’s default option because of certain beliefs and assumptions that legitimize its use, even though there are a range of other options and alternatives. Forced “treatment” is an oxymoron, because it has had life-long negative consequences for people subjected to it, like any other trauma and it has all too often become synonymous with “care.” Briefly, some of the assumptions that underlie the use of force include the notion that people with a mental health diagnosis are unable to know what they need, or that due to the “illness,” they are unable to fully participate in decisions made about them (their care). Throughout this paper we refer to these assumptions and the relationships that evolve from them (one-way “helper/helpee”) as the “traditional system” and “traditional relationships.” In the traditional system, the view of distress (as “illness” and coping with “illness”) also asserts that its view is the only, correct view. As peer support is mainstreamed into traditional mental health services, it faces a dilemma: uphold the principles and values of peer support such as mutuality and shared power, or comply with job descriptions that can include the use of force (e.g. monitoring medication compliance).

The result? Clinician the helper has the power to control the outcomes of the relationship. Only one person’s view is operating, that of the helper, with the power to define the problem, dictate what help looks like, determine progress, and ultimately, define success.

Intentional peer support (IPS) offers the opportunity to find and create new meaning through our relationships and conversations that lead to new ways of understanding crisis. It provides a lens through which to address these issues by talking very overtly about power, who has it, who does not and to negotiate how we can share it. We do this by coming together based on the understanding that both of us have experiences or stories to tell, that explain who we are and how we see the present. This gives both people power, visibility, and expertise. This sort of relationship is more proactive, building mutuality, and shared meaning making. We offer three principles; or ways of thinking about what we are doing in our relationships, and then use four tasks to carry out that intention.
Principles of IPS

Let us start with the principles.

Shifting the focus from:
1. helping (problem solving or fixing) to a focus on learning together;
2. the individual to a focus on the relationship; and
3. fear-based responses to a focus on hope-based responses.

How we put these principles into action is through four tasks.

Tasks of IPS:
1. Connection
2. Worldview
3. Mutuality
4. Moving toward

Discussion

Principle 1: shifting the focus from helping (problem solving or fixing) to a focus on learning together.

Being there for people, stepping in to lend a helping hand, or delivering aid of any kind is crucial to our humanity, especially given the magnitude of suffering all around us. But all too often we are in a hurry to fix or problem solve. One of the challenges, working in traditional mental health contexts, is creating a peer support relationship based on connection and mutuality. We often find ourselves falling into traditional supportive roles where the focus tends to be more about fixing or problem solving. Let us take a look at an example.

Jane talks to Marty, a peer supporter (Table I).

In this conversation, Marty is probably responding to Jane based on what he has been taught to do in order to help Jane learn how to deal with her “depression” with better coping skills.

But what happens if Jane says: “I tried music, and walking, and 100 other things, and nothing works!”

If Marty runs out of ways to support Jane in coping, he likely experiences his own frustration – feeling that he has failed Jane – or, Jane must not be motivated enough. No matter what Marty’s interpretation, he is in a very powerful position to communicate with the rest of the clinical team, and to define Jane’s experiences.

Notes: most peer supporters do much more to create a meaningful relationship. We created this role play only to highlight a point – which many of us working in traditional mental health have been taught to see our experience mainly as an illness, and to see our relationships as primarily supporting people learn to cope with their diagnosis and symptoms.

Table I | Conversation one

<table>
<thead>
<tr>
<th>The conversation</th>
<th>What is taking place in the conversation</th>
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<tbody>
<tr>
<td>Jane: “I’m so depressed” Marty: “Why don’t you take a walk. That always helps me. Or you could listen to music. Who do you like?”</td>
<td>It is likely Jane has been taught that what she is experiencing is “depression” The focus of the relationship is on fixing or problem-solving Jane’s “depression” Marty assumes that his experience is the same as Jane’s since they both share a diagnosis (depression) The intent of the relationship? Jane will no longer feel “depressed”</td>
</tr>
</tbody>
</table>
Now let us listen in to the same conversation, but this time, Marty’s intent is to focus on learning together with Jane, rather than fixing or problem solving (Table II).

When we understand our conversations this way, there is a lot more creativity, and connection that moves us beyond simply coping. When both people are sharing their experiences, and listening rather than trying to define the other’s experience, both people are visible. Both people are sharing in the creation of something new.

In situations of risk

Let us try another scenario – one in which there is potential for the kind of crisis that often leads to forced medication and/or hospitalization. This conversation takes place between Bart, a person living with experiences that have been labeled “psychotic,” and Pete, a peer supporter from a traditional mental health system:

Bart lives with his uncle. Over the past week he has been telling people that his uncle is trying to poison him and that voices are telling him he should protect himself. He believes that at any moment he could be killed. Bart’s doc wants to change his meds, but Bart is refusing, not trusting the doctor, either. Most recently, the voices have been telling Bart he should get a gun.

When risk, or perceived risk, is high, the tendency is to want to control or contain the troubling behavior – in this scenario, Bart’s refusal to see his doctor for meds, and his belief that his uncle is trying to harm him. It would appear to make sense, especially since it sounds like Bart’s uncle could be in danger, too. In the following conversation, Pete is going to focus on problem solving to try to contain, or control what is going on with Bart. Let us see where this leads (Table III).

It would appear that the level of risk has increased as a result of Pete and Bart’s conversation. Disconnection, rather than connection is the more likely outcome of the relationship. At this point, Pete does not have many options, and will need someone to intervene or assess Bart.

At this point, you may be yelling, “Well of course Pete should help Bart get on meds, see his doc, not listen to his hallucinations and definitely not let Bart do something he may regret!” But will that work? And for how long?

This scenario reveals one of the dilemmas in the use of force. Let us say weeks or months have gone by, and Bart is once again incredibly upset, believes once again his uncle is out to get him. But this time, Bart probably will not turn to Pete for help for fear of what others might do to him – despite everyone’s intention to help. In this scenario, refusing, walking away, disappearing, dropping out of services protects Bart. And, it may be the only power Bart has.

Another dilemma is that Bart may go the other way – he may appear, outwardly, to comply. “Sure I’ll go see my doc. Absolutely, I’m taking my meds.” Here, the tragedy is that Bart has learned (as a result of his own extreme distress and others’ response to his distress) to stop

### Table II: Conversation two Jane and Marty

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<tr>
<th>The conversation</th>
<th>What is going on in the conversation</th>
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<tr>
<td>Jane: “I feel so depressed”</td>
<td>Marty focuses his attention on learning together with Jane, about what depression means for her</td>
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<td>Marty: “You know, Jane, I’m not sure we’ve ever talked about what depression means for both of us. I guess I’ve been assuming I know what you mean. I realize now, I know what depression means for me, but I don’t know what it means for you. Would it be ok if we talked about it?”</td>
<td>As their conversation continues, both people experience shared power as they begin to learn more about each other</td>
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Note: Our intention is not to leave Jane alone with her “depression” but rather to build a stronger connection so that they can move toward a deeper understanding of their experiences and each other.
talking about what he is experiencing. He learns that the appearance of compliance is the only way to avert more loss of control over his life. Intervening with force can have other negative outcomes for Bart. If he reacts strongly to that force his reaction is likely going to be mis-identified as symptomatic of his diagnosis, and not as the normal response that it is to his sense of losing control over his life. This scenario demonstrates just how important connection is. Remember, it is only the first step, or first task in creating IPS relationships. Pete is not going to be able to get any farther unless he connects with Bart first. This does not mean ignoring the dilemma that crisis represents, but of maintaining a connection despite it. Connection is the bond that is created when people feel genuinely understood and trusting enough to go a bit deeper. What creates connection? It often happens when people feel heard, and seen. When what they are experiencing is acknowledged and validated. Let us see how Pete validates what is going on for Bart (Table IV).

Pete connects authentically with Bart by acknowledging and validating Bart’s feelings. This is quite different from saying to Bart: “Wow, I can’t believe your uncle is doing that to you! Let us call the police!” Such a statement would be a lie. It would be in-authentic.

Connecting to Bart’s feelings of terror and fear, Pete strengthens his connection to Bart as he then moves to understand what is going on from Bart’s perspective. We call this the second task of IPS – exploring worldview.

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<th>Table III</th>
<th>Conversation one with Bart and Pete</th>
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<tr>
<td><strong>The Conversation</strong></td>
<td><strong>What is taking place in the conversation</strong></td>
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<tr>
<td>Bart: My uncle, he’s trying to have me killed! My doctor is in on it. He’s trying to trick me into taking medication. You’re the only one I trust. You got to help me, Pete! Pete: Hey Bart, take a breath there. Look, I know you think that’s what’s going on, but seriously, no one wants to harm you. You know, I’ve been in bad places myself, not knowing who I could trust. But look, you know me. You know I wouldn’t steer you wrong. Let’s go talk to your doctor together. I’m sure all he wants to do is help you.</td>
<td>Bart sounds pretty scared. The situation he is describing is potentially risky. Pete perceives in Bart’s statements the possibility of threat to self or others. Pete assumes he knows what is going on with Bart, and that he also knows what is best for Bart. He is operating out of concern for Bart, but also from the perspective of risk management. Pete also appears to be attempting to “ground” Bart in Pete’s reality. The focus is Bart’s behavior. Pete tries to use his relationship with Bart to change Bart’s beliefs, but it begins to sound a bit manipulative. Pete perceives or anticipates a situation unfolding in which he may not have a lot of power to control. So, Bart pulls away at a time when connection could be so important.</td>
</tr>
<tr>
<td>Bart: No. No. No way</td>
<td>Pete assumes he knows what is going on with Bart, and that he also knows what is best for Bart. He is operating out of concern for Bart, but also from the perspective of risk management. Pete also appears to be attempting to “ground” Bart in Pete’s reality. The focus is Bart’s behavior. Pete tries to use his relationship with Bart to change Bart’s beliefs, but it begins to sound a bit manipulative. Pete perceives or anticipates a situation unfolding in which he may not have a lot of power to control. So, Bart pulls away at a time when connection could be so important.</td>
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<td>Pete: “Look, you know what’s going to happen if you don’t see your doc, let him help you. I’d hate to see you go to the hospital again. You remember how awful that last hospitalization was, right? You don’t want to go there again, do you? If I were you I’d go ahead and take my meds”</td>
<td>Since Pete’s first offer to go with Bart to see his doc failed, Pete has to up the ante – he has to increase use of coercion. In this situation, Pete uses a veiled threat to try to change what is going on with Bart.</td>
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<td>Bart: Screw you! You’re just like all the others! Pete: Bart! Come on back! Come on man, don’t make me have to call someone!</td>
<td>It is not working. In fact, Bart sounds more alarmed. Bart does not trust Pete. As a result, he may run, or drop out of sight. Force and control appear to be the only outcome of this conversation.</td>
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<tr>
<th>Table IV</th>
<th>Conversation two with Bart and Pete</th>
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<tbody>
<tr>
<td><strong>The conversation</strong></td>
<td><strong>What is happening in the conversation</strong></td>
</tr>
<tr>
<td>Bart: My uncle is trying to poison me. Don’t tell me he’s not. I know what’s going on. I should get a gun. The voices, they say I have to protect myself […] Pete: Bart, that sounds terrifying. I’m sorry you are going through this. If I felt that way, I’d want to protect myself, too</td>
<td>Obviously, Bart is pretty upset, pretty scared. Pete is likely alarmed, too, by what Bart is expressing. Pete connects by validating and acknowledging Bart’s feelings. Notice that validating Bart’s feelings does not mean that Pete sees things the same way as Bart.</td>
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Worldview is something that often gets ignored. It is easy for the person supporting to assume that their own definition of recovery or living well is the only definition. Their “lens,” or “view” sets up a framework for all that happens in the relationship – including how issues are framed, what treatment looks like, what success is, etc. This results in subtle, often inadvertent, attempts to shape the other person’s knowledge of reality – which is another use of coercion. We saw this happen earlier when Pete basically said to Bart – Come on man, that’s not happening. But it can also take on more subtle forms such as, “You want to get better don’t you?” or even “But you’re doing so well right now!”

Worldview refers to how we come to know what we know. Let us explore what this means and why it is relevant. Understanding worldview means understanding that we live lives full of all kinds of experiences which shape our understanding of ourselves and the world. These experiences inform our beliefs and assumptions, or what we consider to be the “Truth.” Thus, no one worldview is the only worldview. We call this holding multiple truths. The reason for exploring worldview as a critical component of building meaningful relationships is that oftentimes we operate out of our own experiences and beliefs, not even always aware that we are directing outcomes of the relationship through the assumption that everyone else sees the world the way they do.

Let us return to our dialogue with Pete and Bart. This time the focus is on learning together with the same two tasks: connection and worldview (Table V).

With this focus on learning together rather than helping you can begin to see that the focus on connection and worldview can lead to having a different kind of conversation (rather than just “teaching Bart how to cope”). Next, we will talk about the power of dialogue and meaning making.

Principle 2: shifting the focus from the individual to a focus on the relationship.

The second principle is shifting from a focus on the individual, to a focus on the relationship. How we put this principle into action brings us to our third task, mutuality – one of the key features of peer support that distinguishes it from other relationships.

We mentioned earlier how easy it can be to want to fix “problems” (I do not want this person to feel sad so I am going to do something to help them feel better). One person assists another person who needs it, and the anticipated outcome involves behavioral change (she will smile more than she cries) as in the earlier conversation with Marty and Jane.

Table V: Conversation three with Bart and Pete

<table>
<thead>
<tr>
<th>The conversation</th>
<th>What is happening in the conversation</th>
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<tr>
<td>Pete: Bart, I am hearing you are really worried about what’s going on. But I’m not sure I understand what you mean when you say your uncle’s face is changing – but I do hear it is really important […] Can you say more?</td>
<td>Pete is Learning together with Bart about his experiences – This is what is meant by exploring someone’s worldview. Think about worldview as being genuinely curious about the other person</td>
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<td>Bart: Why? So, you can run off and tell my doctor? He’ll up my meds and then I’ll be worse than dead, I’ll be a zombie.</td>
<td>It sounds like Bart has been tricked before. He is asking an important question: “Can I really trust you, Pete?”</td>
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<tr>
<td>Pete: No, that’s not why I’m asking. I am not trying to trick you into something. And you don’t have to tell me. I just want to understand as much as I can.</td>
<td>Pete stays authentic. He does not reassure or dismiss Bart’s question</td>
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<tr>
<td>Bart: Well, some days when I look at my uncle his face looks like it is a good face. But then maybe later I look, and his face has changed. Then my voices tell me watch out, you don’t know what might happen. Pete: It kind of sounds like you’ve lost your uncle even through he’s right there. That sounds sad, Bart. It must hurt. I think I know a little of what that feels like.</td>
<td>As Pete listens to Bart, he’s getting a better picture of what life is like for Bart. And, he can certainly relate to the experience of feeling like you know someone, then suddenly, something happens, and you realize you don’t Notice Pete continues to practice connection by validating Bart’s feelings. Also, notice that Pete is using the language that reflects Bart’s language, rather than imposing his own which might sound like: “I think you are having symptoms;” or, “It sounds like you are hallucinating”</td>
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<td>Bart: Yeah. I lost him. Just like everybody else. Pete: For me, when I feel I’ve lost someone, it’s like there’s this big hole right here in the middle of my chest. Is that anything like losing your uncle?</td>
<td>In exploring worldview, Pete is trying to get a clearer picture of what Bart is telling him – so he checks this out with Bart. Pete does not assume that his own experience is like, or not like Bart’s. In other words, Pete does not assume mutuality. He offers his own experience to see if he is really understanding Bart. But he is also giving of himself, and a bit of his own story, too</td>
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Changed behavior does not sound too bad on the surface, especially if what I have been doing keeps getting me into trouble. But we need to recognize that this is not mutuality – even when the person in the supporting role is a peer supporter. Rarely is the supporter vulnerable about their own discomfort or authentic about their own agenda and “good outcomes” have to do with only one of us making any changes:

Vulnerability is a big part of developing mutuality. How?

Returning to Bart who is afraid that his uncle is trying to kill him, and Pete, the peer supporter he has turned to, in what way would you say that Bart is vulnerable? In confiding to Pete, he cannot predict what Pete will do, or say. Pete could use his position as an employee to control what happens to Bart next. But what about Pete? What are his vulnerabilities?

There are a number of ways people express vulnerability. First, vulnerability is about sharing similar experiences as a way of seeing if you can better understand what the other person is going through. It is the opposite of assuming you both share the same experience. It also says to the other person, “Truly, you are not alone. I am standing in this place with you.”

Let us pick up the conversation between Pete and Bart. They were just beginning to talk about loss (Table VI).

Another aspect to vulnerability is authenticity. “Authenticity means erasing the gap between what you firmly believe inside and what you reveal to the outer world” (Professor Adam Grant, University of Pennsylvania).

There are two dimensions in authenticity: First, the content should be from your personal experience. It is never a good idea to make something up because you think you will get a certain response. The expression, or how you say it, has to do with emotional resonance – allowing you to be honest without overwhelming the other person. An example would be if I am angry at you and say, “I am so mad at you!” That is honest, but how I express my anger can either open up or close down any further conversation. The same holds true if I am afraid, or upset, of something you are doing. We will examine this in more detail in the next section.

Table VI  Conversation four with Bart and Pete

<table>
<thead>
<tr>
<th>The conversation</th>
<th>What is happening in the conversation</th>
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<tr>
<td>Pete: For me, when I feel I’ve lost someone, it’s like there’s this big hole right here in the middle of my chest. At least that’s how it feels [...]. Is losing your uncle sort of like that? Pete – You know Bart, I grew up in foster care. I remember every time my case manager took me to a new foster parent I’d think how this time it would be different. This time my foster mom or dad would stay nice even after my case manager left. But every time that door shut, and it was just me and my new foster parents, they stopped smiling. Their faces changed, too, in a way. They stopped being nice. I remember how I felt like I just didn’t know what was real anymore, what I could trust Pete is checking out whether his experience is like Bart’s rather than assuming, “I know just how you feel!” In doing so, Pete is open to Bart saying, No, that’s not what it is like at all! Pete offers his personal experience. He does it in a way that isn’t aiming for a certain outcome Pete allows himself to be vulnerable as he shares this story. Bart could tell Pete to shut up, or Bart could say how Pete’s story has nothing to do with what he is going through. He might even make fun of Pete – “You? I can see why your foster parents never liked you!” Being vulnerable is to give of yourself without any certainty of return. As Adam Grant stated in the quote earlier, Authenticity means erasing the gap between what you firmly believe inside and what you reveal to the outer world. What is true for Pete inside – this story of foster care, and his hopes, and his sorrows – are revealed outside as he shares some of his story with Bart. This shared vulnerability results in a deeper experience of mutuality. The focus is not on one person, but rather on building mutuality. Pete continues to listen as Bart uses his own language to explain his worldview To be continued […]</td>
<td></td>
</tr>
<tr>
<td>Bart: So, it’s like, I don’t know, trust. Something like that? You couldn’t trust a face on a body, either. People are changing their faces on you all the time Pete: That’s a really great way of saying it. Trust is hard. It’s a huge risk Bart: Why did my uncle’s face change on me? Pete: I don’t know, Bart</td>
<td></td>
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</table>
Let us take a look at how Pete shares his vulnerability without overwhelming Bart (Table VI).

Let us review where we are at this point.

First principle – shifting the focus from helping (problem solving or fixing) to learning together.

Tasks to put this principle into action – connection and worldview:

- Pete created a connection at the start by acknowledging and validating Bart’s feelings.
- This connection allowed Pete and Bart to explore, and better understand, each other’s worldviews. They were able to get to this place as Pete kept the focus on learning together with Bart rather than fixing him.

Second principle – relationship (shifting the focus from the individual to the relationship).

Task to put this principle into action – mutuality:

- As we begin to understand the worldviews of both men, there is a sense that they are “in it together.” Pete’s authenticity and vulnerability creates a deepening experience of mutuality. Things are not settled yet. But Bart has not walked away. Pete has not had to rely on coercion or force to hold onto Bart.

We are now ready for the third principle in IPS – shifting the focus from fear-based responses to a focus on hope-based responses.

To sustain mutuality and shared power – even in crisis situations – it is helpful to think about what is it that you hope to create as a result of coming together, rather than thinking only about what you want to avoid. Pete recognizes that in his connection with Bart, the use of force or coercion to avoid a certain outcome will lead to increased fear, increased mistrust, and likely disconnection. And, ultimately, there is no change in the meaning of Bart’s experience. It is likely that Bart will be in this critical place again with others determining whether or not to hospitalize him again.

Instead, Pete is going to focus on what he hopes to create with Bart. This is what allows both men to begin to view crisis in a new light. It allows Pete and Bart to share power, reinforcing the mutuality they have established. Now, Pete and Bart can create something radically different, something entirely new.

Picking up from where we last left off, Bart suddenly gets really upset with Pete. Let us listen as Pete and Bart find a way to navigate their crisis as a result of the work they have already done (Table VII).

Hope-based responses can take time. Sitting with discomfort is challenging especially when things have not gone so well in the past. (e.g. when someone you have felt responsible for takes their own life.) It is ultimately connection that guides us to continue. And connection can go in and out, but a disconnection is not the end of the world; reconnection is always an option. Sometimes it is just about being honest rather than trying to control the situation.

Let us go back to Bart and Pete. We left off with Bart asking Pete, are you going away now? Is that what you are going to do?! (Table VII).

Conclusion

Many of us who have been hospitalized can speak to the experience of getting trapped in the mental health system. Force, including the use of locked units, medication compliance, and adherence to “treatment” plans perpetuates an endless cycle of despair. Our lives seem to be defined by sudden “crisis,” and eventual “stabilization.” Our experience is marked by hopelessness that anything can be different. We wonder if we will ever be able to take back control of our lives.

We believe that this desperate cycle is fueled by a psychiatric worldview that names our experiences of distress as mental illness before it even knows who we are. We are taught (despite views to the contrary) that we are our mental illness, so we become it. We are told that the solution to our despair is to accept that we are mentally ill.
Or we revolt against these dictates which in turn leads to the legitimization of coercion and force. Such interventions are not treatment, but acts that traumatize us and leave us wounded, disconnected from our lives and communities, and untrusting at a time when – more than ever – we need relationships that are supportive.

Peer supporters too often get stuck in the trap of condoning these practices when we know that it is connection and mutuality that both support the healing process and create alternatives to coercive practices. New meaning, or new ways of understanding our experiences is the hallmark of long-term change.

Peer support in times of crisis can halt the endless patterns of failure. When people come together in relationships of mutuality, such patterns of defeat can be re-examined, re-named, and become source of our reconnection to self and to others. This can happen in any setting.

**About the authors**

Shery Mead is the Past Director of three New Hampshire Peer Support Programs including the first peer run crisis alternative. She has done extensive speaking and training, nationally and internationally, on the topics of Alternative Approaches to Crisis, Trauma-Informed Peer Services, Systems Change, and the Development and Implementation of Peer Operated Services. Shery’s Intentional Peer Support has now been adopted by several states as “best practice.”

| Table VII | Conversation five with Bart and Pete |

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<th>The conversation</th>
<th>What is happening in the conversation</th>
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<tbody>
<tr>
<td>Bart – (suddenly screams at Peter) I’ve been trying to tell you all this! I’ve said it and said it and now your face is changing! You are going to tell my doctor everything! You betrayed me! I am going to get my gun!</td>
<td>Bart sounds really scared and angry. Remember, he’s had a lot of experience with others taking over, using hospitalization to control what is going on for him</td>
</tr>
<tr>
<td>Pete: Hey Bart, it’s me. I got to tell you though, it is hard to hear you when you yell at me. And guns really scare me. I’d like to keep talking, but I guess I need us to be able to do that without yelling or guns. I want us to find a way to talk about all this difficult stuff in a way that keeps us able to hear each other, really be with each other. Does that make sense? We can get through this, we know each other</td>
<td>Pete’s response moves through fear to hope. Saying what he needs from Bart is a major part of mutuality. Pete is sharing the responsibility for their connection. He is relying on the relationship, what they have both already come through and learned about each other. Pete says what he needs (not just what Bart needs) to stay connected</td>
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<tr>
<td>Pete does not assume Bart is too ill, or not capable of mutual responsibility for the relationship. Pete is leaning on the mutuality they have already established. This is what we mean by using the relationship to navigate risk together</td>
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<tr>
<td>The hope here comes out of the fact that they have already created a connection once, they can do it again. They know each other. They’ve come through a lot already</td>
<td></td>
</tr>
<tr>
<td>The focus is on the relationship, not on what Bart should do, or could do. So long as both feel their connection (and it may go in and out), there is a sense of possibility – that change is possible as a result of their relationship</td>
<td></td>
</tr>
<tr>
<td>There is a sudden shift that takes place. Bart, in his way, is now returning his focus to their relationship, and not to his own experience of possible betrayal. This shift happens because of Pete’s (unspoken) invitation to be in relationship with him</td>
<td>Pete and Bart’s relationship will continue to evolve. They have found a way to stay connected, and learn more about themselves and each other. Both men are changed, both me are “in it together.” Anything is possible now. Where they go from here is full of hope and possibility</td>
</tr>
</tbody>
</table>

| Bart: I’m sorry! I’m so sorry! I’m sorry – I am so stupid! I changed on you, didn’t I? Are you going away now? Is that what you’re going to do?! | Bart sounds really scared and angry. Remember, he’s had a lot of experience with others taking over, using hospitalization to control what is going on for him |
| Pete: No Bart, I really don’t want to walk away. I just need us to both figure out how to be with each other, even when we are talking about stuff that scares one of us, stuff that isn’t easy to talk about. And this is difficult stuff, this trust, and being with people, and hoping they won’t change on you […] But I also know that if one of us needs to walk away, we will find a way to come back together |
| Pete: What do you need from me, Bart, when you are having a rough time of it? Bart: I want you to talk to me about real things. I want to know you will do what you say, not lie to me. I want you to hear me, hear what I’m trying so hard to say. I want you to tell me if my face is changing. I want to tell you when I think your face is changing. That’s what I want, Pete |
| Pete: I can do all those things, Bart |

Pete: I want you to talk to me about real things. I want to know you will do what you say, not lie to me. I want you to hear me, hear what I’m trying so hard to say. I want you to tell me if my face is changing. I want to tell you when I think your face is changing. That’s what I want, Pete |

Pete: I can do all those things, Bart
This trauma-informed approach sees connections and relationship as the core of healing and growth. Her publications include academic articles and training manuals. Shery’s current interests include: developing a theory and practice base for peer operated programs, de-pathologizing the effects of trauma and abuse, and finding research and evaluation models that accurately reflect the work of peer programs. Shery Mead is the corresponding author and can be contacted at: sherymead@gmail.com

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Why I chose to leave mainstream psychiatric services: a peer supporter’s personal perspective

Sue Irwin

Abstract
Purpose – The purpose of this paper is to share the experiences and reflections of a paid peer support worker (PSW) working on an acute ward within mainstream psychiatric services.
Design/methodology/approach – A PSW’s reflective and narrative account of working in an acute ward setting over a 12-month period.
Findings – Working as a paid PSW within mainstream services can create personal moral conflicts and challenges which can sometimes compromise individual authenticity and integrity.
Originality/value – This paper is written from a personal perspective and as such is highly original.
Keywords Peer support, Mainstream mental health services, Personal perspective
Paper type Viewpoint

If we plant a seed in a desert and it fails to grow, do we ask, what is wrong with the seed? No. We must look at the environment around the seed and ask, what must change in this environment such that the seed can grow? (Deegan, 1996).

Introduction
Four months have now passed since I left my post as a paid peer support worker (PSW) on an acute in-patient ward within mainstream mental health services in the UK. I left because I had reached a point where I felt I could no longer work in an environment which compromised my own values, and the values of peer support. It is now time to reflect upon why I made that decision, based upon my own experiences. Although I do not have years of working in mental health services nor a paper certificate hanging in a frame on my wall, I do have almost two decades of experience of using mental health services, of spending many hours speaking with and listening to my peers, and I have the scars on my body and in my mind which are qualifications enough. My hope is that this paper will encourage an informed and constructive debate around the very real problems that mental health services are facing today, and although it sometimes feels a frightening and lonely path to follow by questioning the status quo, my conscience will not allow me to ignore what I see as madness within modern day psychiatry.

Where did it all begin?
My own personal journey of healing has been shaped by the damaging effects of childhood abuse and trauma and the subsequent emotional distress that I experienced over many years. The long-term effects began to manifest themselves in a truly distressing way after the birth of my third child and what to others might have seemed like an ordinary internal procedure during labour, was the trigger for deeply buried memories and feelings from this abuse. Shortly after the birth, I entered the mysterious world of psychiatry and its treatment of the mind.
When I first came into contact with mental health services, I felt vulnerable, I felt like that child from years before who was confused and unable to assert herself, who would agree to anything just to please. Essentially I was terrified and screaming out to be loved and cared for. I believed in and put my trust in professionals to help me. At the time I did not realise that the imbalance of power that exists between doctor and patient mirrored the powerless situation I found myself in as a child.

My interactions with clinicians would often leave me feeling guilty and ashamed. On one occasion whilst discussing my abuse of alcohol, I was told that if I loved my children I would stop drinking immediately. After an attempt on my life whilst an in-patient, a senior nurse said to me “did you not think of the staff”. The diagnosis of a personality disorder left me feeling that not only was I mad, but I was also bad. The fact that clinicians told me I had to be compliant with a medication regime, left me feeling powerless, that I had no choice in the matter. I was labelled “demanding”, an “attention-seeker” and told my behaviour was inappropriate, but from my perspective this behaviour seemed understandable given what had happened to me.

On the occasions when I was admitted to an acute ward, I felt frightened and bereft that I was separated from the very people I loved the most.

The catalyst for my healing began when I was taken off all psychiatric medication (albeit in a rather brutal manner). Fortunately, I was able to find the courage and access support outside of mainstream mental health services and it is somewhat ironic that this process really began to flourish when I finally felt confident enough to liberate myself from the community mental health team that had been treating me for almost two decades. It has been important that I have been able to choose the path that I wished to follow and I have been able to make what I see as informed decisions by researching and educating myself. I have managed to move away from the role of dependent “revolving door patient” by taking risks, by having the support of trusted friends and family and by forming a safe, trusting, equal and therapeutic relationship with a person-centred counsellor who has not been risk averse.

So how is it that my encounters with statutory mental health services hindered my ability to heal and why did I feel so disempowered, hopeless and re-traumatised, and behave in such a passive way?

The dilemmas of being a peer supporter

I debated long and hard whether to apply for and become a paid PSW within my local National Health Service Trust. After 18 years of using mental health services, I asked myself many times whether I would be able to, or even whether my conscience would allow me to, work within an existing system of psychiatric care that had essentially left me feeling disempowered, utterly hopeless, re-traumatised, passive beyond recognition and a great deal “sicker” than when I first entered the system. If I worked within it, would I feel that I was condoning a system that had essentially harmed me? Would recovery practices be embedded sufficiently into the organisation for me to support people in a recovery focussed way? Would I be able to or need to challenge existing practices? As a person labelled with a number of psychiatric diagnoses, would I be taken seriously and seen as a valuable and credible member of the team? How would I cope with and feel about returning to paid work after 20 years out of the employment market?

My decision to go ahead and apply was driven by a burning desire to prevent what happened to me, happening to others – to make a difference and support people in a different way. This sentiment has been the driving force behind peer support since the 1970s when peer support was established “in reaction to negative experiences of mainstream mental health treatment and dissatisfaction with the limits of the mental patient role” (Penney and Prescott, 2016). It was also with the hope that I might participate in the improvement of current mental health service delivery as an “agent of change”. Chamberlain (1978) states that grassroots peer support is characterised by equitable relationships among people with shared experience, voluntariness, choices, the belief that giving help is also self-healing, empowerment, positive risk taking, self-awareness and building a sense of community. Bringing these relationships into mental health services was a change I wanted to be a part of, a change I felt from my own experiences was sorely needed.
Essentially, I felt my aim as a PSW on the acute ward was to create a trusting, mutual and equal partnership with someone, one that felt safe for both of us. I was not there as an expert, nor to tell people what they needed to do or what they should do. For me this partnership meant that perhaps we could learn from each other and grow together. My own experiences, I felt, helped me to understand other people’s perspectives and have the capacity for empathy and compassion towards others. I would sit for many hours listening to people’s stories, to what had happened to them and what had been done to them. At times these stories would be intensely painful and distressing and it was challenging for me not to try to fix anything or find an immediate solution. But from my own personal experiences I felt that sometimes all that was needed was for someone to simply “be” with that person in that moment of acute distress, for someone to perhaps place a comforting hand on a shoulder or take hold of a hand and just say “I am here with you and you are safe”.

Despite the passion I described above, within me, why then did I choose to leave and work outside of statutory mental health services after such a short time? I have four good reasons […]

1. Because a Tsunami is approaching

The worrying direction that psychiatry is still taking is summed up for me by a statement from a former president of the American Psychiatric Association. It reads: “We must examine the fact that as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model” (Sharfstein, 2005, p. 3).

During my time as a PSW, I witnessed a system that was over stretched and jaded by constant funding cuts. I witnessed compassionate staff with too little time to spend building relationships, and I witnessed frustrated and distressed people, who entered with hope that somebody would listen and left with so much less than they deserved. My belief that mental health services appear to be in crisis is shared by many. In its response to the latest publication of the psychiatric bible, DSM-5, a 2013 press release from Mental Health Europe opened with the statement “Western psychiatry is in crisis”.

The government’s independent mental health taskforce report published in February 2016 painted a devastating picture of England’s mental health services, revealing that the number of people taking their own lives is soaring, that three-quarters of those with “psychiatric conditions” are not being helped, and that sick children are being sent “almost anywhere in the country” for treatment. A study by Viola and Moncrieff (2015/2016) found that the number of long-term (over five years) claimants of benefits with “mental disorders” increased by 87% per cent from 2000 to 2011. Two-thirds of “mental disorder” claimants were classified as having a depressive or anxiety disorder. This rising trend also corresponds to massive increases in the use of all types of drugs for “mental disorders”. There are of course other important social factors which may contribute to these figures and obtaining paid employment is not necessarily a sign of someone’s “recovery”, but my question is, if these medical interventions and treatments are as effective as we are led to believe, why then is there this rising trend in disability claims? Why then, whilst working on the acute ward, did I encounter so many people who had been using services for so many years?

It was difficult for me to work within a system that held onto the belief that human distress and suffering is mainly due to biological deficiencies (chemical imbalances or faulty genes). I know through my own experience, and through reading, that this belief is not reliable or even valid (Moncrieff, 2008, 2013). Is it possible that this belief is creating more distress? I also have to question whether the assertion that “mental distress is an illness like any other” is actually as helpful as it sounds. A service model for mental health based on the traditional (but unfounded) medical assumption that what we require most to treat illness is hospital beds, doctors and nurses (Morrison, 2014/2015) is possibly one of the causes for the crisis in mental health services today.

I am constantly hearing demands for mental health services to be better resourced, for more money to be put into the system and to a certain degree I agree that services or support needs to be better resourced. I also believe that there needs to be a paradigm shift in the way we understand and support people in distress with equal emphasis on the social, psychological and cultural causes. To me it makes no sense to simply pump more money into an existing medical model of care that is not as effective in helping people to heal as is sometimes made out.
During my time as a PSW I began to see that the current way of providing mental health support was underfunded and unsustainable. But I also saw that more funding is not what is needed to change the culture or to strengthen the values of recovery within mental health services. It was a sad realisation that there is so much more that needs to change than just funding. Funding would not have helped staff to feel more comfortable sharing their own lived experience, it would not have changed the risk assessment procedures that straight-jacket people, it would not have changed the easy way that medication was used so liberally, nor reduce the stranglehold that pharmaceutical companies have over the psychiatric system. It would not have changed the process of admitting people to hospital against their will under the Mental Health Act without fair and due representation, as is afforded to all other citizens. And as a PSW, to work within this system, to be implicitly endorsing this culture was ultimately too much of a compromise.

2. Because the doctor does not know best

The assumption that “doctor knows best” still permeates society as a whole today and people are encouraged to seek medical advice and do so for many of their difficulties. People trust and believe in the expertise of clinicians, and why shouldn’t they? After all the medical profession has science and training on its side. As a PSW, I saw how this assumption can lead to an imbalance of power between patient and doctor and tends to overlook the valuable expertise of people living with distress and their families. It can and often does lead to the person taking on a passive role in their treatment as well as feeling disempowered. I wonder if this is even more true in mental health services, where people often feel overwhelmed and vulnerable when they come into contact with professionals, where many (like myself) already feeling powerless and helpless, find it difficult to withstand or challenge the powerful messages of the medical world. People thus feel forced to enter into a medical system of care and their individual experiences are grouped into a one size fits all set of psychiatric diagnoses. The dominant evidence-based treatments on offer tend to be purely medical and opportunities to access the many other alternatives that can help people to make better sense of their experiences and assist and support them to heal seem few and far between and are often the ones which are most underfunded.

Gary Sidley’s (2015) comments describe this phenomenon when discussing a person reporting or displaying experiences such as voice hearing or expressing beliefs that seem bizarre or illogical:

“In practice, the person struggling with unusual experiences is forced to choose between either accepting the dominant psychiatric view that they have a chemical imbalance in their brains, or rejecting this conclusion and risking the subsequent coercion into treatment or loss of support.

I am not wishing to minimise or underestimate in any way the fact that people’s experiences of emotional distress can be, and often are, intensely painful and overwhelming (I can certainly bear witness to that), and I can also affirm that the process of healing can be a hugely challenging and agonising journey. However, I believe that the way western psychiatry explains people’s experiences of distress in biological terms focussing on the reduction of symptoms and concentrating on what is “wrong” with the person rather than what matters and what is strong, seems to ignore the social context of these difficulties thereby eliminating the important need to address the significant and damaging psychological effects of traumatic life events. It is my understanding that, as humans, we are unique individuals, our responses to life events be they traumatic or otherwise shape the way we perceive the world and can manifest themselves in many different ways. With regard to childhood abuse in particular, these responses can often be seen as “unusual” “abnormal” or “inappropriate” depending on the culture in which we live and western societies can struggle to understand and embrace these responses as understandable and meaningful.

In the 12 months I worked on an acute ward I came across people who were incredibly angry, who felt that they were being forced to be compliant with medication regimes which they felt were harming them. They were told that the fact that they were questioning medical advice was a sign that they lacked insight into their illness and therefore this proved that they were mentally ill. On one occasion I was asked by a clinician if I felt a person I was supporting lacked insight into their illness. I responded by saying that in my opinion the person’s reasoning for questioning the use of medication was quite understandable and this did not to me mean they were mentally ill. The clinician did not ask me any further questions.
A particularly difficult situation arose for me, when it was suggested during a weekly review meeting with a person who had been on the ward for a number of weeks whether electroconvulsive therapy (ECT) might help. The person was able to say that they did not wish to have this treatment. Later the following week, and outside of the review, the person’s keyworker said to me that they would be pushing for ECT at the next review.

3. Because the system crushes hope

Hope is one of the central themes which facilitates “recovery” and hopelessness is an important factor in suicidal behaviour so it would seem imperative that promoting and encouraging hope would be part and parcel of a modern mental health service. There have been a number of documents and articles published emphasising the need for mental health services to adopt the principles of “recovery” (see Department of Health, 2004, 2006, 2009; Repper and Perkins, 2012) and guidance reports for services to use when implementing recovery-orientated practices (Shepherd et al., 2010; Repper and Perkins, 2013).

Why then do services still seem to be extinguishing hope for many of those that use them? From a personal perspective my hopelessness grew from the message from professionals that I had an illness like any other and that my “symptoms” were the result of a chemical imbalance in my brain which required drugs to rectify. I began to believe that I had no control over my thoughts, feelings and emotions and slowly became dependent on services. I was told I should be compliant with a medication regime and that I would more than likely have to remain under psychiatric care for the rest of my life. I felt helpless and unable to challenge this and utterly despondent that continuing to take medication would mean I would have to endure the unhelpful side-effects – severe weight gain, blunted emotions, lack of motivation and energy, apathy, a feeling of complete indifference as well as what Breggin (2008) describes as medication spellbinding.

Whilst working on an acute ward, I came across a number of people who told me that they had a “severe and enduring mental illness, an illness like any other” and that as they felt they had no control over this illness, they had to rely on doctors and nurses to treat them and be compliant with medication that was being prescribed. Many of these people felt hopeless for a meaningful and fulfilling future life and felt resigned to living a life without hope, which was incredibly hard for them. Some would look at me in confusion when I asked them about their hopes, their dreams or their aspirations.

I could not bring myself to continue working within a modern psychiatric system, which emphasises the biological causes of human distress, almost completely disregards the significant psychological effects of traumatic life events and stigmatises people in distress by labelling them with what in my opinion are often meaningless to the individual and judgmental psychiatric diagnoses. I also wanted to be true to myself and felt that to be an authentic peer supporter, and maintain my integrity, I needed to remove myself from a clinical setting.

4. Because the Traumatised are being re-traumatised

In her powerful TED talk Eleanor Longdon speaks of the need for psychiatry to ask not what is wrong with you, but rather, what has happened to you?

There is overwhelming evidence to suggest that trauma or adverse events in a person’s life are a common cause of mental health problems. Trauma can take many forms, ranging from childhood abuse (physical, emotional and/or sexual), bullying, rape and violence in adulthood, war trauma and loss. Those who have endured the most severe abuse histories eventually become psychiatric patients and many or even most psychiatric patients are survivors of childhood abuse (Herman, 1992). A 2008 review of 59 studies of the most severely disturbed psychiatric patients found that 64 per cent of the women and 55 per cent of the men had been physically or sexually abused as children (Read et al., 2008).

The damaging long-term effects of child abuse often include feelings of guilt, shame, self-blame and anger. It is also common for people to feel powerless, helpless, and afraid and find it difficult to trust both themselves and others.
As a person who experienced abuse in childhood, I spent 18 years under the care of statutory mental health services and as the years of being a mental health patient passed, I increasingly began to feel the same feelings of guilt, shame, blame, powerlessness, helplessness, fear and worthlessness being replicated the longer I remained within the system. My voice as a child had already been silenced and my voice as a patient was silenced once again.

**Time to change the environment**

It is my opinion that until there is a revolution in the way western societies understand and support people experiencing emotional distress people will continue to suffer. As I mentioned earlier, almost two decades as a “psychiatric patient” had had a detrimental effect on my mental and physical wellbeing. I have struggled to make sense of how this happened and how I myself allowed it to happen. I hear many professionals and reputable organisations within the current psychiatric system vehemently state that massive advances have been made in the discipline of psychiatry over the last 50 years, that treatments have improved, are safer and are more effective, that society’s awareness of emotional distress is improving and that stigma and discrimination are becoming less of a problem. I am not convinced.

How then, can the environment be changed so that the way we respond to those experiencing emotional distress is transformed and “recovery” becomes a reality?

I have spent many hours reflecting on this question, and have struggled to come up with a response that would not involve a further 4,000 words. It feels a daunting task and I do not believe that there is a simple or quick solution, after all our experiences are many and varied, and the causes of people’s distress can be complex.

The term “recovery” is being used more and more within the realms of mental health services as a means of describing a different approach to understanding distress. Whilst “recovery” has been a very personal journey for me, the principle themes which appear to underpin the process are those of having hope, of being and feeling in control and of having opportunities to live a meaningful and fulfilling life (Repper, 2011). There are some who say that the concept has been hijacked by government and services as a way to place more responsibility (if not blame) onto individuals. Despite this, it is an idea that I welcome and personally find refreshing, mainly because it offers up the ideas of hope and optimism and that healing from distress (even in the severest of instances) can be and often is possible. I think it is important to point out, that “recovery” can and does happen with the support of clinicians, but it also can and does happen without the intervention of clinicians. Mental health professionals often do not hold the key to healing. People need to have the choice as to who they want to be involved, whether they want to have contact with mainstream services, and, if not, to be helped to access alternative support and opportunities.

Feeling in control is one of the key elements that facilitates “recovery” and a culture of shared decision making would help people to feel empowered. Access to a wide range of support including talking therapies, medication, peer support and self-help guidance is vital, as is honest and balanced information about the risks and benefits of that support.

Whilst I can see some areas within mainstream services where recovery focussed practices are taking shape – early intervention services, recovery colleges and the introduction of open dialogue teams, for example – further development and funding for peer led community organisations would enable people to choose which type of support they wish to access.

The provision of affordable and accessible opportunities enabling people to develop past or new roles would facilitate “recovery” and help people to feel part of their local communities.

Rather than simply using the standard and current method of diagnosing distress using the DSM-5, a variety of frameworks to help people make better sense of their experiences would reduce the stigmatising effect that these often meaningless labels can have on a person. This would also recognise the psychological impact of trauma, as well as reflect people’s cultural, social and spiritual perspectives.
Changing the language that services use to describe people’s distress from one of “illness” to one of “recovery” could help to encourage active participation in the healing process and inspire the belief that “recovery” is possible.

Positive risk taking and a reduction in the time consuming and often futile risk assessments that professionals are required to complete would encourage people to take on a more proactive role. Unfortunately, whilst the culture of blame that exists in society today, and the fear of liability that dominates services remain intact, this move might not be an easy task.

Educating the workforce using a trauma-informed model of care would help staff to appreciate the re-traumatising effect that current service provision can have on survivors of trauma and help them to ensure that maintaining a sense of safety for the individual, promoting empowerment and facilitating reconnection is at the forefront of the work that they do.

Change within mental health services will also require change in the political and social domains. Government must reflect on the way its policies affect people’s wellbeing and we all as a society must reflect on the way we view human distress. This I believe will require us to show humility, understanding, awareness and compassion for each other’s struggles and value and respect difference, creativity and individuality.

My continuing journey – a footnote

There has been a recurring theme that has increasingly begun to enter into my thinking over recent years, and it is one that I have grappled with for a long time, but one which I am learning now to embrace. As I do, I notice how my world has begun to take on new meaning and how my relationships with others are changing and blossoming. It is a theme that I have heard spoken many times, in many places, and by many people, but it has been one which I have found hard to accept or even recognise.

Showing myself compassion is slowly becoming part of my healing process and I am beginning to believe that I am “good enough”. I cannot deny that I have found it difficult to rejoice in and embrace myself as a unique human being, who has qualities and skills and who makes mistakes, who accepts that distress is an understandable response to some of life’s challenges, who has emotions that are meaningful and who is also prepared to embrace and rejoice in the uniqueness of others.

I am still working hard to try to repair the damaging effects of past abuse and trauma and am delving deep into the very core of my being, my innermost soul. It is an incredibly painful journey and is by no means easy, but it is possible and most definitely worthwhile.

My passion for peer support continues and I am currently helping to create a community-based service in my local area. My dream of joining the United Nations as an ambassador for peer support remains intact although not yet a reality.

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Further reading


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Abstract

Purpose – As peer support services have become increasingly used in mental health settings as a recovery-oriented practice, so has the body of published research on this approach to care. The purpose of this paper is to provide an update on the current evidence base for peer support for adults with mental illness in two domains: mental health and recovery, and physical health and wellness.

Design/methodology/approach – To provide a robust, non-redundant, and up-to-date review, first the authors searched for meta-analyses and systematic reviews. Second, the authors found individual studies not included in any of the reviews.

Findings – Peer services are generally equally effective to services provided by non-peer paraprofessionals on traditional clinical outcomes. Although some studies found peer services to be effective at reducing hospitalization rates and symptom severity, as a whole, the current evidence base is confounded by heterogeneity in programmatic characteristics and methodological shortcomings. On the other hand, the evidence is stronger for peer support services having more of a positive impact on levels of hope, empowerment, and quality of life.

Research limitations/implications – In addition to the need for further high-quality research on peer support in mental and physical health domains, the authors also question whether measures of hope, empowerment, and integration into the community are more relevant to recovery than traditional clinical outcomes.

Originality/value – This paper provides an original, robust, and up-to-date review of the evidence for peer services.

Keywords Physical health, Serious mental illness, Consumer-provided, Peer services

It has now been over 25 years since paid peer staff were first introduced into mental health care, building on the successes of the mental health consumer/survivor movement and promising to bring some of the healing aspects of mutual support into formal services for adults with mental illness. While the growth of peer support both inside and outside of formal services has been robust and global in nature, research evidence demonstrating the effectiveness of this new form of service delivery has lagged behind. This is undoubtedly due to multiple factors, but is likely to be at least in part due to the continued confusion or lack of clarity about what precisely constitutes peer support that sets it apart from traditional mental health services, especially those historically provided by paraprofessional staff; that is, other staff that do not have credentials in psychology, social work, nursing, psychiatry, or rehabilitation. In fact, the first few studies of peers who were hired to provide mental health services were feasibility studies of whether or not these peers could provide traditional services, such as case management and residential support, at least, as well as the non-peer staff who had been providing these services previously. Those studies showed that the deployment of peers caused no harm and did not produce any worse outcomes than traditional services provided by non-peers (Davidson et al., 1999); a finding we will see below has been replicated numerous times since.

A second complication is whether peer staff should simply be added to existing programs, such as assertive community treatment teams or inpatient units, or should rather be conceptualized as offering new and separate services of a different nature with perhaps a different focus or aim. It has taken some time for persons in recovery to develop new approaches that build explicitly and directly on their shared experiences and the value of reciprocity characteristic of the mutual

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support groups out of which peer support has emerged. Not all peer-provided services acknowledge, integrate, or are based on these experiences and values, and would not be considered by many in the peer community to embody peer support at all. While a peer providing case management or outreach services may prove to be more effective than a non-peer in doing so, this should not be taken to be a testament to the power of peer support per se. Thus, there have been attempts to identify sub-types of peer support such as: mutual support groups characterized by reciprocal relationships; peer support services involving uni-directional support that is different from, but may be combined with, traditional mental health services; and peers as providers of traditional mental health services. Indeed, what peer support consists of remains largely to be determined by people in recovery themselves as they continue to innovate, thus rendering the evidence gathered to date to be preliminary and suggestive, rather than definitive in nature.

It remains important, nonetheless, to continue to assess the effectiveness of peer-provided services as they continue to evolve and mature, and the following review summarizes the nature of the evidence collected to date. To provide a robust, non-redundant, and up-to-date review of the evidence for peer services, first we searched for meta-analyses and systematic reviews using search terms that included combinations such as peer support, mental health services, and consumer-provider. Second, we found individual studies not included in any of the reviews. All articles were found using MEDLINE, Embase, and Google Scholar because collectively these databases provide sufficient review searches (Bramer et al., 2016). To limit the scope of this review to adults with mental illness, we focused on US studies or international studies in English and excluded articles focusing on depression and veterans. As we will see below, the 30 or so studies conducted thus far have been reviewed and re-evaluated in different ways by different teams, using different indicators of quality and methodological rigor, and thus drawing different conclusions. We will try, in what follows, to tease these differences apart and to produce a somewhat coherent, if multifaceted, picture of what has been learned thus far about the effectiveness of different types of services provided by peers in different roles. Following this review, we will examine the implications of this knowledge for future programmatic development and research.

Findings

As peer services have begun to mature, five out of the eight publications appearing in the last two years are primarily either meta-analyses of randomized control trials (RCTs) or systematic reviews of earlier RCTs and observational studies of peer-provided services. We describe both the findings of these reviews and three more recently published studies (not included in these reviews) (Table I). For simplicity, we have divided our review into those which focus on: mental health, psychosocial, and recovery-oriented outcomes; and physical health and wellness outcomes. Despite the uptake of peer services in mental health settings, the authors of these meta-analyses and reviews uniformly note that more rigorous research is needed on this topic. Because of several methodological limitations (e.g. poor randomization, blinding of raters, and reporting of outcomes) and notable variations in program and participant characteristics, a nuanced picture emerges about the strength and generalizability of the evidence garnered thus far.

Mental health outcomes

A Cochrane review of 11 RCTs through 2012 (Pitt et al., 2013) concluded that having peer providers on mental health teams is associated with psychosocial, satisfaction, clinical, or service use outcomes that are equivalent to (no better or worse) those provided solely by non-peer practitioners employed in similar roles, particularly for case management services. There was “low-quality” evidence that care teams with peer providers resulted in small reductions in clients’ use of crisis and emergency services compared to teams consisting of only non-peer staff, but no differences were found in quality of life, empowerment, social relations, satisfaction, or hospitalization rates.

A second meta-analysis (Lloyd-Evans et al., 2014) of 18 RCTs consisting of mutual support groups ($n = 4$), peer support ($n = 11$), and peer-provided mental health services ($n = 3$) came to similar conclusions. There was little or no evidence that these services resulted overall in positive effects on hospitalization, overall symptoms, or service satisfaction. On the other hand, there was
Table I  Review articles for peers support for adults with serious mental illness (SMI)

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<th>Study</th>
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<td><strong>Mental health outcomes</strong></td>
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<td>Pitt et al. (2013)</td>
<td>Meta-analysis of 11 RCTs from 1979 to 2012 (9 conducted in USA) involving consumer providers to compare to consumers vs professionals staff in the same mental health service role, or mental health services with and without consumer-providers as an adjunct to the service</td>
<td>1. Psychosocial (quality of life, function, social relations, empowerment) 2. Clinical (general symptoms, depression) 3. Adverse outcomes 4. Client satisfaction 5. Use of services 6. Service provision patterns</td>
<td>Involving consumer-providers in mental health teams that results in psychosocial, mental health symptom, and service use outcomes for clients that are no better or worse than those achieved by professionals employed in similar roles, particularly for case management services. Low-quality evidence for involving consumer-providers in mental health teams results in a small reduction in clients’ use of crisis or emergency services.</td>
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<td>Lloyd-Evans et al. (2014)</td>
<td>Meta-analysis of 18 RCTs from 1982 to 2013 (15 conducted in USA) consisting of mutual support groups (n = 4), peer support services (n = 11), or peer mental health providers (n = 3)</td>
<td>1. Hospitalization 2. Employment 3. Clinical (overall psychiatric symptoms, psychotic symptoms, depression, anxiety) 4. Psychosocial (recovery, hope, empowerment, quality of life) 5. Service satisfaction</td>
<td>From small numbers of studies in the analyses it was possible to conduct, there was little or no evidence that peer support was associated with positive effects on hospitalization, overall symptoms, or service satisfaction. Some evidence peer support was associated with positive effects on measures of hope, recovery and empowerment at and beyond the end of the intervention, although this was not consistent within or across different types of peer support.</td>
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<tr>
<td>Fuhr et al. (2014)</td>
<td>Meta-analysis of 14 RCTs (9 conducted in USA) for SMI (n = 10) and depression (n = 4) comparing peer services to usual treatment (superiority trials) or provided by health professional (equivalence trials)</td>
<td>1. Psychosocial (quality of life, hope, social functioning, self-esteem, loneliness, recovery) 2. Clinical (changes in symptoms)</td>
<td>For SMI, evidence from three high-quality superiority trials showed small positive effects favoring peer-delivered interventions for quality of life and hope. Results of two SMI equivalence trials indicated that peers may be equal to improving clinical symptoms and quality of life. No effect of peer-delivered interventions for depression was observed on any outcome.</td>
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<td>Chinman et al. (2014)</td>
<td>Systematic review and rating of evidence quality of 20 studies from 1995 to 2012 (11 RCTs, 9 quasi-experimental/correlational studies) involving: peers added to traditional services, peers in existing clinical roles, and peers delivering structured curricula</td>
<td>1. Psychosocial (quality of life, self-esteem, recovery, hope) 2. Social (family burden, social network size) 3. Clinical (symptom change) 4. Service satisfaction 5. Service uptake/engagement 6. Therapeutic relationship 7. Service use 1. Inpatient use and duration 2. ED use and duration</td>
<td>Overall level of evidence for each type of peer support service was moderate and effectiveness varied by type of peer service. Compared with professional staff, peers added to services or delivering curricula associated with reduced inpatient use and improved range of recovery outcomes. Effectiveness of peers in existing clinical roles was mixed.</td>
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<td>Croft and Iwanski (2015)</td>
<td>Service utilization analysis using propensity score to create matching 139 pairs of users and non-users of respite program staffed by trained peers on subsequent service use</td>
<td></td>
<td>Odds of any inpatient or ED service use after start of peer respite program were 70% lower among respite users but odds increased with each additional respite day. Among those who used any inpatient or ED services, longer respite stay associated with shorter length of stay in inpatient or ED settings but with diminishing returns with negligible decreases predicted beyond 14 respite days.</td>
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<td><strong>Physical health outcomes</strong></td>
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<td>Cabassa et al. (2017)</td>
<td>Systematic review of 18 articles from 1990 to 2015 (12 conducted in USA) consisting of various health interventions involving peers. Rated the methodological quality of studies, summarized intervention strategies and health outcomes, and evaluated the inclusion of racial and ethnic minorities in these studies</td>
<td>1. Self-management (patient activation, goal setting, problem solving) 2. Health behaviors (diet, activity level, smoking) 3. Self-rated health status and symptoms or complaints 4. Body weight and BMI</td>
<td>Beneficial intervention effects observed for a limited number of health outcomes related to self-management, dietary habits, and communication with doctors. Mixed and limited intervention effects were reported for all other health outcomes. The most promising interventions were self-management and peer-navigator interventions. None of the</td>
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some evidence that these services had an overall positive effect on self-rated hope, recovery, and empowerment at, and beyond, the end of the intervention. However, this effect was not consistent within or across the different types of peer services. More specifically, mutual support programs tended to be associated with enhanced empowerment but not hope or recovery, whereas peer support had positive effects for recovery and hope but not empowerment. As in the Cochrane review, the authors cited weaknesses in the studies, including high risk of bias and a great deal of variation in participant characteristics and program content, which make it difficult to identify which factors in implementation might affect reported outcomes.

A third meta-analysis (Fuhr et al., 2014) of ten RCTs evaluated the effectiveness of peer-delivered services in improving clinical and psychosocial outcomes among individuals with mental illness. Results revealed evidence from three high-quality RCTs showed peer services were superior to usual care conditions on having positive effects on quality of life and hope. Results of two other trials indicate that peers appear to be equal to non-peer staff at improving psychiatric symptoms and quality of life in clients with mental illness. Results further suggest that individual interventions work better than group-based ones, however, this effect appears to plateau over the long term and does not seem to persist at six months. The observed equivalence in clinical and psychosocial outcomes between interventions delivered by a peer or a non-peer may not be generalizable due to the small number of studies included in the analysis.

Chinman et al. (2014) conducted a systematic review of 20 studies consisting of 11 RCTs and nine quasi-experimental or correlational studies. Similar to Lloyd-Evans et al. (2014), peer services were divided into different categories; peer providers added to traditional services, peer staff in existing provider (i.e. typically non-peer) roles, and peer providers delivering structured curricula. Chinman et al. concluded, based on what they deemed as moderate evidence, that adding peers to traditional services and peers delivering curricula improve outcomes compared to non-peer staff alone. More specifically, traditional services provided by peers reduce inpatient services use, improve patient relationships with traditional providers, and increase engagement with care. On the other hand, the evidence for the effectiveness of peer staff in existing provider roles was more mixed with only one of the three studies that was reviewed reporting positive outcomes. Similar to the findings from Lloyd-Evans et al. (2014), peer support services also tend to have a more positive impact on increasing levels of empowerment and hope about recovery. Nevertheless, Chinman and others conclude that the evidence for peer support services is “encouraging (but clearly not definitive)” (p. 8).

### Table I

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<th>Study</th>
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| Swarbrick et al. (2016) | Within-subjects pre-post study to examine impact of peer-delivered wellness coaching with 33 consumers on wellness goals and health-related quality of life | 5. Cardiometabolic indicators (A1c, fasting glucose and lipids, blood pressure)  
6. Health care use  
7. Quality of life | articles were able to disentangle the unique contributions of using peer specialists from the overall effects produced by actual health interventions since none compared the impact of peer-based health interventions to the same health intervention delivered by non-peers. Coaching participants reported significant progress toward attainment of individually chosen wellness goals at 2-4 weeks and 8-10 weeks after establishing their goals. Participants also reported significant improvement in self-reported physical health, general health, and perceived health that were sustained 90 days later. |
| Dickerson et al. (2016) | Observational pre-post study to evaluate impact of peer mentors to enhance smoking cessation intervention for 30 consumers. Peers co-facilitated 3-month professionally led behavioral group and provided 6-month individual mentoring | 1. Physical health (number healthy days and Duke Health Profile form)  
2. Self-rated wellness goal attainment | Program participants had a significant decline in carbon monoxide levels and number of cigarettes smoked per day. A total of 22/30 (73%) made an attempt to quit smoking but only 3 (10%) achieved sustained abstinence. |

**Notes:** BMI, body mass index; ED, emergency department.
A more recent study that was not included in any of the previously described reviews provides additional information on the effectiveness of peer-delivered respite services. Croft and Işıvan (2015) examined the impact of a public mental health peer respite program on subsequent inpatient psychiatric or emergency service use. Respite users were significantly less likely than matched non-respite users to use any inpatient or emergency services. Moreover, when such services were utilized, respite users had significantly shorter lengths of stay in inpatient and emergency settings.

Physical health outcomes

Cabassa et al. (2017) conducted a systematic review of 18 studies of peer-based health interventions for people with mental illness. The interventions included self-management classes, smoking cessation, peer navigator programs, healthy lifestyle, and multifaceted programs conducted in a range of settings (e.g. community mental health clinics, primary care settings, psychiatric emergency departments, and programs for first episode psychosis). Health outcomes covered a range of areas as well including: self-management attitudes and behaviors (patient activation, goal setting, problem solving); health behaviors (diet, physical activity, smoking, medication adherence); self-rated health status and self-reports of symptoms or health complaints; body weight and body mass index; cardiometabolic indicators (A1c levels, fasting glucose and lipids, blood pressure); use of health care services (primary care, emergency department); and quality of life.

Like other authors, Cabassa et al. (2017) concluded that the strength of the evidence generated from these studies is compromised due to several methodological limitations. Beneficial intervention effects are observed for a limited number of health outcomes related to self-management, dietary habits, and communication with doctors. The effects of peer-based health interventions on physical activity, smoking, medication adherence, weight-related outcomes, and cardiometabolic indicators were limited. The most promising interventions were self-management and peer navigator interventions. However, Cabassa et al. note that a majority of the research they evaluated were pilot studies consisting of small samples receiving comparatively brief interventions.

Two more recent studies have focused on physical health and wellness. Swarbrick et al. (2016) evaluated the impact of a pilot program involving peer wellness coaching on self-chosen wellness goals and perceived health. Using a within-subjects pre-post design with 33 adults in recovery, results included significant progress toward goal attainment and self-reported general health that was sustained for 90-day post-wellness coaching. Dickerson et al. (2016) evaluated a structured six-month smoking cessation program in which peer mentors co-led group sessions and worked individually with adults with mental illness trying to quit smoking. Despite rigorous training, supervision, and high working alliance, relatively modest success was achieved for tobacco-related outcomes. Participants demonstrated reductions in number of daily cigarettes and carbon monoxide levels and 73 percent attempted to quit smoking during the intervention, but only 10 percent achieved sustained abstinence.

Conclusions

Based on recent meta-analyses and systematic reviews of studies on peer services in the last 25 years, a number of notable determinations can be made about the evidence for this approach to care for adults with mental illness. In regards to traditional clinical outcomes (e.g. hospitalization rates, symptom severity), the evidence clearly supports the inclusion of peer services is not detrimental to care quality and results in at least equivalent outcomes to usual care conditions and/or services provided solely by non-peer staff. Only one study included in the review articles (i.e. Chinman et al., 2014) observed a negative finding with the presence of a peer on an ACT team being associated with greater hospital days (van Vugt et al., 2012).

Although the specific moderating conditions have yet to be elucidated (e.g. what type of peer service, service delivery mode), there is some evidence that peer services can modestly reduce psychiatric inpatient service use and crisis emergency services. If the scope of outcomes is expanded to include facets of recovery, the evidence is stronger for peer support services having
a greater positive impact on clients’ levels of hope, empowerment, and quality of life. In the physical health and wellness domain, the most promising peer support services are for modestly increasing self-management (e.g., self-efficacy, locus of control, problem solving, and action planning), adopting healthier diet, and communicating more effectively with physicians.

Discussion

Reviews of the effectiveness research on peer services paint a picture of mixed results. Whereas the evidence is stronger for peer support enhancing more recovery-oriented outcomes than traditional clinical ones, this may be in part because of heterogeneity in the setting and type of peer support. For example, research suggests that more structured peer-delivered self-management programs, such as the Wellness Recovery Action Planning (Cook et al., 2009) and Building Recovery of Individual Dreams and Goals through Education and Support (Cook et al., 2012), are more consistently associated with positive clinical outcomes, such as decreased symptom severity. Research involving less structured and defined peer roles may contribute to the equivocal evidence for peer support.

Another factor that may contribute to some questions about the generalized effectiveness of peer services is well-documented barriers to implementing peer services. Two recent articles that collectively synthesize over three dozen qualitative studies involving peer staffs’ perceptions and experiences at work observed common themes of negative attitudes among non-peer staff, lack of credibility of peer roles, ambiguous roles and tasks, and poor organizational arrangements (Vandewalle et al., 2016; Walker and Bryant, 2013). These sentiments are echoed in a recent national US survey of nearly 600 peer support staff in which 64.3 percent report seeing or feeling stigma or discrimination from non-peer coworkers and in which feeling respected by professional staff emerges as the second strongest predictor of job satisfaction (Cronise et al., 2016).

These findings raise additional questions regarding whether we are in fact targeting the mechanisms of recovery-oriented care and community outcomes, rather than the focus being on traditional psychiatric and medical-related outcomes. Peer supporters are trained to connect with other people in recovery by using their shared lived experiences in ways in which many providers are not trained to do. Few studies measure or describe these mechanisms. More qualitatively driven questions may add to the development of quantitative instruments that can be used to further test the mechanisms of peer support. As these mechanisms are identified, perhaps barriers to implementation of peer services might decrease because part of the challenge is that agencies are trying to fit peers into traditional roles rather than create roles that specifically focus on mechanisms such as connection, relationship building, mutuality, and assisting people to thrive in their communities. In addition, more research is needed to elucidate the concept of “peer” and more specifically, how the concept of “similar lived experiences” contributes to recovery-oriented and community related outcomes.

References


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Peer support services: state of the workforce-state of the field in the USA

E. Sally Rogers

Abstract
Purpose – Peer support and other consumer-provided services have burgeoned within the USA during the past 30 years and are now a central component of mental health services nationally. However, their growth has been uneven and somewhat dependent on state initiatives, policies, and funding. Recent programs have matured along myriad paths, resulting in a variety of program typologies, service structures, and funding streams, but with common values, missions, and principles. The paper aims to discuss these issues.

Design/methodology/approach – The landscape of peer specialist services in the USA, as well as innovations afoot, is reviewed. The empirical information that speaks to the efficacy of peer support and the need to better understand the mechanisms by which it is effective is described.

Findings – Although peer support has grown exponentially across the USA, its growth has been uneven. Evidence suggests that peer specialists experience role ambiguity within many existing programs and systems. Though the empirical evidence for peer services has grown, research has been most favorable for manualized, group interventions. There is still a need to better understand how individual peer support is beneficial and effective, and how individual peer support can best be utilized to promote the best outcomes for those served.

Research limitations/implications – In order for the workforce of peer support specialists to continue to grow and for services to be responsive and innovative, we need to better understand the mechanisms by which peer support is beneficial and how it can be structured and delivered to promote the best outcomes for those served. The “core conditions” of helping relationships promulgated decades ago by Rogers along with research on self-disclosure may be useful frameworks for understanding and researching the effectiveness of peer support.

Practical implications – More research is needed to better understand the effectiveness of peer support services and how best to insure that they are well-integrated into the mental health programs and systems in which they serve.

Originality/value – There is a need to understand why peer support is effective and how best to sustain peer specialists in their roles within the mental health system.

Keywords USA, Peer support, Recovery, Mental health, Peer specialists

Paper type Research paper

Introduction

Peer-delivered services have proliferated greatly over the past three decades and are now a central component of the mental health and behavioral health care systems in the USA (International Association of Peer Supporters (iNAPS), 2016; Mental Health America, 2017a; US Department of Health and Human Services, 2017). Nationwide, recent data suggest that peer support services are delivered in 35 out of 50 states using current public funding mechanisms (Mental Health America, 2017b). Peer-delivered services have been suggested as a critical component in a recovery-oriented mental health system by one of the largest institutes focused on mental health and were endorsed by the federal agency responsible for insuring individuals with disabilities as being an evidence-based service that is eligible for payment (or reimbursement) through public health insurance mechanisms (US Department of Health and Human Services, 2007, 2017). Research suggests that peer support has grown beyond traditional mental health settings and is now being delivered in an array of ancillary settings (Chinman et al., 2014; Cronise et al., 2016).
Peer and mutual support programs began in the USA as self-help and 12-step programs (Solomon, 2004) and ultimately evolved to address the needs of mental health consumers (e.g. Schizophrenics Anonymous; Salem et al., 1998). Several significant social movements and paradigm shifts have influenced this development including initiatives that emphasize the right to self-determination, that embrace a philosophy of “nothing about us without us,” and those that stress dignity, equity, and mutuality in helping relationships (Clay et al., 2005). As embodied in the Americans with Disabilities Act (US Department of Justice, Civil Rights Division, 1990), social justice and civil rights have become critical to the philosophical underpinnings of peer-delivered services. Clearly, what began as a fledgling and largely volunteer service based on mutual aid has evolved to include practice and ethical standards, reimbursement mechanisms, defined professional roles, and funded positions in many mental health settings. Together, these changes have greatly altered the landscape of behavioral health care services in the USA. However, the training, certification, and regulations governing peer specialists are uneven and there are many states and locales at present in which peer support is not currently available. A recent movement is underway from Mental Health America, one of the largest national mental health advocacy organizations in the USA, to provide a credentialing process that would cut across state lines and set a national standard for peer specialists in terms of training and certification (www.NationalPeerSpecialist.org).

**Early research on peer-delivered services**

Many of the early published writings in the USA that focused on peer-delivered services were descriptive, explicating core values, guiding principles, and key ingredients. There appears to be broad agreement about these values and principles which include an emphasis on non-hierarchical relationships, self-determination and choice, positive role modeling, reciprocity, support, sense of community, self-help, empowerment, “telling one’s story,” consciousness raising and education, acceptance of diversity, recovery, and advocacy, among others (e.g. Van Tosh and del Vecchio, 2000; Campbell, 2004; Solomon, 2004; Holter et al., 2004; Johnsen et al., 2005; Davidson et al., 2006). However, while there is consensus on the values underlying peer support, there is less clarity or agreement about job titles, roles, and tasks with peer specialists alternately referred to as peer mentors, peer support specialists, recovery coaches, among others. According to recent data, the job tasks of peer specialists also vary enormously, depending on the setting (Schwenk et al., 2009; Cronise et al., 2016).

In the USA, the International Association of Peer Supporters (INAPS) (www.inaops.org), a relatively new organization devoted to promoting peer support services and specialists, has developed an active national (and somewhat international) membership. They are a new professional association and provide a central repository of materials for peer specialists and information sharing. They have also participated in the development of guidelines for the delivery of peer services with the Substance Abuse and Mental Health Services Administration, the largest federal body funding and guiding mental health services. According to INAPS, consensus has been reached on the core ethical and practice guidelines governing peer support and peer specialists (see “National ethical and practice guidelines”). These initiatives to clarify and reach consensus about peer support, coupled with the recognition by federal entities mentioned above, suggest increasing acknowledgement of peer support as a valuable part of the mental health array of services. Evidence for what and how peer services affect the lives of those served is a critical next step.

**National ethical and practice guidelines:**

1. peer support is voluntary;
2. peer supporters are hopeful;
3. peer supports are open minded;
4. peer supporters are empathetic;
5. peer supports are respectful;
6. peer supporters facilitate change;
7. peer supporters are honest and direct;
8. peer support is mutual and reciprocal;
9. peer support is equally shared power;
10. peer support is strengths focused;
11. peer support is transparent; and
12. peer support is person driven.

Source: Promulgated by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, available at iNAPS.org

Evidence in the USA for the effectiveness of peer-delivered services

Early observational studies of peer services in the USA provided some evidence for the ability of peer services to enhance social networks, improve mental health and coping, reduce reliance on professional services, and increase social support (Kyrouz and Humphreys, 1996; Kyrouz et al., 2002; Van Tosh and del Vecchio, 2000); however, these studies lacked adequate controls and often did not differentiate between peer support and other types of peer-delivered services. Although peer-delivered services have grown, rigorous empirical evidence for their effectiveness vis-à-vis traditional or other services remains equivocal (Davidson et al., 2006; Pitt Lowe et al., 2013; Fuhr et al., 2014; Lloyd-Evans et al., 2014) and somewhat limited in terms of rigor (Rogers et al., 2009; Pitt et al., 2013; Fuhr et al., 2014; Lloyd-Evans et al., 2014). Recent reviews of peer-delivered interventions concluded that there was little evidence from high-quality studies to support their effectiveness (Bellamy et al., 2017; Lloyd-Evans et al., 2014; Pitt et al., 2013), while other reviews reached more positive assessments overall (Chinman et al., 2014; Fuhr et al., 2014; Repper and Carter, 2011).

Several recent randomized trials have yielded evidence specifically for the effectiveness of structured, peer-led interventions (e.g. Wellness Recovery Action Planning (WRAP); Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, Floyd, Hudson, Macfarlane, Carter, and Boyd, 2012; Cook, Steigman, Pickett, Diehl, Fox, Shipley, MacFarlane, Grey and Burke-Miller, 2012; Van Gestel-Timmermans et al., 2012) including a peer-led anti-stigma intervention (Russinhova et al., 2014). These studies found the peer-delivered interventions effective in terms of reducing symptoms and improving other subjective outcomes such as hopefulness, internalized stigma, empowerment, and recovery. However, while these group interventions are delivered by individuals with a “lived experience” they do not necessarily focus on the provision of individual peer support.

Empirical evidence for individual peer support

Few studies exist which examine individual peer support using rigorous research methods. One trial pairing peer mentors with individuals hospitalized for psychiatric episodes demonstrated fewer re-hospitalizations and hospital days (Sledge et al., 2011), but other recent studies involving the provision of individual peer support found modest or limited evidence (Eisen et al., 2012; Salzer et al., 2016; Rogers et al., 2016; Greenfield et al., 2008). Taken together, the literature to date suggests an inadequate empirical base for the effectiveness of individual peer support.

Continuing growth and understanding of peer support, but also ambiguity

In addition to understanding the effects of peer support, it is critical to understand how peer specialists are being integrated into the workforce. Cronise et al. (2016) conducted the largest known survey of peer providers in the USA to date. Detailed questions were posed about the roles, activities, training and supervision, and satisfaction level of almost 600 peer specialists across many states. While peer support specialists were first employed as adjuncts to traditional mental health services, results of this survey suggest that their roles and the settings in which they work have expanded significantly. As uncovered by Cronise and confirmed by other colleagues (cf. Balogun-Mwangi et al., under review; Swarbrick et al., 2016), many variations and extensions
of peer support are now taking hold including those that focus on physical health and wellness interventions, that support residential and employment interventions, and who provide financial literacy services, among others.

However, the survey conducted by Cronise et al. also confirms anecdotal information about the nature of the work performed by peer specialists. That is, while peer specialists report high levels of job satisfaction, they also feel undervalued by other mental health professionals, and report that their work roles are often ambiguous or not viewed as complimentary to other mental health or behavioral health care services. This finding was also articulated by Moran et al. (2013) in a qualitative study of the challenges associated with providing peer support. Clearly, more attention should be directed to understanding how we can integrate and support peer specialists in the workforce in order to create the most rewarding work experiences for peer specialists and meaningful outcomes for those served.

**The working alliance – parallels with the peer support relationship**

As described above, few studies exist which support the effectiveness of individual peer support and even fewer address the question of the mechanisms by which peer support may be effective. There have been no empirical efforts to “unbundle” the effective group-led services such as WRAP to determine what components are most central to improving people’s lives (i.e. is it the group support, role modeling from peer leaders, the educational material, or other features of the service which are potent?). Several recent qualitative studies have addressed the mechanisms by which peer support may be effective. For example, Cabral et al. (2014) found that recipients most valued the shared lived experience of mental health challenges with their peer specialists and viewed the peer relationship as helping to improve their mental health. Gidugu et al. (2015) drew similar conclusions in a qualitative study examining the effects of peer support which suggested that the shared “lived experience” was “a critical and unique dimension that cannot be duplicated by other mental health providers” (p. 450). Gidugu et al. found that other types of support (e.g. tangible support) and role modeling were critical components of effective peer support. Peer specialists were able to convey feelings of being listened to, respected, and valued as a person. These conditions in turn created an atmosphere of trust and openness, further laying the groundwork that enabled other types of emotional, practical, and social supports to be accepted and to yield positive change. More recently, in another qualitative study, Balogun-Mwangi et al. (under review), confirmed the necessity of the shared lived experience as being fundamental to forming a bond between the peer specialist and recipient of support services.

These studies are reminiscent of the volumes of research on the therapeutic alliance, also called the working alliance, or the helping relationship more generally. Though different in critical ways, this literature may provide a useful framework for understanding why individual peer support is effective. Some researchers have emphasized components of the helping relationship that center around the bond that is formed, the necessity of shared goals, and agreement about the tasks needed to achieve those goals (Horvath and Greenberg, 1991). The working alliance is the key relationship construct examined across all helping modalities and types of therapeutic interventions; it implies collaboration, partnership, and safety and is a process that fosters change (Horvath and Greenberg, 1991). The vast research base on the healing relationship confirms its centrality in the healing process (e.g. Horvath et al., 2011; Marsh et al., 2012; Tryon and Winograd, 2011). In the counseling and therapeutic literature, research suggests that the relationship is significantly related to outcomes (Horvath et al., 2011).

The “core conditions” of the helping relationship that were articulated decades ago by Carl Rogers (1975, 2007), operationalized and researched by others (e.g. Truax and Carkhuff, 2008), may be particularly relevant to the peer relationship. Rogers and other humanists suggested that the helping relationship needed to be person centered, a value highly regarded in the peer principles of self-determination and choice. He also stressed the importance of unconditional positive regard, empathy, warmth, respect, and genuineness. Regarding empathy, Rogers (1975) stated:

> The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the “as if” condition.
Individuals receiving peer support report the experience of feeling unconditionally regarded (Balogun-Mwangi et al., under review), as well as perceiving warmth, respect, genuineness, and immediacy that comes from both the shared experience and from transparency and self-disclosure in the peer relationship (“sharing one’s story”). These “core conditions” allow trust to build and set the stage for other practical assistance and tangible supports to be offered and utilized. Acceptance as a human being, and not a “patient” as well as the lack of being judged was repeatedly cited in the Balogun-Mwangi study as being critical to the peer relationship and different than many experienced with their mental health providers (Balogun-Mwangi et al., under review; Gidugu et al., 2015). As a result of demonstrating unconditional positive regard and empathy, Rogers (1975) stated “We can say that when a person finds himself sensitively and accurately understood, he develops a set of growth-promoting or therapeutic attitudes toward himself,” setting the stage to change.

In addition to the literature on the core conditions, “telling one’s story” is a key component of peer support and has a rich literature in psychology and other helping professions. Research suggests that self-disclosure when properly timed and matched to the person and the circumstances can increase trust for the discloser (Derlaga and Berg, 1987), a critical element in the peer specialist relationship. Recently, a large meta-analysis confirmed that self-disclosure strengthened the working alliance between counselors and clients, helped to build rapport and engagement, and may be an effective way to model reciprocal self-disclosure (Henretty et al., 2014).

Research and practical implications

Peer support services have burgeoned in the USA in the last few decades and are now in integral component of the mental health and behavioral health care system nationwide. Recently, peer support has received national recognition, a professional association has been formed, and there is now focus on standardizing the credentials which will promote national certification rather than piecemeal, state-by-state approaches. The Affordable Care Act was considered a mechanism which could bolster the peer specialist workforce (Myrick and del Vecchio, 2016); however, recent societal and political changes in the USA may alter that trajectory.

While there is general consensus about the values and principles that underlie peer support, there is less clarity about roles and tasks, or how best to use the skills and abilities of peer specialists to compliment other roles in the mental health system. Evidence for the effectiveness of group and manualized peer-delivered services has grown as the field has grown and there are now several systematic reviews of peer services because of that growth. Yet, the evidence for individual peer support has not kept pace with that for group-delivered and structured interventions such as WRAP (Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, Floyd, Hudson, Macfarlane, Carter and Boyd, 2012).

More research into individual peer support is needed with special attention paid to the mechanisms by which it is effective. Recent empirical evidence suggests that the “lived” and shared experience of having a psychiatric condition allows the relationship between peer and provider to grow and to be effective. The person-centered approach articulated by Rogers, including the necessary conditions of a helping relationship, as well as research into the helping alliance, and how self-disclosure can be best used to assist the recipient of peer support, are all concepts with a research base that may provide a framework to better understand and to research peer support.

Gaining more clarity about the roles and tasks of peer specialists and the mechanisms by which they are effective are related in that greater clarity about the effectiveness of peer support can assist the mental health field to better understand how peer specialists can improve the lives of individuals with psychiatric conditions.

References


Further reading


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Fay Jackson and Tim Fong

Abstract

Purpose – The purpose of this paper is to provide a perspective on peer work and insights from Flourish Australia’s journey in growing a thriving peer workforce. Flourish Australia is a large not-for-profit organisation that has been supporting people with their recovery journeys for over 60 years. The organisation provides, predominantly, non-clinical community-based support to enable people who live with a mental health issue and/or psychosocial disabilities to lead contributing lives in their community.

Design/methodology/approach – Flourish Australia developed and implemented a number of strategic directives in order to support the growth of a peer workforce. Central to these directives were policy positions that encouraged a shared understanding of the value and contribution that people with a lived experience of a mental health issue add to an organisation. From this policy foundation, the Why Not a Peer Worker? strategy and Transformation Peer Worker strategy were implemented and embraced by hiring managers across the organisation.

Findings – The “Why Not a Peer Worker?” campaign, coupled with the Transformation Peer Worker strategy, resulted in an increase in Flourish Australia’s peer workforce of almost 600 per cent over an 18-month period to now number 145 positions.

Research limitations/implications – This paper provides organisations who are seeking to develop or grow their peer workforce with practical ideas that have been successfully implemented by Flourish Australia that can be discussed and debated when developing a peer workforce.

Originality/value – This paper provides unique insights into Flourish Australia’s peer workforce journey.

Keywords Mental health, Recovery, Lived experience, Human resources, Mental illness, Transformational change, Peer workforce, Peer work, Peer worker, Mental health issue, Recovery journey, Recovery Action Framework

Paper type Case study

Peer work

In the past, peer work has been viewed by many as being little more than conversations and coffee shared between two people who have experienced a mental health issue. Peer work is much more than this, but even on this level there has been little recognition of the strong value of this connection, sharing and conversation.

Arguably, peer work has also been thought of as an unskilled profession; a role with low or little expectation or validity; and one that is not required to perform to a professional standard. In some instances, peer work has been seen as work that people do and do not get paid for, or is disguised within another role.

Peer work has proven its worth to people who access services, carers and families, to organisations and services, clinical and non-clinical staff alike, and to funders and decision makers. There is now a growing empirical evidence base that is reinforcing the efficacy and impact of peer work (Repper and Carter, 2011; Repper et al., 2013).

In Flourish Australia, peer work has played a vital role engaging with people accessing mental health programmes, staff and other support services. By drawing on lived experience of a mental health issue, peer workers are able to build respectful, professional, and appropriate relationships that are based on mutuality, reciprocity, and above all, hope.

We have found that peer work offers many advantages to the person receiving the support. Having a shared identity and acceptance, increasing emotional resilience, the development of...
new skills and sources of independence, and improved mental health and wellbeing are just some of these benefits to the person receiving the support.

The peer workforce has now had decades of experience, honing ethical ways of supporting people who have been traumatised and have experienced severe psychological distress and recovery. In Flourish Australia, peer workers have acted as a soothing balm from the distress and trauma that people often experience in clinical and other therapeutic treatment settings. They have walked alongside people on their recovery journeys.

With all these benefits and more, the question that must be asked is not why would we have a peer workforce, rather, why would we not want a large peer workforce to support not only the people experiencing psychological distress, their families, carers and communities, but to also complement and empower teams to provide the most healing culture a service and workplace can provide?

How Flourish Australia grew its peer workforce

Flourish Australia operates across 64 sites throughout New South Wales and South East Queensland, two Australian states. Our workforce consists of approximately 700 staff with almost 50 per cent of those staff openly and proudly identifying as having lived experience of a mental health issue. Flourish Australia supports around 4,700 people with lived experience annually.

Flourish Australia’s peer workforce journey was not hurried. In fact, our journey into understanding peer work in the mental health sector commenced in 2002, well before many other comparable organisations began to do it. In these early days, Flourish Australia realised the positive effect that peer work had on supporting people with their recovery journeys. Although the empirical evidence base was still evolving, Flourish Australia noticed a positive impact between peer worker and the person receiving the support. At this time, and what has not changed since these early days, is that peer worker roles were real, paid jobs – people with lived experience of a mental health issue were placed into jobs that demanded the personal experience of a mental health issue as a core role requirement.

Flourish Australia has stayed true to the essential requirement of a personal lived experience of a mental health issue being pivotal to the peer worker role. We have embedded what peer work means and, importantly, have ensured that this meaning is clearly conveyed through all levels of the organisation.

The commitment to growing and supporting a peer workforce as a profession takes considerable effort. It also takes leadership from experts who have a personal lived experience of a mental health issue and who have the necessary mandate to challenge an organisation to think more laterally about what peer work means to them and what peer work can offer to the people accessing their service. Flourish Australia was mindful of meeting the challenge so that the existing workforce fully understood how peer work contributes a unique set of skills within a multi-disciplinary environment and how that was relayed in policies and procedures.

Most organisations are cognisant of the complexity involved of embarking on any transformational change management process, particularly when a change in workforce composition is involved that will need a change in workplace culture to succeed. Before Flourish Australia began contemplating growing a peer workforce, it was important that the organisation was fully engaged, committed and understanding of the reasons why. It is important that organisations accept that peer work is a value-adding proposition that brings with it a unique set of skills to the workplace.

Flourish Australia has a clearly stated organisational commitment, and organisational “culture” that identifies our workforce as leaders in person-led recovery-oriented and strengths-based support services. This has provided an essential foundation. Importantly, people with lived experience are the focus of all Flourish Australia’s work and are collaborative partners in determining the organisation’s development, direction and evaluation. People with lived experience play an integral role in informing our efforts in growing and developing the peer workforce.

Flourish Australia agreed from the outset that the jobs for peer workers must always be “real” jobs with realistic expectations and good employment conditions, be well supervised and
provided quality opportunities for learning and development. Peer workers become part of a multi-disciplinary staffing establishment and do not take away from other disciplines. It is the opposite; they enhance an organisation’s service offering by providing personal knowledge and experiences that can impel other disciplines to create more holistic and effective support programmes.

As such, the value of peer work is not just restricted to the person with a mental health issue receiving the support. Peer work brings to the workplace a unique insight into the experiences of people living with a mental health issue. It is this insight that represents peer work’s point of difference and organisations can leverage off this insight to develop a new level of deep understanding about what it is truly like to live with a mental health issue. This can only lead to increased empathy and better outcomes for people accessing mental health services.

Flourish Australia identified that the growth of their peer workforce seemed to be losing traction and a more concerted strategy was needed to invigorate efforts and drive their policy direction.

In May 2015, Flourish Australia instituted the affirmative action strategy that consisted of two main policies. The first was a strategy named “Why Not a Peer Worker?” The strategy affirmed that for every vacant position that worked directly with people with a mental health issue, before being advertised or filled, hiring managers must respond to the question; “Why Not a Peer Worker?”.

Flourish Australia required hiring managers to provide reasons why a peer worker should not be considered for a vacant position that worked directly with people with a lived experience of a mental health issue.

Challenging hiring managers to justify why a peer worker could not fulfil the role that would have had been historically filled by a non-peer work role proved to be very effective. In Flourish Australia’s experience, there were very few circumstances that would justify not appointing a peer worker to a position. Challenging managers to think more intently about peer work was the first hurdle that was required to be successfully navigated.

The next step was to ensure that hiring managers maintained efficacy with recruitment practices and understood the importance of maintaining fidelity and preserving merit-based recruitment. A fundamental failure point for any recruitment practice is not following this mandate.

In instances where a suitable peer worker was not identified through a recruitment process, and where there was an urgent need to fill a vacancy, the recruitment campaign would revert back to the vacancy that existed before the peer work position was put forward. This option provided hiring managers with a great deal of comfort and reinforced our position that merit-based selection must apply. However, this only occurred after a peer work option had been thoroughly exhausted and hiring managers were required to demonstrate to their senior manager why a suitable peer worker could not be found. And accountability was ensured by the entire recruitment process being reported at the executive level.

The second strategy that was engaged in an effort to grow Flourish Australia’s peer workforce was to provide existing employees with a lived experience of a mental health issue to apply for their existing position to be transformed into a peer work role. The “Transformation Peer Work” Strategy proved to be another effective means of growing Flourish Australia’s peer workforce.

How Flourish Australia overcome resistance to peer work

The majority of Flourish Australia’s service offerings are non-clinical. However, this did not prevent our public sector partners making requests of non-clinical staff to provide clinical functions. One such practice was the request to manage and dispense medication to people accessing the service. Flourish Australia’s peer workers do not engage in activities that require clinical training...
and experience. In fact, none of Flourish Australia’s non-clinical workforce have this mandate. It soon became apparent that where non-clinical staff were requested to complete clinical tasks, this had the effect of stifling any chance of growing the peer workforce in these areas.

Flourish Australia found that non-clinical staff engaging in work of a clinical nature have the effect of changing the nature of the relationship between the person in receipt of the support and the employee. This could not be allowed to take place between the peer workers and the people accessing the service. Although Flourish Australia recognises that medication plays an important role in people’s recovery, clinical practices belong to people who are clinically trained. We identified that more work needed to be done with our clinical partners to change policies and work practices and to design better and safer ways for people to access and administer medications.

Ensuring that hiring managers have the correct information available about peer work was also important in overcoming resistance to growing a peer workforce. Flourish Australia developed a peer work “myth busting” programme bringing hiring managers together and provided the opportunity to dispel some of the peer workforce myths that would have otherwise stymied any chance of growing the peer workforce.

Another example of ensuring Flourish Australia overcame resistance to peer work was to bring all senior managers together and provide them with the opportunity to discuss any concerns they had about growing the peer workforce. Senior managers were provided with an opportunity to seek assurances that peer work is subject to the same organisational policies and expectations that apply across the organisation. As the conversations proceeded, an echo of commonality developed.

Once a common understanding had been reached with regard to employment practices, the issue of what peer workers actually do was then addressed. Copies of non-clinical frontline staff position descriptions were reviewed with senior managers. As the position description was being reviewed, the group would discuss the duty or responsibility and if there were any impediments to peer workers carrying out those duties or responsibilities. It was found that in “actual fact” there were no impediments to peer workers carrying out the work that another non-clinical staff were currently performing. Furthermore, the use of lived experience purposefully in everyday work was recognised as a value-add. The meeting was adjourned with a renewed understanding of peer work and the ability to support, manage and grow a peer workforce.

Supporting transformational change

To succeed in developing and/or implementing an effective value-added peer workforce, open, and sometimes robust, discussions at a senior level are crucial – in the same way they are crucial to introducing any major change. These discussions provide the platform helps the organisation decide if it is ready, and has the capacity, to successfully implement, grow and support a peer workforce. The state of readiness and capacity of an organisation to embrace and grow a peer workforce should be thoroughly assessed before embarking on the peer work journey.

The process that led to the adoption and implementation of the “Why Not a Peer Worker?” strategy coupled with a “Transformation Peer Worker” strategy was carefully planned and managed over a 12-month period. It was underpinned by executive sponsorship and a foundation of supporting policies and procedures (Meagher et al., 2013). The key supporting policies for these strategies were Flourish Australia’s Embracing Inclusion Policy and the Recovery Action Framework (RAF) (Flourish Australia 2014).

The “Embracing Inclusion: Employment of people with lived experience” Policy (2014) affirms our commitment to employing people with lived experience of a mental health issue, describes how we will support people at work and confirms the importance of growing our peer workforce. The policy describes Flourish Australia’s experience in actively pursuing the employment of people with lived experience of a mental health issue and sets clear goals. Embracing Inclusion (2013) sets out how we will achieve clear goals and a commitment from the organisation on how to get there.
Following on from the Embracing Inclusion Policy (2013), Flourish Australia’s RAF (2014) was co-developed with people with lived experience and staff, endorsed by our board and then implemented. The impetus for the RAF was our realisation that two vital questions needed to be resolved:

1. How do we inform attitudes and behaviours of staff, partners and the people who access our services to make them more supportive of recovery?
2. What do we need to do to achieve continuous improvement across the organisation to fully implement recovery practices?

Our work was inspired by the UK Centre for Mental Health’s Implementing Recovery through Organisation Change (ImROC) programme and particularly its “Ten Organisational Challenges” (Shepherd et al., 2010). However, we added a slightly different focus and developed 8 organisational accountabilities.

The RAF spells out the “8 Organisational Accountabilities” with associated activities that help us improve our recovery-orientation and that we thought essential to providing the best services Flourish Australia can provide. These were supported by three vital behaviours we identified underpinned our commitment to recovery-oriented services:

1. encourage each other to use strengths-based language;
2. hold recovery conversations; and
3. engage in reflective practice.

The 8 organisational accountabilities, which are stated clearly so that they are adhered to (Table I).

The organisational accountabilities emphasise our fundamental commitment to people with a personal lived experience of a mental health issue who access Flourish Australia’s service. They are our collaborators in service development, service delivery, the management of mental health services and service evaluation.

Key lessons from the “why not a peer worker” approach

Role clarity

Peer workers are not helpers. Best practice in peer work ensures that they are personal supporters, facilitators of change and bearers of hope. Peer workers model resilience, recovery, hope, a “can do, even if you don’t feel like it” attitude, commitment to improve their own lives and contribute to the improvement of others.

The peer worker role requires people to use their lived experience in their everyday work in an appropriate, purposeful and timely manner. If a person does not have a personal lived experience of a mental health issue, how is this inherent position requirement achieved?

<table>
<thead>
<tr>
<th>Table I</th>
<th>Flourish Australia’s eight organisational accountabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational accountability 1</td>
<td>Our day-to-day interactions with people and the quality of their experience will support them to follow their own unique path</td>
</tr>
<tr>
<td>Organisational accountability 2</td>
<td>Our comprehensive applied research, development and training programmes (either within Flourish Australia (previously RichmondPRA) or from external sources) are approved of and/or designed, led and delivered in partnership with people with a personal lived experience of a mental health issue</td>
</tr>
<tr>
<td>Organisational accountability 3</td>
<td>We have a clearly stated organisational commitment, and organisational culture that identifies our workforce as leaders in recovery-oriented, strengths-based and person-led support services</td>
</tr>
<tr>
<td>Organisational accountability 4</td>
<td>Our services will be person-led, supporting people to make individual choices focusing on their strengths, their desires and potential to change and learn</td>
</tr>
<tr>
<td>Organisational accountability 5</td>
<td>We will help people develop their own plans that are strengths and recovery focussed, working in partnership and supporting dignity of risk (wherever legal) instead of being unreasonable risk adverse</td>
</tr>
<tr>
<td>Organisational accountability 6</td>
<td>People with personal lived experience are active collaborators in everything Flourish Australia does</td>
</tr>
<tr>
<td>Organisational accountability 7</td>
<td>We support staff in their recovery journey whilst maintaining expectations of professionalism and accountability</td>
</tr>
<tr>
<td>Organisational accountability 8</td>
<td>We provide opportunities for people to build a life beyond or in-spite of symptoms, past traumas or choices, which have hindered people living the lives they would wish for</td>
</tr>
</tbody>
</table>
Role clarity is paramount if the peer worker position is to be provided with the best chance to succeed and to fully integrate into an existing workforce. And, importantly, people employed in peer work need to understand how to use their lived experience in an appropriate and effective manner to connect with people.

Given this, Flourish Australia found that it is not advisable to confuse the peer worker role with other forms of peer work. From the experience of Flourish Australia, a peer worker role needs to be clearly expressed as an individual who has a personal lived experience of a mental health issue. This by no means devalues the contribution of other peer work roles, such as peer workers from a carer background, but it does emphasise that to do peer work, it is a requirement to have a personal lived experience of a mental health issue.

Utilising people with vicarious exposure or experience in peer worker roles but do not have a personal lived experience of a mental health issue, although well intended, may have the unwanted effect of diluting the significance that a personal lived experience has on the effectiveness of peer work. As such, any strategy or commitment to growing a peer workforce must clearly delineate between different types of peer work and the intended purpose of the peer worker position.

Peer workers who think critically, strategically and are visionary also contribute a great deal of value to shaping service delivery models, policies, protocols, connecting with stakeholders, building bridges between communities, strategic plans and all other components of a good service and healing community.

Providing support for peer workers that is based on usual processes for staff members

Peer workers abide by ethical boundaries that ensure people do not become dependent upon them or lead to complications that may inadvertently lead to compromised wellbeing for one or both parties. Peer workers support the people they serve to build healthy relationships with their families, friends and to discover new relationships.

Not everyone is ready to fulfil the role of being a peer worker. Peer workers need to have good interpersonal skills, be non-judgemental, fair, patient, have a willingness to listen, be solution orientated and display empathy. A peer worker needs to be at the right place in their recovery journey that means they can mentor and support others, develop the skills required for peer work, and keep themselves well.

It is important to re-emphasise that peer work, like all professions, is subject to the same workplace expectations as apply to all employees. A peer worker is not appointed to a position just because they have a lived experience of a mental health issue. Peer workers are appointed to roles because they meet the inherent requirements of the position and have demonstrated that they can be effective in using their lived experience in every day work.

Once employed within Flourish Australia, peer workers are subject to the same organisation policies, procedures and expectation as all other employees. This normalisation of workforce expectations cannot be over-emphasised. Peer work is subject to the same work expectations, the same productivity levels, and is subject to the same organisation policy and procedure framework as all other positions. In fact, a peer worker should additionally be expected to build and uphold a respected culture of peer work both within the organisation and external to the organisation.

Having a mental health issue does not excuse a peer worker, or any other employee, from underperforming in their role. Although a mental health issue is not an excuse for underperformance or poor conduct in the workplace, organisations do need to be mindful of mitigating circumstances. It is important to explore reasonable adjustments when addressing concerns that may arise in the workplace, but this is equally true for all employees.

If a peer worker is not working to a high standard and to their position description within Flourish Australia, they may be asked to undertake further training, mentoring, and possible performance management. It is important to note that there is very little difference in what is required with
respect to the performance and conduct of a peer worker and other designated lived experience roles to any other employee.

If performance concerns arise in a workplace, in any position that relates to a person’s health or personal situation, it is unlawful in Australia, and in many other countries, to make decisions based on those personal circumstances. In fact, in Australia it is a requirement to explore reasonable adjustments in the workplace, where needed. The emphasis is on the word “reasonable”.

Reasonable adjustment is often misunderstood or misinterpreted by organisations or individual employees. The intent of reasonable adjustment is to explore the “reason” for the requested adjustment, if it is possible (or we are “able”) to make an adjustment in the workplace without causing undue hardship, causing the inherent requirement of the position description to significantly change, or placing an unreasonable financial burden on a service or organisation.

In the main, there are no differences in supporting a peer workforce as supporting any other part of the workforce. If you ask any employee what they value the most when at work, they will tell you that they want to be treated like everyone else in the team. Employees want transparency in work practice, responsiveness when flexibility is needed, and equality and recognition for the work they do. People with a lived experience of a mental health issue want to have the best opportunity to perform their duties to the highest standard. They want the opportunity to prove that they are valuable members of the workplace and the community. And they too want reasonable adjustment in the workplace if available.

As with any profession, sometimes effective professional support can be provided by people from similar training and backgrounds, and not necessarily entirely from a direct line manager. For example, as nurses benefit from the support and guidance of a more senior or specialist nurse, peer workers benefit from the support and guidance of a more senior or experienced peer worker. This does not devolve the line manager’s responsibility to provide day-to-day support and guidance to the employee, but rather recognises that the responsibility for an employee’s professional development is richer if shared by suitably qualified professionals.

**Concluding remarks**

The question is no longer whether mental health organisations need a peer workforce. The challenge is to identify how best to incorporate peer work into an organisation delivering a mental health service so it becomes an important part of the culture, and an essential part of its success. Peer work strengthens an organisation’s service offering, provides a value-add proposition to an existing workforce, and neatly aligns to organisation’s mission statements and increasingly government mental health strategic plans.

Peer workers must be treated the same as all other employees. They must have equal rights and equivalent pay according to the position being performed. Their contributions must be valued. However, coupled with receiving equality of employment comes equal responsibility for peer workers to deliver a high standard of support for the people who access mental health services, and to fulfil all other duties expected of a peer worker just like any other staff member.

The “Why Not a Peer Worker?” and “Transformation Peer Worker” Strategies were extremely successful in growing Flourish Australia’s peer workforce over a relatively short period of time. The strategies resulted in the added benefit of imploiring hiring managers to develop a greater understanding of peer work. These strategies became an important aspect of the transformational change process needed to develop a collegiate culture that recognises the significant contribution that peer work brings to people with a lived experience of a mental health issue.

The challenge for mental health services and organisations, clinical and non-clinical staff alike, as well as for funders and decision makers, is not to have discussions about peer work stymied by a validity and efficacy debate. The emphasis and commencement point should start with a simple turn of phrase: “Why Not a Peer Worker?”
References

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Peer support in community settings: getting back to our roots

David Crepaz-Keay

Abstract

Purpose – The purpose of this paper is to look at peer support in the context of broader communities.
Design/methodology/approach – It builds on the author’s experience working with the Mental Health Foundation of developing delivering and evaluating several self-management and peer support initiatives in a variety of settings with a range of different peer groups. It will consider what constitutes a peer and a community, and explore the notion of community solutions for community problems.
Findings – Peer support in community settings has the capacity to address social isolation, build skills and self-esteem and give individuals a better quality of life – it can also add value to whole communities and reframe the way entire groups are considered within them. It has the ability to be both more accessible and less stigmatising and thus reach more people. This also offers community based peer support as a contributor to preventing the deterioration of mental health and potentially reducing the impact of mental ill-health.
Social implications – The author needs to think more in terms of whole community and get better at improving how the author measures and articulates this community benefit. This will allow us to make better decisions about how best to apply resources for long term whole community gain. Peer support and peer leadership needs to be at the heart of this process.
Originality/value – This paper places a familiar approach in a different setting placing peer support firmly outside services and within communities.

Keywords Leadership, Community, Peer support, Mental health

Paper type Research paper

Introduction

Peer support in mental health is a high-profile subject, the recently published UK the “Five year forward view for mental health” (Mental Health Taskforce, 2016), for example, highlights just how important it is to creating sustainable mental health services. Peer support is, however, nothing new, and is certainly not the exclusive preserve of the mental health field, a recent study (NESTA and National Voices, 2015) identified over 1,000 research papers on peer support from across the world covering a range of long term physical and mental health conditions. Beyond health conditions, peer support has been established for healthy behaviours such as weight loss, smoking cessation and managing addiction. Just within mental health, a great variety of peer support approaches exist; some of which are explored in detail in this journal and elsewhere (see, e.g. Crepaz-Keay and Cyhlarova, 2015). This paper will focus on peer support with a mental health context, located in broader community settings.

Peer: a person of the same age, status or ability as another specified person (OUP, 2017)

In order to explore peer support in more detail, it is important to understand what is meant by a peer. From the preceding dictionary definition, “status” is probably the most apt of the stated peer criteria. For the most part, in mental health this is taken to mean at least a shared experience of mental ill-health or service use, or even psychiatric diagnosis, and it has been argued that peer support requires “other shared experiences, identities and backgrounds” (Faulkner and Kalathil, 2012). This is particularly important in community settings where people may not be explicitly
sharing their psychiatric or service use background. The Mental Health Foundation has
developed a range of peer support initiatives, starting with secondary mental health service users
(Crepaz-Keay and Cyhlarova, 2012) and transferring the learning to other potential peer groups.
We have often found that even where shared experience of service use is explicitly part of
community based initiatives, peer groups benefit from other shared experiences including
(but not limited to) age, ethnicity, gender, geographic community and experience of other long
term conditions, disabilities or even family circumstances.
The Mental Health Foundation has used this experience and learning to develop peer support for
groups who experience either elevated risk of mental ill-health or poorer mental health, including
prisoners, single parents and members of the armed forces. For these groups, mental health is
often a taboo subject and peer relationships become the primary focus, with mental health as a
secondary issue.

Community: a group of people living in the same place or having a particular characteristic
in common (OUP, 2017)

To consider peer support in community settings it is worth looking at the roles the community as
an entity can play. This could take a number of forms:

- being a physical or geographic location for service provision;
- being a collection of assets available to provide support;
- as a collection of interdependent people whose relationships constitute a community; and
- as an entity that could have collective mental health.

Although communities are evolving and new types of communities building on the infrastructure
provided by social media now sit alongside the more established concepts of communities of
interest and other non-geographic communities; geographic communities are still the most
significant entity for most people. Recent guidance in England (Public Health England and NHS
England, 2014) identifies that both place-based, and where people share a common identity or
affinity, have a vital contribution to make to health and wellbeing, and that these communities
should be seen as assets and contributors rather than the location of a government policy.
This should mark a shift from the concept of delivering mental health services in community
settings (DH, 1990) which followed the closing of the long stay psychiatric asylums.

Community solutions for community problems

The notion of addressing mental health problems through community solutions is certainly not
new. The historic example of Geel in Belgium demonstrates community support for people who
experienced mental ill-health from the thirteenth Century, and possibly much earlier (van Bilsen,
2016). The idea of a whole community approach to community mental health is probably better
demonstrated in the work of Franco Basaglia and colleagues in Gorizia and Trieste in Italy in the
1960’s and 1970’s (Schepers-Hughes and Lovell, 1987), which, unlike the more separatist
therapeutic communities associated with the anti-psychiatry movement in the UK, marked a
significant attempt to engage whole communities using cultural approaches to community mental
health. This heritage has been built on in East Lille in France where many issues which would be
seen as clinical concerns of individual patients elsewhere are seen as civic issues for local civic
bodies to address (Crepaz-Keay et al., 2015; Roelandt et al., 2014). It also recognises the
contribution of collective peer activity to this (Mezzina et al., 1992).

But the focus remains on fixing broken individuals, underpinning the notion that mental illness
remains a fault within the patient, although the discussion includes more people and is no longer
purely biochemical. There is even a risk that some models of peer support can reinforce this.
This could happen by, for example, peer workers who have “recovered” showing their peers how
they too can “recover”. A more radical approach, one which requires a shift in thinking away from
the broken individual, would be to consider what really affects people’s mental health rather than
what causes mental illness.
Mental health: a person's condition with regard to their psychological and emotional wellbeing (OUP, 2017)

There are many ways to describe, define or measure mental health and wellbeing. The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) (see Tennant et al., 2007) is widely used (the Mental Health Foundation has used it to assess the impact of our peer support work (Cyhlarova et al., 2015)). The scale includes a number of items that are about the relationships between people rather than individual symptoms and this emphasises that mental health exists, at least in part, in the relationship between people. Many people who experience mental ill-health feel isolated, experience discrimination and often have low self-esteem, and public attitudes to people who have a psychiatric diagnosis often reinforce these problems (Thornicroft, 2006).

The isolation and discrimination were not addressed by the relocation of mental health services from institution to community. The transfer did, however, mark a distinct change in the ethos of mental health services from dependence to independence. Though this was an improvement and certainly offered a stepping stone to improved self-esteem, the individualistic nature of independence as a goal did little to challenge isolation or discrimination. If, however, it is a stepping stone towards interdependence, which recognises the importance of relationships between people, then it can start to contribute to a broader whole community approach based on relationships between people rather than problems with individuals (Crepaz-Keay et al., 2015). These relationships start to look like a community, particularly when they involve reciprocity and acknowledge that everyone has something to offer, and everyone has needs (exactly the elements which WEMWBS picks up with questions like: “I’ve been feeling useful; I’ve been feeling interested in other people; and I’ve been feeling close to other people”).

More recently there has been explicit thinking on community mental health (Goldie et al., 2016) which has two broad ambitions: first, to apply a socio-ecological approach to mental health improvement that aims to work across the multilevel of individuals, families, communities and structures (including settings such as schools, prisons and workplaces); second, to make use of available community resources and support social inclusion by developing social prescribing through local health and social care professionals and ensure that mental health improvement is viewed and measured as a central outcome in community investment and regeneration actions.

What does it mean for mental health peer support if communities are collections of interdependent people and other assets and we stop thinking about them as a location for mental health service delivery? If we start by acknowledging that there are inequalities within communities (and that these inequalities include unequal distribution of health and wellbeing, resilience and vulnerability and skills and abilities, including those skills relating to relationships) then we can see that some building and maintenance work needs to be done.

Peer support offers an effective tool to contribute to this process. One of the recent Mental Health Foundation projects, Creating Connections, has built peer support for single parents. Established in Newport and Cardiff in South Wales, an area where historically single parents have been perceived as a problem and a cause of problems, the project has used peer support to harness single parents as a community resource. Building on the experience of previous projects with mental health service users, but also recognising that many single parents (predominantly mothers) had both a high risk and prevalence of mental ill-health combined with a strong resistance to seeking help (because they perceive a risk of having their children taken into care and negative behaviour towards them and their children in schools and other settings) the project focussed on increasing wellbeing and working together to produce resources for the broader community.

Peer leadership

Creating Connections, like its predecessors, has been designed and delivered by peers of the beneficiaries. We describe this as peer leadership. Peer leadership takes the phrase “expert by
experience” not as a bland assertion, but rather as a technical progression from having characteristics, traits or experiences that are perceived as a problem for others to solve, to being an active participant in a diverse community through the development and application of individual and collective skills and resources (Goldie et al., 2016).

We explicitly recognise the value of the experience of being a single parent alongside the challenges it brings. We help people reframe their self-perception and how others see them. This is common across all our peer support projects and one of the most frequent benefits people report is that it is the first time they have been given the opportunity to help someone else. This simple statement underpins the real benefit of peer support wherever it takes place, but it is particularly important in community settings where it makes the concept of asset based approaches come alive.

Many people with poor mental health or who experience mental ill-health do not use specialist mental health services at all; either receiving support through primary care, or through the voluntary sector (possibly even as a service primary care could refer to when explicit mental health support may not be appropriate). For these people, peer support is possible only where it is embedded in community settings. For some, our single parents, for example, it provides an alternative to mental health support which is both more tailored and less stigmatising than a mental health service. In these situations, it also has the potential to contribute as a preventative measure, reducing the risk of mental health deteriorating.

People become part of a community not just by being included, but by bringing something to the community and being given the opportunity to contribute. Clearly any contribution needs a recipient, and peer support provides an excellent balance of opportunities to share and exchange skills as well as building capacity. As this capacity grows, so does the number of potential beneficiaries. What starts as a small peer group of people helping each other (though usually led by one or two people with more experience) can expand to other groups within the community. Our peer support group members have gone on to establish among other achievements, a community choir, community social events, broader educational work and sustained peer support well beyond funded projects.

**Blocks, barriers and challenges**

Peer support in community settings is not straightforward. Although operating without the constraints of established mental health services or existing service settings offers a degree of freedom and flexibility, it adds logistical and resource issues and reduces access to existing locations and administrative support that may be on offer to service based peer support. We have found that the most constructive approach to these challenges is to support peer groups to take on responsibilities for themselves. In some cases, this is a slow process and additional support is required for many months, in other cases one or two people, often those with previous leadership or administrative experience, can take on the roles as part of their new peer leadership roles.

Most of the peer groups we develop or work with experience multiple disadvantage or discrimination. This means people may be marginalised within the broader community, they are likely to be poorer than average and more likely to experience other health difficulties. This may make them reluctant to take part in collective activities; many will not feel part of the broader community. This social isolation is a key issue that both underpins mental health difficulties and can easily be reinforced by them, this may be even more of an issue in rural settings and for some community groups (Faulkner and Kalathil, 2012).

Caring responsibilities can also isolate and constrain people. Caring responsibilities can increase the risk to people’s mental health and reduce their ability and capacity to engage more widely. Understanding and resolving this has been a key part of our work with single parents. The starting point was making sure that the caring needs were identified and, where necessary, resources such as child care were made available to facilitate meetings as peer groups were developed. As the groups evolved, people began to support each other in the caring responsibilities and what started as additional needs and barriers often became the focus of effective peer developed resources.
How do we know if it is working?

The evidence for the effectiveness of peer support is established and growing. There is good evidence to suggest that peer support works. A major review identified evidence that peer support had been found to (taken from NESTA and National Voices, 2015):

- have the potential to improve experience, psycho-social outcomes, behaviour, health outcomes and service use among people with [...] mental health conditions;
- potentially improve experience and emotional aspects for carers, people from certain age and ethnic groups and those at risk, though the impact on health outcomes and service use is unclear for these groups;
- be most effective for improving health outcomes when facilitated by trained peers[...];
- work well when delivered face-to-face[...];
- be most effective for improving health outcomes when it is based around specific activities (such as exercise or choirs) and focus on education, social support and physical support; and
- work well in a range of venues, including [...] community venues.

Whole community benefit

Where there is a need for much more evidence (and even some reliable tools) is broader community benefit. It would help to make the case that mental health requires community solutions to community problems as an alternative to the traditional fixing broken individuals.

There are a few obvious indicators that are currently (if not always easily) available to test these community benefits. Many cost benefit analysis tools can show the potential economic benefit of peer support (Iemmi et al., 2015) which clearly offers benefits to the whole community. There has been considerable work on return on investment and social return on investment which may also contribute. The creation of community resources can also provide tangible measures of benefits, particularly as these become more broadly accessible. More could be done to identify and quantify the community benefits of collective activities and to shift further from think of these as simply the sum of individual benefits.

Realist evaluation (Pawson and Tilley, 1997), a methodology of growing importance in social research, which uses a model of contexts, mechanisms and outcomes to evaluate processes in real world settings, may help to increase our understanding of how peer support benefits communities as a whole, rather than aggregating individual benefits. Realist evaluation can help us to understand how, for example, social context will have an impact on outcomes and what processes are important rather than testing “active ingredients” as if peer support were a drug treatment used in a randomised control trial.

Conclusion

The move away from institutional care is generally regarded as progressive, but we have also lost some of the incidental benefits that accrue from people with a common experience spending a significant amount of time together. Peer support was a common and intrinsic part of life in a psychiatric hospital but the days of this as a catalyst for collective activity are long gone. Peer support services in mental health settings may fill this gap for those who are receiving care in acute- and high-dependency settings, but there is a complementary need for people when they leave these services.

Some of the physical institutions may have been torn down, but institutional thinking and the fear of difference lives on and deters individuals, families, teachers and employers from supporting each other or seeking help. What peer support within the community does is relocate mental health within the human experience of living as collective beings, getting away from the years of being seen as “other” which needed to be dealt with in special places by special people.

Peer support in community settings has the capacity to address social isolation, build skills and self-esteem and give individuals a better quality of life – it can also add value to whole communities and reframe the way entire groups are considered within them. It has the ability to
be both more accessible and less stigmatising and thus reach more people. This also offers community based peer support as a contributor to preventing the deterioration of mental health and potentially reducing the impact of mental ill-health.

To achieve this potential, we need to think more in terms of whole community and get better at improving how we measure and articulate this community benefit. This will allow us to make better decisions about how best to apply resources for long term whole community gain. Peer support and peer leadership needs to be at the heart of this process.

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Just a peer finding my way in a crisis house

Carlina May Whitmore

Abstract

Purpose – The purpose of this paper is to share reflections and key learning points from the experience of offering peer support within a crisis house setting.
Design/methodology/approach – A reflective account of experiences of offering one-to-one peer support and the learning that has been taken from these experiences.
Findings – Key reflections centre on the importance of being emotionally honest and supporting personal well-being while offering peer support.
Originality/value – While there is a great deal written about the theory of peer support work, few first persons accounts of peer working have been published. This paper provides important insights into the nature of peer support work.

Keywords Crisis, Peer support, Personal account, One to one

There is no rulebook on how to be a peer, no solid list of things to do and say when people are in crisis and certainly no manual on how to build relationships and connect with our fellow humans.

Two years ago, I embarked on my journey into the world of peer support at Haven House, Nottingham’s brand new six-bed crisis service. I stepped into Haven House feeling I knew everything about being a peer (I didn’t), I thought I was prepared (I wasn’t) the truth is that out of the safety of the training room I felt lost, however I quickly found my feet and established my own way of working. I am in no way suggesting this is an approach others should follow, this is just my approach and my personal experiences of being a peer support worker in a crisis house.

Keep it simple and you will blend in fine

It was my 1st week in the house and everyone seemed to have a job to do, a routine of paperwork, support plans, risk assessments, and numerous other tasks were being handed out left right and centre. Meanwhile I felt as though I had done little more than float around wondering what I was meant to be doing. I would have been more than happy to partake in the mandatory routines of the house but it was decided my role would be different and I would be free to mould it.

I was bombarded with questions from my colleagues “what is a peer? What is your role? What do you do?” In my mind, all I heard was “What makes you different to the rest of the team” and all I felt was I needed to justify my existence in the house. I felt like I stuck out like a sore thumb, the token mad woman that didn’t quite fit in. I answered with definitions of peer support and huge chunks of my story which all too often left me feeling over exposed and I hadn’t really answered the question. I quickly realised a simple reply would be enough and so I settled on “I have a lived experience and give support”.

And so, I became accepted, I was a valid member of the team.

Now that I had mastered introductions how would I approach the guests?
Anne

I had just come out of handover armed with all this information about Anne, the overdose that led to her being referred, her “history”, her “presentation”, what meds she was on. To be honest I didn’t really care to know all this third hand information, I just wanted to meet her and check she was ok. I went to the lounge where Anne was sat on the sofa she looked quite tired and tearful. I really wanted to go over and give her a big hug but at this point I was still a stranger to her. I thought back to when I was on the ward and how all these people I had never met were addressing me by my name like they knew me, so I figured I would ask her name even though I already knew it.

“Hi I’m Carlina, may I join you?”

She didn’t reply but moved over to make room for me.

“What is your name?”

“I’m Anne”.

“I’m going to make a drink would you like one”.

“Ok I will have a tea one sugar”.

I returned with the drinks to a thank you and a smile.

We sat on the sofa in silence for a few minutes whilst I wracked my brain thinking what I should say, I noticed her posture had become more relaxed and she had shifted her position to face me so I asked how she was feeling.

“I feel exhausted, I might go to bed”.

I sensed she wanted to talk but could see she was struggling to stay awake. So, I told her I would be around until 4 and we could talk later if she liked.

“Ok, thank you Carlina” she replied before going off to bed.

A couple of hours later Anne joined me in the garden and asked if I would walk to the shop with her before I finished. On the way, we spoke about what had brought her to Haven House and sleep appeared to be the main thing affecting her mental health. Anne explained to me how she lay awake most nights worrying about whether she had locked the doors or left the cooker on until it became so bothersome she had to get up and check the whole house. I could see this routine had taken its toll on her and she was becoming frustrated that nobody was offering her a solution.

“How about when we get back we write down a list of all the things you check around the house”.

“You mean like a checklist?”

“We could do a checklist if you like?”

“Well I’ve tried everything else so why not”.

We returned to the house and worked together to create a checklist of things for Anne to tick off before bed. I asked where she would keep it.

“I will leave this on my fridge”.

“Oh but what if you wake up, would you then get out of bed to check the checklist?”

“Well, I never thought of that, hmmm, I do have a bedside table, I could keep it there”.

“Would that be better than the fridge?”

“Yes, because then I don’t have to get out of bed”.

“Then that’s a great idea Anne, I will go print this off and then I will make us a cuppa”.

As I passed she reached over and gave me a hug, she smelt like violets and I realised I would never smell violets again without thinking of Anne.
Jenny
So far, I had managed to offer support in a gentle way, I had stuck to all the principles and held hope for numerous guests. I was in every essence a non-judgemental, non-directive peer worker but most importantly I had managed to keep myself safe and well.

And then I met Jenny.

Everything about Jenny reminded me of myself, it was like looking into a mirror and seeing all the elements of my past staring back at me. Jenny and I were the same age, had a similar childhood and had both been through some very abusive relationships. We connected instantly, but this was by far the most challenging relationship I have experienced as a peer. A relationship which would touch my emotions and test the limits of my own recovery.

I had just returned from holiday and was reading through the handover notes when one of my colleagues asked if I could do a wellness plan with Jenny. It was Jenny’s third day in the house and from what I had read she seemed to be getting on well with everyone and I was intrigued to meet the woman with a similar history to my own. I found Jenny at the dining table talking to one of the other guests, I introduced myself and asked if I could join them. The two of them were discussing medication and Jenny was leading the conversation asking questions and giving Dave solutions to his queries. I noticed Jenny did not talk about herself at all but was focussed on supporting Dave and appeared to be very comfortable doing so, I sat and observed this naturally occurring peer support for about 15 minutes before asking Jenny if we could speak in private.

We went into the relaxation room and started working through her wellness plan. She spoke about her ex-partner a lot, the two of them had separated three weeks earlier due to the violence he had inflicted on her over their six-year relationship. She was desperately trying to do everything to feel in control (meditation, art, running, you name it she had tried it!).

“Nothing seems to work” she said “and nobody understands”.

I wanted to reassure her, tell her I understood but my mind was racing, as she spoke about what she had been through I suddenly became aware of all my emotions and an uncomfortable feeling came over me. The thing is that I did understand, every single word she had said related to my own experience and I felt her pain as if it were my own. I remembered all the useless things people had told me in that situation (he’s not worth it, go to woman’s aid, here’s some medication) these were all the same things Jenny had grown sick of hearing too. I quickly realised I was angry, not with jenny but angry that the both of us had experienced the same thing, what I hadn’t realised is that I had become tearful.

“Would you like a tissue” Jenny asked.

“Oh, my god” I replied “look at me getting emotional when I’m supposed to be supporting you”.

I don’t know why, but both of us started giggling and decided to go for a cigarette instead.

I went home that day feeling like I had failed in some way and pondered how I could offer support without it affecting my own mental health. I updated my own wellness plan and decided that I would be honest with Jenny and explain why I had got so upset.

The following morning I approached Jenny and asked if we could have a chat. First, I apologised for getting so emotional then explained how I had been through a similar situation and had found the conversation we had quite difficult as it bought back a lot of feelings for me.

“How did you get over it?” she asked.

I wanted to say all the right things, tell her it’s going to be fine and that it gets easier but I couldn’t as this wasn’t the truth of my experience. Up until now I had been completely open and honest and didn’t want to undermine our mutual relationship with a lie.

“I haven’t” I replied.

She looked at me as if searching for some glimmer of hope.
“But I do have a lot more good days now and I can go out whenever I like which is great”.
“I guess that’s something” she said whilst we both laughed.

For the remainder of her time in the house I supported Jenny with practical tasks like housing and meal plans and made a point of reminding her just how well she is doing. It was difficult to separate my feelings from Jenny’s at times so I made extra time to do all the things that keep me well, as well as seeking support from my supervisor.

On her last day, Jenny gave me a card, inside it she had wrote “thank you for being you”. This really touched my heart and hammered home the true meaning of being a peer. Despite struggling with my emotions and despite having to up my own support I was still able to help her by being honest and being me.

My golden rule
If ever there were a rulebook on how to be a peer, then I think my golden rule would have to be just be yourself. Be honest about your good days, honest about your bad days, the meltdown you had yesterday because you ran out of coffee, and all the challenges of recovery. The fact that I do not have all the answers and do not claim to have it all figured out yet is what truly inspires the guests I work with to have hope. It’s by sitting beside someone in crisis and saying what I truly feel and admitting that my life is still very much a work in progress that I have managed to build strong connections and be the peer that I am today.

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