Peer support in mental health services

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Peer support in mental health services

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Purpose of review
Considering international diversity in the implementation of mental health peer support and an increasing research interest in peer support work (PSW), this review focuses on priorities in current research and practice. With grassroots in informal services for people with mental health problems, peer support has been strengthened by the recovery paradigm in mental health policy, and there are steps towards integration in statutory services.

Recent findings
Current issues include benefits of peer support, its efficacy and effectiveness. The value of peer support in formal and informal settings is discussed, and organizational change processes and the challenges in peer support implementation are discussed. Recent studies have identified the need for a clarification of roles, competencies and job structure and for adequate training and supervision. Along with reported benefits for consumer and PSW involvement in care revealed by mixed method studies, destigmatization at the personal and system level is a crucial PSW component.

Summary
Various types of peer support merit further evaluation. Assessing the impact of peer support on service users, peer providers and organizations require complex intervention studies, using mixed methods designs with qualitative exploration of underlying processes and experiences to complement high-quality controlled trials.

Keywords
consumer providers, peer support, recovery, social inclusion

INTRODUCTION

Peer support exists in multiple forms ranging from spontaneous mutual aid to peer-run self-help groups, to peer support work, like peer-led advocacy organizations or peer involvement in mental health services. Peer support is generally provided independent of conventional mental healthcare with formal partnerships in some cases [1,2]. Driven by recovery orientation in national mental health policies, some US states, Canada, Australia, New Zealand, Scotland, Wales and England have proceeded to different stages of conceptualizing and implementing peer support services (PSS) in voluntary and statutory mental healthcare [3,4▪]. German-speaking countries' peer support work (PSW) initiatives have built on the 'trialogue movement' (of users, carers and professionals) [5]. Without similar levels of policy input, in some European countries, ex-patients/users, mental health professionals and researchers have co-produced training programmes for 'experts by experience' and thereby supported the employment of PSWs in mental health services [6–9]. The development of mental health peer support projects has spread to South America, Africa and Asia [10,11]. The English language bias for publication in international research journals and the limited command of foreign languages by the reviewers preclude us from appraising more contributions from non-English-speaking countries.

Considering the enormous international diversity in implementation and research on mental health PSW, this review focuses on emerging priorities in research and practice. Current issues include the development of specific roles of peer staff based on their unique experience in coping with severe

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KEY POINTS

- Peer support has a long tradition in informal services and may complement mental healthcare promoting recovery orientation and destigmatization.
- Reflecting the values and principles of informal peer support and of trialogue activities of service users, carers and professionals could help improve mental health services.
- Crucial issues for implementation include the clarification of role and job description of peer support workers and nonpeer staff, organizational support strategies, training and adequate supervision.
- Assessing the impact of peer support on service users, peer support workers and organizations require complex intervention studies using mixed methods designs with qualitative research into process and subjective experience complementing controlled trials.
- High-quality research on peer support work efficacy and effectiveness should test different models of peer support work against usual care and against each other.

mental illness (SMI), on peers' genuine helping skills, and on the role of PSW in formal care settings. Much recent research deals with the challenges and barriers to the implementation of PSW, with organizational change processes induced by peer specialists and with the changes brought about by PSW in traditional mental health services.

NEW REVIEWS ON PEER SUPPORT WORK

New reviews in the field deal with the development, characteristics, impact and future directions of PSW. Davidson *et al.* [4▪] reflect more than 25 years of PSW, and the authors describe three stages in practice and research. There was an initial phase of assessing the 'employability' of people with experience of SMI, with peers mostly given roles as aides to professional staff. The second stage compared PSWs with nonpeer staff, both in conventional roles. The third stage concentrated on crucial ingredients of PSW [12,13]. Recently, peer support leaders, mental health policy makers and researchers have begun to consolidate specific values of PSW grounded in experiential expertise from severe mental illness to sustained recovery [14,15,16▪▪].

Pitt *et al.* [17▪▪] conducted a systematic review of randomized controlled trials (RCTs) for the Cochrane collaboration. They included 11 studies on formal peer support in mental health published between 1979 and 2011 ($N = 2796$ participants). The quality of the studies was assessed as moderate to low. Studies were split in two categories: five trials compared PSWs with professionals in similar roles, four studies compared PSW with case management. No significant differences in symptoms, hospital admissions, service use, psychosocial functioning or client satisfaction were found. In a second category, six trials compared usual care with services with PSWs in adjunct roles, four with PSWs in mentoring or advocacy roles. There were no significant differences in quality of life, social relations, client satisfaction, hospital admissions, but a small reduction in emergency service use and a larger number of met needs. With these small benefits and no adverse effects found for PSW, Pitt *et al.* conclude in their review that PSW's support was noninferior to support by mental health professionals. The majority of trials included clinical and service use outcomes and general functioning. Only two RCTs [18,19] measured outcomes such as hope, empowerment or consumer-defined recovery [20,21]. In view of the variability found in PSW training and practice, limitations of meta-analytic comparisons need to be borne in mind. Hardiman [22] comments that the advantages of PSW may not emerge when PSWs are engaged in subordinate roles or take on roles preshaped in the conventional care system (as was the case in most trials included in the Cochrane review). The author calls for collaborative research including specific PSW contributions and outcomes important to service users.

The meta-synthesis by Walker and Bryant [23▪▪] investigates qualitative and mixed methods studies of PSW in adult mental health services published between 1990 and 2010 including 27 articles with PSWs in statutory mental health services and in settings with shared leadership. Outcomes from a consumer, PSW and service provider perspective were included. PSWs were found to be role models, to easily build rapport with people in recovery and to destigmatize mental illness [23▪▪]. Consumers working with PSWs experienced increased hope, motivation and social networks. In mental health services, PSWs were involved in teaching nonpeer staff about recovery, and they reported discrimination and prejudice from nonpeer colleagues. Identifying pivotal outcomes in studying PSW is considered important [24▪].

TAKING ON PEER SUPPORT ROLES: EXPERIENCES AND RECOMMENDATIONS

In a review of the literature on peer support in mental health services, Repper and Carter emphasize the need to ask 'not only whether PSW makes a difference, but also in what circumstances, with whom and how' [14]. PSW roles in different settings vary with respect to activities and skills [25]. Earlier studies found PSW training and job tenure to

decrease hospitalization, increase employability, skills acquisition and job functioning [26,27]. Enhanced well-being, self-esteem, empowerment and benefits in several wellness domains were described [28,29]. Recent studies on PSW emphasize a lack of role clarity and job descriptions.

Moran *et al.* [30▪] conducted a mixed-methods study exploring work experience in a sample of 31 PSWs in conventional and peer-led mental health organizations in a US city in 2009. Specific challenges experienced in traditional mental health organizations were direct and indirect expressions of prejudice among colleagues, relationship problems with co-workers, a lack of recovery orientation in the work environment and being the sole peer provider in the setting. Poor work conditions and work overload were frequent. A lack of PSW training and insufficient homogeneity of peer training practice were reported.

Using data from 31 in-depth interviews, Moran *et al.* [31] studied the motivation to work as a PSW in mental health services. Recurring themes included the feeling that work aligns with personal values, the freedom to disclose mental illness, using lived experience as a resource for others, feeling competent to help others, connect, reciprocate and end social isolation. The qualification of lived experience of SMI as shareable knowledge can transform stigmatized behaviour into an asset.

These findings are corroborated by Davis's study of factors that predict job satisfaction among PSWs [32]. A survey examined role clarity, psychological empowerment, supervisory alliance, co-worker support and procedural participation among members of the US National Association of Peer Specialists (now INAPS). One hundred respondents met the inclusion criteria of paid employment within professional teams in community-based health agencies. In this sample, only role clarity and psychological empowerment significantly predicted job satisfaction. Clarity of roles may facilitate the transition from 'dependent client' to PSW. The factor structure for psychological empowerment was found to be specific for PSWs. Competence scores were higher for individual tasks, but were not related with organizational power. A tentative interpretation suggests that depth of understanding and partnership with clients may have priority over leadership and management concerns.

It is of interest that disclosure of SMI and peer identity can present a double edged sword. Kemp and Henderson [33▪] studied challenges reported by PSWs in Western Australia. In a group of seven PSWs, the nominal group technique highlighted challenges: lack of role clarity among PSWs, need to clarify the peer role with other consumers, fear of stigma following relapse, how, to what extent and when to disclose to clients and PSW colleagues, and the quality of training of PSWs with respect to the right to disclose, purposefulness of disclosure, creating safety and adopting an attitude of 'a listening heart'.

Studies on PSW roles have identified the need for clarification of core competencies, helping skills, boundaries but also for specific solutions to disclosure, stigma and discrimination experiences. Destigmatization at both the personal and system level is considered a crucial PSW component [34]. Anti-stigma campaigns with reductionist illness concepts fail to reduce social distance [35]; authentic help is required to reintegrate illness experience [36]. In a recent study on self-stigma and its impact on life goals, Corrigan *et al.* [37] point out the importance of PSWs building a constructive relationship with no hierarchy, sharing strategies and resources useful in facing daily life challenges with the aim of strengthening self-efficacy and re-empowerment.

Schulz, against the background of delivering PSW in a German in-patient and outpatient facility for 2 years, describes her role as PSW. She values the possibility of disclosure not only of her grief, but also of having emerged from past hopelessness. Disclosure helps clients feel less ashamed of desolate living situations as they learn that their PSW counterparts have experienced cracks in their lives, too. Clients often experience feelings of loss of dignity and autonomy in mental health settings, whereas peers strive to provide confidentiality and respect as a well tolerated space for clients' self determination [36].

PSW programmes that are popular in English-speaking countries comprise GROW groups, Wellness Recovery Action Planning (WRAP), Intentional Peer Support [38] and other programs. Cook *et al.* [39] conducted an RCT to compare the peer-led illness self-management intervention WRAP with usual care and included 519 adults with SMI assigned to the 8-week intervention or a wait-list control. Outcomes were assessed at baseline, at end of treatment and at 6-month follow-up. WRAP group participants reported significantly greater symptom reduction, significantly greater improvement in hopefulness and in quality of life. The findings suggest that programmes with a clear PSW role may translate to beneficial impact.

IMPLEMENTATION AND ORGANIZATIONAL CHANGE

An increasing number of studies have explored the organizational challenges arising from the introduction of PSWs into various mental health services. Lack of role clarity, of job structure and insufficient workplace strategies have been considered as significant barriers undermining PSW [40–42]. The role of

management to provide work routine structures for PSW implementation at all organizational levels has been stressed by Chinman *et al.* [43] and Kemp and Henderson [33▪] who recommend training for nonpeer staff to reduce stigma and discrimination. The need to promote an understanding of PSW as part of a strategic commitment to recovery has been a prime concern in recent studies [30▪,44].

Chinman *et al.* [45,46] undertook pioneer work using implementation science to address barriers to PSW introduction in the Veterans Health Administration's PEER project. They conducted a cluster RCT of PSW work in the Veterans Administration's Assertive Community Treatment (ACT) teams using a range of recovery-related outcomes. For 1 year, six full-time PSWs were assigned to three VA-specific ACT teams with 149 patients enrolled at intervention sites. Three control teams delivered usual ACT to 133 patients. Results showed a small significant increase in patient activation only. As in the van Vught *et al.*'s study, which tested ACT teams with PSWs against usual ACT in the Netherlands [47], PEER PSWs were introduced into teams immediately after training, at different time points or with changes between teams during the study period. In both studies, PSW use was recorded, with only 36% of Veterans Administration patients having had more than five PSW contacts. These important factors may have resulted in specific PSW effects being amalgamated. The authors suggest PSWs may have enhanced recovery orientation in teams.

Hamilton *et al.* [48▪▪] studied the processes of integrating PSWs in the PEER study through interviews and focus groups with all stakeholders. The planning and carrying out of the PEER project was guided by use of the Simpson Transfer Model distinguishing four stages of role introduction and diffusion of innovation theory. In the preimplementation stage, Veterans Administration's ACT teams received education as did the PSWs who attended a 30-h certification training. Boundaries and confidentiality issues were explored in advance, an understanding of building hope, being encouraging in the PSW role was introduced, and PSWs were educated to share information of 'clinical relevance' with team staff. Supervision in the implementation stage facilitated skill building wherein PSWs lacked work routines or instrumental knowledge. In the practice stage, trouble shooting helped resolve role conflicts and develop support strategies in case of PSW relapse. The tiered implementation strategy and external facilitation helped avoid challenges, for example dual relationships, confidentiality breaches and workplace discrimination. When PSW responsibilities had been demonstrated, all staff found PSWs to be valuable new team members.

In England, researchers, service user researchers and service managers with experience of mental health problems co-designed and co-produced a qualitative, comparative case study of emergent PSW roles [49]. The study explored 10 selected statutory, voluntary and partnership mental health services working with PSWs. The project's conceptual framework was informed by the PSW evidence, by organizational research into role adoption and by experiential insight from collaborators with experience of mental distress. It consists of seven domains related to the core expectations of the PSW role: training, job description, team working, personal support, strategic support, human resource management, leadership and management. Data were collected by interviews with 89 stakeholders. Using a pattern matching approach to analysis, the study aimed to test the international evidence base on PSW role adoption in 10 English mental health providers. Triangulation of perspectives between PSWs, nonpeer staff, users, managers and commissioners explored tensions in the implementation process. There was broad consensus that two themes were crucial for successful implementation of PSW: developing a supportive organizational culture and identifying the essential ingredients of PSW. Facilitators were valuing the experiential knowledge and specific relationships PSWs can build with users, enabling PSWs to retain a peer identity, support from staff, management and other PSWs, building organizational strategies to assure a good fit between PSW values and mental health service practice. Common barriers were lack of shared understanding of the PSW role, overformalization of the PSW role, redefining of the PSW role to fit traditional clinical practice structures and cultural inflexibility. The study highlighted some findings thought to be setting-specific. Overall themes for organizational change were: employing a critical mass of PSWs, flexibility in teamwork, supportive multilevel management, challenging conventional practices, allowing PSWs to address stigmatization, supporting change in mental health discourse and changing organizational culture to value PSW as a distinctive model.

PEER SUPPORT: ADJUNCT SERVICE MODEL OR BEST PRACTICE?

Research into the emerging roles of peer support in mental health services consistently elicits the need to define the essence of PSW, and stakeholders have called for guidance [16▪▪,44,49]. A considerable gap separates the new world, with a development of guidelines and best practice models of PSW services in the USA and Europe, where recent research has explored the variety of roles, organizational settings and peer support cultures.

Daniels *et al.* summarize the development of a set of principles for PSS drawn from the experience of US states with formal reimbursement plans [16▪▪]. The Centre for Medicare and Medicaid Services acknowledged PSS as 'an evidence-based mental health model of care, which consists of a qualified peer support provider who assists individuals with their recovery'. Since 2009, the US wide Pillars of Peer Support initiative has brought together a group of representatives from formal mental health and governmental organizations, consumer networks and peer service organizations. Annual Pillars' summits helped develop the 25 principles or Pillars of Peer Support Services (POPS), which define the core ingredients of the education, certification, employment, professionalism and community advocacy for PSS. Sets of level-of-care criteria for PSS have recently been established by Optum, a US provider of specialty health solutions, by reviewing research findings and governmental sources [50]. In partnership with clinical service providers and consumer organizations, Optum has developed a range of best practice PSS, which are authorized and paid alongside other traditional services.

In German-speaking countries, trialogue projects (user-carer-professional) can be considered a specific PSW forerunner [51]; one such project (Irre menschlich Hamburg) has become a best practice model of the European Union in 2013 (http://www.inno-serv.eu/content/changing-perceptions-people-mental-illnesses-irre-menschlich). One noteworthy feature is the participation of relatives in the Hamburg PSW project, part of psychenet [52]. A recent scoping report summarizes the diversity of self-help or peer support groups as well as peer-led programmes in England [2]. A majority of participants in user-run programmes value role equity, the mutuality and reciprocity of relationships and the nonhierarchical organization. They clearly articulate worries of losing technical support and funding to the prioritization of emerging PSW roles in services. Faulkner and Basset [53▪] report tensions between more or less formalized peer groups from a consultation with five service user and peer support groups. Members of mutual support groups had divided opinions regarding payment, equity and professionalization among PSWs. All 52 participants valued being members of a group experienced as a 'safety net'.

Dillon and Hornstein [54] describe the principles, values and psychological processes in Hearing Voices Groups in the UK and USA. Helping one another to become aware of talents and strengths, members use and improve empathy and role-taking. According to the authors, Hearing Voices groups 'significantly widen the range of experiences to which people are exposed so that their thinking about their own minds expands'. For these growth processes to occur, groups need to provide sanctuary, safe spaces to share stigmatized or taboo experiences.

In view of the implementation of PSW in formal mental health services, Faulkner and Basset [53▪] highlight 'the need so many of us have for meeting other people like us, for creating our own space'. Their findings from consultations with service users suggest mental health policy makers and commissioners of services 'should aim for a plurality of peer support and ensure that informal peer support is flourishing as an essential basis for more formal peer support' [55].

CONCLUSION

The various forms of peer support ranging from PSW in mental health services, user-run programs [1], collaborative projects [56], clubhouse models [57,58] to trialogue initiatives merit further evaluation. Assessing the impact of PSW on service users, PSWs and organizations requires complex intervention studies, using mixed methods designs with qualitative exploration of processes and experiences to complement controlled trials. Finally, there is an urgent need to strengthen high-quality research on PSW efficacy and effectiveness. Different models of PSW should be tested both against usual care and against each other. These studies will be important in guiding implementation and funding decisions.

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Conflicts of interest

There are no conflicts of interest.

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