

ARTICLE

Peer workers in mental health services: literature overview

Steve Gillard & Jessica Holley

Steve Gillard is a senior lecturer in social and community mental health at St George's, University of London. He completed a PhD in 1999 on youth, identity and conflict in the Department of Peace Studies at the University of Bradford before focusing his research interests on service user involvement in mental health research and the coproduction of mental health services. He moved to St George's, University of London in 2005, where he is currently the head of the section of mental health.

Jessica Holley is a PhD research student in the section of mental health at St George's, University of London. Her PhD focuses on the relationship between risk and recovery in community mental health services. She completed an MSc by research in health psychology at Gloucestershire University before moving to London in 2009 to start her PhD.

Correspondence Dr Steve Gillard, St George's, University of London, Institute of Population Health Research, Cranmer Terrace, London SE23 3AE, UK. Email: sgillard@sgul.ac.uk

SUMMARY

Peer worker roles are being introduced in mental health services in the UK and internationally, to support individuals in their recovery. There is substantial qualitative evidence that demonstrates benefits at an individual level and some evidence of impact on service use and costs, although there are currently few high-quality randomised controlled trials supporting these findings, especially from the UK. A growing body of research indicates that careful consideration of organisational issues regarding the introduction of peer worker roles – the distinctiveness and shared expectations of the role, strategic alignment, organisational support – might maximise their impact. Properly supported and valued peer workers are an important resource to the multidisciplinary team, offering experiential knowledge and the ability to engage patients in their treatment through building relationships of trust based on shared lived experience.

LEARNING OBJECTIVES

- Appreciate the origins of the peer worker role and how the role has been introduced into mental health services to date.
- Understand the evidence for the benefits of peer worker roles, for patients, peer workers and mental health service delivery.
- Demonstrate awareness of the organisational and team-level barriers to and facilitators of introducing peer workers into, or alongside, existing multidisciplinary mental health teams.

DECLARATION OF INTEREST

None.

problems (National Institute for Mental Health in England 2005). Support for individual recovery has been identified as a guiding principle in UK mental health policy and practice (Department of Health 2011). The implications of this for contemporary psychiatric practice have been noted, including a shift away from the psychiatrist as an authoritative expert to a role that also requires learning from and valuing the patient's experiential expertise (Roberts 2004). It is currently unclear how the emerging peer worker role fits into that changing treatment dynamic.

Different terms are used to identify peer support roles in mental health services. Except where referring to specific examples, we will use the term peer worker throughout this article to indicate that we are referring to a formal job that is defined by the explicit use of shared lived experience. We also note that many people involved in peer support do not use the term 'patient', in part because peer support can aim to foster the development of identities that are not defined by medical treatment.

Peer workers – why now?

People have long supported and been supported by their peers in their experiences of emotional and psychological distress, within both mental health services and the private sphere (Davidson 2012). Definitions of peer support have been offered:

'... people who have like experiences can better relate and can consequently offer more authentic empathy and validation[...]Maintaining its non-professional vantage point is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience.' (Mead 2006: p. 4)

It has been noted that the same principles that define informal, one-to-one peer support also apply to peer support groups (Seebohm 2010). Again, whether naturally occurring or in the form of organised mutual support groups such as the Hearing Voices Network or Depression Alliance, peer support in a group setting has a long tradition. Since around the turn of the millennium, service user- or peer-led organisations (Munn-Giddings 2009) have increasingly brought the principles of peer support to mental health service provision in the UK. With new commissioning arrangements

Peer workers – people with personal experiences of mental health problems, employed to explicitly use those experiences in supporting patients – are increasingly being introduced into mental health teams in the UK and internationally. Peer support has been recognised as an important facilitator of individual mental health recovery (Department of Health 2008). Individual recovery – as distinct from medical recovery predicated on symptom alleviation and remission – focuses on how people learn from their experiences of mental illness to maximise their potential and live well with their mental health

in place in health services in England, peer-led mental health service providers are likely to play an important role going forward. Such organisations offer a range of services – including advocacy and vocational services as well as peer support groups – and intentional peer support (IPS) features increasingly in that offer. First described in the USA, IPS involves peer-based relationships that are intentionally rather than naturally formed, and can include the unidirectional provision of peer support – the peer worker role – as part of a package of mental healthcare (Davidson 2006).

Peer worker roles, either paid or unpaid, first emerged in voluntary sector mental health services in the UK, and this momentum has been picked up in the statutory sector. Mental health workforce policy identified the potential for ‘peer supporters’ to fill skills gaps in mental health teams (Department of Health 2007). More recently, the implementation framework for UK mental health policy (Department of Health 2012) recommended that mental health service organisations provide peer support as a means of improving recovery outcomes. As part of the NHS Confederation’s Implementing Recovery through Organisational Change (ImROC) programme, a number of demonstration sites have been established to support the development of formal peer worker roles within mental health National Health Service (NHS) trusts.

What do peer workers do?

As a result of this dynamic, peer worker roles are currently being introduced into mental health services across the UK. It is important to have insight into what peer workers do to understand where the role fits into contemporary psychiatric practice. Many early examples of formal peer worker roles – on which a number of UK initiatives have been based – originate in North America, New Zealand and Australia, as shown in the following examples.

New Zealand

A range of peer support services in New Zealand work closely with public mental health providers. ‘Peer supporters’ accept referrals from clinical teams, work with patients on hospital wards and in crisis services, and hold joint meetings with patients and clinicians (Scott 2011). Much of this work is located within the parameters of holistic Maori health frameworks in which spiritual, mental and physical aspects are considered as a whole and not treated as separate entities. Peer support is grounded in relationship and mutuality, understanding and not judging peers’ world views, and creating a genuine learning environment (Scott 2011).

The USA

Recovery Innovations of Arizona (RIAZ) is a ‘consumer run’ agency in the USA that employs ‘peer support specialists’ in the majority of posts in community and hospital-based mental health services (Daniels 2010). Peer support specialists act as recovery role models to help patients engage with and develop personal recovery plans. Plans are designed to promote key concepts of individual recovery such as hope, empowerment, personal responsibility and social inclusion. Based on each individual’s goals, peer support specialists offer a wide range of support activities, skill building and case management (Daniels 2010).

England

In England, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) launched one of the earliest statutory sector peer worker programmes in the UK, training peer support workers using the Arizona training programme to be employed as members of multidisciplinary teams throughout the Trust. CPFT defines a peer support worker as ‘someone with significant experience of mental distress, who works alongside others with similar difficulties in order to facilitate recovery through promoting hope and providing support based on common experiences’ (Pollitt 2012: p. vii).

Nottinghamshire Healthcare NHS Trust similarly employs peer support workers across its adult mental health services, but developed a bespoke, accredited training for peer workers – in partnership with the University of Nottingham and local user-led organisation Making Waves (Repper 2012) – that includes a focus on peer support workers telling their own ‘recovery stories’ in their work.

A different approach has involved an established peer-led service provider – CAPITAL Project Trust – being commissioned to introduce independent peer workers to in-patient wards in Sussex Partnership NHS Foundation Trust (Ockwell 2012). These roles are in addition to the existing statutory mental health service team, unlike the NHS approaches referred to earlier where peer workers have been employed in place of other support worker roles. Some of the issues around these different approaches are considered below.

What are the benefits of introducing peer workers?

A literature review reported a large number of qualitative studies finding that peer worker roles offer a range of benefits for patients, peer workers themselves and mental health service delivery (Repper 2011) (Box 1).

Benefits for patients

A growing body of research has specifically explored the impact of peer workers from the perspective of patients who are receiving peer support. Coatsworth-Puspoky *et al* (2006) conducted a qualitative study to explore and describe the peer support relationship, finding that the ability of peer workers to bond with patients began to address issues of social isolation. Ochocka and colleagues (2006) found that participation in mental health consumer initiatives led to improvements in quality of life, and increased social integration, sense of independence and empowerment for people with severe mental health problems.

Benefits for peer workers

Other qualitative studies have suggested that the role helps peer workers to move forward in their own recovery. Consumer-providers working on a peer support programme for people with co-occurring mental health and substance use disorders reported that adopting a helper role benefited them by way of skill development and personal discovery (Salzer 2002). More recently, it has been shown that working as a peer worker can fulfil individual autonomy, competence and relatedness needs where that work corresponds, respectively, to personal values, uses personal experiences as a resource to help others, and provides opportunities to connect and reciprocate with others (Moran 2014).

Peer support has also been found to be beneficial for peer workers in more practical ways. Mowbray *et al* (1998) found that, 1 year after being employed, peer workers reported improved financial situation, and valued the structure, supervision and safety which the job provided in their daily lives. Experience of stigma in the workplace has been identified as a reason for not seeking employment by people with experience of mental health problems (Marwaha 2005). In a study conducted by Ochocka and colleagues (2006), peer providers explained how being involved in peer support made it less likely that they would identify stigma as an obstacle for getting work and more likely to seek and sustain employment.

Benefits to mental health service delivery

The organisational benefits of introducing peer workers into mental health service teams have also been identified. In a qualitative study in New Zealand, peer workers and their managers described the importance of peer support services working in an integrated way with clinical services (Scott 2011); peer workers were able to improve information-sharing with patients and developed a non-clinical, non-judgemental and 'hopeful'

BOX 1 Benefits of peer workers

For patients

- Decreased social isolation
- Improvement in quality of life
- Increased independence and confidence

For peer workers

- Development of skills
- Personal discovery
- Improved financial situation
- More likely to seek and sustain employment

For mental health services

- Improved information-sharing
- Better understanding of the challenges faced by patients
- Potential reduction in hospital admissions

approach to writing notes. Patients have noted that peer workers have better understood the challenges patients face, enabling different relationships to develop with peer workers compared with non-peer staff (Coatsworth-Puspoky 2006).

In a study of a peer support programme for veterans in the USA, it was noted that patients, administrators and providers were enthusiastic about peer workers serving as a 'bridge between the mental health system and the patient to improve service delivery' (Chinman 2010: p. 185). Finally, in an evaluation of a peer-run decision support intervention at an out-patient psychiatric medication clinic in the USA, medical practitioners reported that peer workers gained a more holistic understanding of their client's needs, whereas patients found that their concerns were more likely to be heard by peer workers (Deegan 2008).

What are the outcomes of peer worker interventions?

Service use and cost outcomes

A number of quantitative studies evaluating the peer worker role have indicated potential beneficial service use and cost outcomes of employing peer workers. For example, in a US comparison group study contrasted a peer support out-patient programme with traditional care, there was a 50% reduction in hospital readmissions over a 1-year period among out-patients receiving the peer support programme (Davidson 2006). Another comparison group study found that consumers involved in a peer support programme demonstrated longer community tenure than those who had not been involved in the service, as well

as significantly fewer hospital readmissions over a 3-year period (Min 2007).

Lawn and colleagues (2008) conducted an observational study which evaluated a peer support service in Australia over a period of 3 months and found there was a reduction in readmission rates and that 300 bed-days were saved compared with historical controls. The cost and productivity case for introducing non-professional roles into the UK health and social care workforce has been made (Department of Health 2009). Claims have been made on the basis of these and similar pilot studies for the cost savings of employing peer workers (Trachtenberg 2013).

Improvements in psychosocial outcomes

Improvements in individual psychosocial outcomes have also been indicated. A US cross-sectional survey (Corrigan 2006) demonstrated a significant association between receiving support from 'consumer-operated services' and individual levels of empowerment and recovery. A US before-and-after study of community-based peer support (Resnick 2008) found significant improvement in empowerment in the cohort as a whole, and in the 'as treated' subsample (those receiving more than ten sessions of peer support) significant improvement in confidence as well.

Although the potential for improvement in outcome is indicated, randomised controlled trial (RCT) evidence is more equivocal. A recent Cochrane review (Pitt 2013) reviewed 11 RCTs, all of which were based in statutory community mental health services (2 of the trials were partnerships between statutory and peer-led providers). Nine studies were from the USA, one was from Australia and one from the UK. Five trials compared peer workers with mental health professionals in similar roles (four of these were case management roles and one a group therapy facilitator role). Six trials compared mental health services with and without peer workers in an additional role (four of these were mentoring or advocacy roles and two were referral to additional peer-led services). The review found no evidence of significant differences in a range of psychosocial, satisfaction or service use outcomes, with the exception of a small reduction in use of emergency services in two of the studies. There were no significant differences in costs in any of the studies considered.

The review authors caution, first that the quality of existing evidence is low because of issues about randomisation, masking of assessment and contamination between study aims, and second that clearer description of the peer worker role (including tasks, training and supervision) as well

as greater differentiation between peer worker interventions and treatment as usual is necessary to aid evaluation (Pitt 2013).

Organisational issues about introducing peer workers

Given that such a range of peer worker roles and problems for formal evaluation are emerging in mental health services, organisational issues about role development and implementation merit serious consideration. A wider literature on role adoption in public services has identified a number of organisational conditions that facilitate successful introduction of a new role, many of which are reflected in emerging research on the challenges of implementing peer worker roles in mental health services. Those issues fall into four key domains: distinctiveness of the role; shared expectations of the role; strategic alignment; and organisational support.

Distinctiveness of the peer worker role

Distinctiveness in the tasks associated with a new role, compared with other roles in the team, has been shown more widely to be a key facilitator of new role adoption (Dierdorff 2007). There is qualitative evidence that suggests that the absence of a clear job description for peer workers creates challenges for team working (Kemp 2012). In a survey of managerial and human resources staff in agencies employing peer workers in the USA, role conflict and confusion, allied to poorly defined job structure, were identified as undermining role integration (Gates 2007). In addition, where new roles become a repository of unwanted tasks for the team, it has been noted how the role can become diluted (Bach 2000); for example, a peer worker might not have sufficient time to focus on core relational aspects of the role if generic support tasks take up the bulk of their time. Where peer workers are to be introduced as members of the multidisciplinary mental health team there are arguments in favour of standardising and regulating the role (Stewart 2008). However, others have suggested that such formalisation will undermine the peer 'essence' of the role (Faulkner 2010), that there is a risk of peer workers becoming 'socialised' into the working culture around them, and of the distinctiveness of the role being lost (Schmidt 2008).

Role distinctiveness can be easier to achieve where peer workers are introduced in new roles that complement the existing mental health team, although in these cases a different set of challenges can arise. Peer workers have described the experience of being 'othered' by the professional team (Berry 2011) or of having to negotiate a

complex identity that is neither staff nor service user (Gillard 2013) and of feeling disempowered as a result.

Shared expectations of the peer worker role

Shared expectations, across the organisation, of a new staff role has been indicated as another key facilitator of role adoption (Dierdorff 2007). A Delphi study of 92 practitioners, researchers and peer support practitioners from 17 countries (Creamer 2012) suggested that placing clear boundaries around what is and what is not expected of the role, particularly in training, could help identify appropriate distribution of tasks between peer and non-peer staff. Allied to this, the ability of workers to bring power to a new role, especially in the case of non-professional roles is crucial (Turner 1990). For peer workers, power lies in the knowledge they bring – derived from their own lived experience – and the capability of using that insight to build relationships with patients (Gillard 2013).

The potential benefits of introducing peer workers can be undermined where expectations of the role are not shared; for example, where peer workers are not given sufficient autonomy to use their lived experience in their role (Moran 2012). Difference in expectation of whether or not peer workers should work to conventional, clinical practice boundaries has been highlighted (Mead 2006), and resistance among existing staff can also be encountered where there are perceived challenges to professional jurisdiction (Currie 2009). This might especially be the case where a peer worker role has been introduced into a team in place of an existing staff role.

Strategic alignment

Alignment of a new role with other strategic drivers in the system has been indicated as a generic facilitator of role adoption (Turner 1990), and innovative practice in UK mental health services has been shown to lead to sustainable organisational change where it aligns with a number of strategic agendas (Gillard 2012). Where the introduction of peer workers is specifically linked to organisational delivery on a recovery or social inclusion agenda, for example, there might be greater clarity of expectation around the function of the role. Conversely, peer workers have reported that their role felt undermined where attitudes to individual recovery were not shared by their managers and co-workers (Moran 2012). It has been suggested that strategic alignment has to be established on a number of levels – organisation, team and individual – for it to be effective (Nadler 1980).

There is evidence to suggest that demonstrating the value of peer worker roles, through explicit reference to the role in organisational mission statements, further supports successful introduction of the role (Gates 2007).

Organisational support

Practical support on an organisational level, including provision of appropriate training and supervision, also facilitates role adoption (Turner 1990). Specific challenges for peer workers, related to the demands of using their own lived experience in their work, have been identified (Davidson 2006). Qualitative research from the UK has indicated that peer workers do not always feel that the support they are provided with responds to role-specific challenges (Gillard 2013). The need for role-specific training that focuses on when and how to share lived experience has been indicated (Repper 2011). In the UK, new guidance has been issued that responds to these needs (Repper 2013).

Discussion

The literature presented here is indicative of a range of potential benefits of introducing peer worker roles into mental health services: personal benefits for patients and peer workers; reductions in service use and associated cost; practice-level benefits to the mental health team. Research focusing on organisational issues around new role development and implementation has suggested that the peer-specific qualities of the role can become diluted where a range of organisational conditions are not in place to support role distinctiveness within the wider team and organisation. Indeed, the introduction of new, non-professionally qualified roles into mental health services in the UK has arguably been characterised by dilution (Dickinson 2008). Likewise, trials to date have not indicated definitive effectiveness or cost-effectiveness of the peer worker role. This is in part because of the quality of studies, but also because of a lack of definition of what it is that peer workers do that is different to the roles of the mental health professionals they work alongside.

Given the current impetus to introducing peer workers into mental health services in England, and that the energy and commitment required to develop a new role is considerable, it is vital that those organisational lessons are learned. Guidelines on evaluating complex interventions such as workforce change also suggest that careful definition of the intervention is necessary to properly evidence the effectiveness of this type of organisational change (Medical Research Council 2000). Future peer worker role development and

future research into peer worker roles in the UK require a similarly thoughtful approach.

Further, the potential for peer workers to promote 'recovery-oriented attitudes, the peer movement, and mental health system change' has been noted (Moran 2012: p. 309), although peer workers have highlighted the difficulties around challenging stigmatising and discriminatory language in the workplace (Jacobson 2012). Recent research by ourselves and colleagues (Gillard 2014) is indicative of the role peer workers can play to drive cultural change in mental health services in England, improving patient experience and the quality of mental healthcare as well as empowering patients to take more control over how they use services and in their wider lives. These dividends will only be realised where appropriate training, supervision and support is made available to peer workers, and where the role is valued strategically through the organisation. There need to be shared expectations about the role of the peer worker, whether working within or alongside the multidisciplinary team. Overformalising the role is likely to undermine the specific 'peer' qualities that it brings.

Specific lessons for psychiatry are not immediately tangible. To date, in the UK, with the exception of a very small number of mental health NHS trusts, there are very low numbers of peer workers to whom a service user can be referred for either alternative or additional support in their individual recovery. As we have shown, there is a paucity of evidence around peer workers and medication management. But new roles are continually emerging within the NHS workforce, and new partnerships with peer-led services are prominent on the commissioning agenda. Where the role is properly valued and supported, peer workers are a powerful resource for the multidisciplinary team, offering different, experiential knowledge and insight, and the ability to engage patients in their treatment through building relationships of trust based on shared lived experience. The peer worker is an important potential partner in supporting the recovery of people using mental health services.

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MCQ answers

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MCQs

Select the single best option for each question stem

1 The origins of the peer worker role can be found in:

- a the UK Department of Health's 2011 mental health policy
- b Arizona, USA
- c naturally occurring peer support between people experiencing mental health problems
- d National Institute for Health and Care Excellence guidance
- e the patient-led recovery movement.

2 There is strong evidence that introducing peer workers into mental health teams:

- a reduces unplanned use of mental health services
- b reduces the cost of providing mental health services
- c is experienced by patients and peer workers as supportive of their personal recovery

d leads to tensions within multidisciplinary mental health teams

e improves levels of empowerment and confidence in patients.

3 Peer workers can best work with the psychiatrist by:

- a making sure patients take their medication
- b keeping people out of hospital
- c providing another option to which to refer patients
- d improving recovery outcomes
- e offering a resource to the team based on their shared lived experiences with patients.

4 Current research suggests that successful introduction of peer workers into mental health teams is best facilitated by:

- a assigning tasks to peer workers that do not need to be done by professionally qualified staff

b a shared understanding across the team of the role of peer workers in the team

c making sure that peer workers work to existing clinical boundaries

d standardising the peer worker role

e being careful not to define the peer worker role.

5 The widespread adoption of peer worker roles in mental health services would be best supported by:

- a acting on existing RCT evidence
- b creating a new regulated peer worker role within the statutory mental health services
- c demonstrating that peer workers cost less to employ than other mental health workers
- d ensuring that training and support is in place that enables peer workers to use their distinctive experiences in their work
- e replicating the findings of research from outside of the UK.