2012

Peer support in a mental health service context

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Abstract

This chapter will first summarise the range of definitions that have been provided for peer support, in a mental health context. Clarifications of the different aims of peer support initiatives aud the potential psychological processes that underpin them are then provided. Three key forms that peer support groups may take are then described and we track Sam as he experiences peer support in the context of job seeking. A summary of existing empirical evidence for peer support groups is provided before examining some of the necessary tensions that may exist between the alternative views of those coming from inside the consumerlsurvivor/ex-patient (clslx) movement perspective, and the traditional discourses based on the medical approach. A series of recommendations is then offered for those who are working or about to work within a peer support framework in mental health. The recommendations include things to do and things to avoid.

Keywords

service, health, mental, support, context, peer

Disciplines

Education | Social and Behavioral Sciences

Publication Details

Oades, L. G., Deane, F. P. & Anderson, J. (2012). Peer support in a mental health service context. In R. King, C. Lloyd, T. Meehan, F. P. Deane & D. J. Kavanagh (Eds.), Manual of psychosocial rehabilitation (pp. 185-193). United Kingdom: Wiley-Blackwell.

Chapter 16

Peer Support in a mental health service context.

Lindsay Oades, Frank Deane and Julie Anderson

Overview

This chapter will first summarise the range of definitions that have been provided for peer support, in a mental health context. Clarifications of the different aims of peer support initiatives and the potential psychological processes that underpin them are then provided. Three key forms that peer support groups may take are then described and we track Sam as he experiences peer support in the context of job seeking.. A summary of existing empirical evidence for peer support groups is provided before examining some of the necessary tensions that may exist between the alternative views of those coming from in the consumer/survivor/ex-patient (c/s/x) movement perspective, and the traditional discourses based on the medical approach. A series of recommendations is then offered for those who are working or about to work within a peer support framework in mental health. The recommendations include things to do and things to avoid.

Definitions of Peer Support

There are several ways to conceptualise peer support. The working definition for this chapter is a process of mutual support where persons voluntarily come together to help each other address common problems or shared concerns (Davidson, Chinman, Sells, & Rowe, 2006). Solomon (2004) defines peer support as “social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change” (p. 393). Moreover, the participation in this process is usually intentional, and the social context enables the person to find resources and structures that enhance his or her ability to deal with the problems and concerns.

Adame and Leitner (2008) explain that the medical model underemphasises issues such as social conditions, political oppression, family systems, interpersonal

relationships, spiritual crises, and the trauma of physical and sexual abuse that are experienced by many people seeking help. In contrast, the peer support model is based on the premise that significant interpersonal relationships and a sense of community provide a context for personal recovery and empowerment.

One important distinction within approaches to peer support is those groups that generally accept the overall mental health system, and seek to work to reform it, improve it and assist consumers to have more choices within this system. Those who identify more with the survivor/ex-patient philosophy will more likely seek alternatives outside of the system. This distinction can be thought of as two different discourses; the medical discourse of symptoms and "objectivity" versus a discourse related to individual suffering situated within social and political environments that often include oppression and injustice. It has been asserted that "peer support, …., becomes a natural extension and expansion of community rather than modeling professionalized caretaking of people defined as defective" (Mead, Hilton & Curtis, 2001, p. 136). There is usually a greater expectancy of reciprocity in the relationship between peer support workers and those they work with compared to more "expert" professional workers.

Whilst peer support definitely includes emotional healing as a result of shared interpersonal experiences, psychiatric survivors and ex-patients will often adopt a more politically oriented definition of empowerment that emphasises political activism and advocacy work to an equal if not greater extent than individual peer support (Crossley & Crossley, 2001; Everett, 2000). Several authors have described how peer support groups foster alternative views of the meaning of recovery which may be more about recovering from iatrogenic trauma than mental illness itself. For example, the stigma associated with mental illness, and the consequent disadvantage and disenfranchisement experienced by those with mental illness, may be an important theme within a group of peers. An important component of peer support lies in understanding that it occurs in a political context, and is a social process.

Forms of Peer Support Initiatives

There are several schemes that have been used to describe the different forms that peer support initiatives can take. Using the foci of groups described by Cohen and Mullender (2005), peer support groups can be classified as:

(a) *Remedial*, focussing on the personal processes of recovery
(b) *Interactional*, emphasising the interpersonal relationships and personal experience; and,
(c) *Social*- integrating the personal, interpersonal and political. The social classification involves social change and empowerment.

Solomon (2004) describes processes underpinning peer support as social support, experiential knowledge, helper-therapy principle, social learning theory and social comparison. Groups can also vary in how conservative or radical they are with regard to their level of political activism (Solomon, 2004).

Davidson et al (2009) suggest that there are three forms that peer support groups may take, (1) naturally occurring mutual support groups, (2) consumer-run services, and (3) the employment of consumers as providers within clinical and rehabilitative settings. Employment of consumers as providers within clinical and rehabilitative settings in many ways is a product of system change from the original activism. Across these three broad forms, many specific terms have been used to describe peer support initiatives, as illustrated in Table 1.

Table 1 Terms used to describe peer support initiatives

Consumer delivered services (e.g., Salzer & Shear, 2002)
Consumer drop-in centres (Mowbray, Robinson, & Holter, 2002)
Consumer-operated self-help centres (Swarbrick, 2007)
Consumer-run businesses (Kimura, Mukaiyachi, & Ito, 2002)
Consumer-run services (Goldstrom, et al., 2006)
Consumer-run organizations (Clay, Schell, Corrigan, & Ralph, 2005)
Consumer/survivor initiatives (Nelson, Lord, & Ochocka, 2001)
Mutual-help groups (Corrigan, et al., 2005)

Mutual support groups (Chien, Thompson, & Norman, 2008)
Self-help agencies (Segal & Silverman, 2002)
Self-development programs (e.g., Oades et al, 2009)
Self-help programs (Chamberlin, Rogers, & Ellison, 1996)

Peer support programs can sit within traditional community based psychosocial rehabilitation services as a peer partnership model. This means they give up some control of legal, financial and content of the program (Solomon, 2004).

Peer support sits on a continuum of helping relationships. On the continuum are unidirectional intentional relationships, with professionals and peers in service settings. Moving along the continuum to reciprocal relationships such as reciprocal groups facilitated by peers as providers of conventional services, to naturally occurring reciprocal relationships with peers in community/and or service settings (Davidson et al., 2006).

Sam's experiences of peer support

Sam is very committed to getting a job. He is assigned an employment consultant to work with him on individual placement and support. This is an example of a one directional relationship with a professional in a service setting. Sam's confidence in gaining work is low because of his past employment history. The employment consultant suggests that Sam meet regularly with a peer mentor, employed by the service (one directional intentional relationship with a peer). Sam continues to meet the employment consultant and the peer mentor. The peer mentor shares her experience in gaining employment and the issues and strategies for working with a mental illness. The employment consultant works on needs assessment, goal setting and goal attainment with Sam and the peer mentor, as a team.

The peer mentor suggests an eight week peer education course around recovery developed and facilitated by peers employed by the service (reciprocal groups facilitated by peers as providers). In the peer education course Sam meets other

people with similar experiences to himself whilst they work as a peer group on issues such as dealing with stigma, medication, personal treatment strategies, consumer rights and communication. At the completion of the course Sam has made new friendships, feels confident to update his skills, and has renewed hope in looking for work. Eventually Sam gains part time employment. The peer mentor suggests to Sam that he may wish to attend employment dinners with other people who work and have a mental illness. The employment dinners are supported by the psychosocial rehabilitation service and are peer run (self help mutual support, intentional, voluntary reciprocal relationships). Sam meets other people with similar interests and they decide to go to the pictures on a regular basis (Friendship, naturally occurring reciprocal relationships).

Necessary Tensions in Peer Support Contexts

We use the phrase "necessary tension" to capture the political essence of many peer support initiatives. One ongoing tension relates to payment for peer support workers. As Crossley (2004) explains, the trend for members of the c/s/x movement to be sought out and paid for their expertise is a double-edged sword: "At one level this is a victory for the moment. However, as some consultants and activists recognize, it changes the modus operandi of the movement in significant and not always desirable ways. A political model is replaced by a business model", (p. 176). However, many may argue that the situation is less polarised than this. A peer support employee can have a position description that includes strong advocacy and organisational change. This may be outside the original view of early advocates within the c/s/x movement but may still generate major system transformation.

A further key issue relates to concerns of existing staff members whom do not identify as peers. Some mental health professionals may feel concerned about peer support workers for a range of reasons, including reduced productivity, increased risk, or simply having their own jobs replaced. An alternative view is that peer support workers are additional resources that will help divert the overload of clients from already overworked mental health professionals (Solomon, 2004; Solomon & Draine, 2001)

The partnership model is where—consumers (who have psychiatric diagnoses) partner with mental health professionals (who do not have psychiatric diagnoses) in the coordination and delivery of services. Everett (2000) cautions against aspects of partnership models asserting that those in marginalized positions of power can try to exert their influence on partnership models but their voices will never carry the same weight as mental health professionals "because the powerful retain exclusive rights over the definition of what is and is not 'normal' ", (p. 164). As the employment of peer support workers increases within mental health services, the partnership model may take on added complexity, or possibly cease to lose its original meaning. Whilst there is a service provider and a service user, the issue of whether the service provider identifies as having used a mental health service or experienced a mental illness may become subsumed as one type of expertise, i.e. lived experience complementing professional training (Blanch, Fischer, Tucker, Walsh, & Chassman, 1993)

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A Summary of Evidence from Peer Support Programs

The traditional empirical approach with randomised experimental design seen as the highest standard of evidence may be of little value to many involved in peer support initiatives. This again is part of the necessary tension that occurs, and is yet another example of the differences in the medical paradigm which places great importance on "objectivity" and a c/s/x perspective which highly values subjective personal experiences and context.

The empirical literature on peer support consists largely of quasi-experimental studies, qualitative reports, and anecdotal accounts of innovative programs, as opposed to randomized trials. There has been a systematic review of empirical studies that assessed whether participating in mutual help groups for mental health problems leads to improved psychological and social functioning (Pistrang, Barker, & Humphreys, 2010). The twelve studies that met the criteria provided limited but promising evidence that mutual help groups benefit people with three types of problems: chronic mental illness, depression/anxiety and bereavement. These authors report that five of the 12 studies demonstrated no differences in mental health outcomes between mutual help group members and non-members. None of the studies

showed evidence of negative effects. The studies varied greatly in terms of design quality and more high-quality outcome research is needed.

Repper and Carter (2011) reviewed research on peers offering support for people with mental health problems working from professionally led mental health services (e.g., statutory or public services). They located seven randomised controlled trials that described a wide range of peer support work intervnetions. For example, peers employed as cse managers, additional to team members, in outpatient and inpatient services. They reported “inconsistent findings” across studies due to highly variable outcome measures. However, the most consistent finding appeared to be that those services using peer support workers demonstrated a reduction in hosptial admissions and longer community tenure amongst those consumers or mental health services with whom they worked. A range of other benefits were reported from either single studies or qualitative studies. These included a greater sense of indpendence and empowerment, improved social functioning, feeling more accepted, understood and liked, experiencing stigma as less of barrier to employment. There were also multiple benefits reported for the peer support workers themselves (e.g., personal growth, esteem).

The evidence base for peer support in mental health services is growing but there is a need for organisational studies. That is, it is not sufficient to conceptualise peer support initiatives only at the individual level and assess the benefits and the psychological and functioning of the indivdiual. Peer support initiatives should also be investigated as to how they lead to organisational transformation of culture, and how they interface with the policy related to recovery oriented service provision (Slade, Amering, & Oades, 2008). The following is a brief example of a peer support service provided by a psychosocial rehabilitation service in Australia that attempts to addresses some of the organisational issues that arise.

Example of a peer support service

The example is set in a psychosocial rehabilitation service that incorporates peer support services. The service established a Consumer Participation Unit (CPU) which broadly aimed to facilitate communication and understanding of the lived experience

of mental illness in the context of traditional service provision. Staff who have experienced mental illness were employed. Their role was to facilitate community participation, participation within the organisation, and participation by individuals with their own health care planning. The role of the unit in the organisation was to inform and support the organisation on consumer issues. A specific example of activity facilitated by the CPU was the establishment and support for a speaker's bureau of peers to educate the community and staff on the issues to do with having a mental illness. The CPU trains and supports peers to facilitate an eight week peer education course. The unit co- trains staff on rehabilitation practices. It works with day programs to incorporate peer programs within traditional service offerings. It also aims to bring the latest evidence and practice on peer support and consumer issues to the organisation within a recovery framework.

Recommendations Regarding Implementation of Peer Support Initiatives

In their review Repper and Carter (2011) identified a number of challenges in peer support work. These challenges include multiple *Boundary* issues such as being perceived as more of a friend to service users as a result of sharing personal information and experiences. *Power* issues emerge as a result of peer workers being formally employed with all of the associated benefits, thus potentially elevating their status in relation to consumers they work with. Similarly, they may be viewed as "patients" amongst other professional staff with whom they work, undermining their status. *Stress* as been identified as a potential challenge since it could result in recurrence of mental health problems. Worry about this concern may mean that fewer demands are placed on peer support workers by line management, which may limit the roles they are able to play in the service. The final challenge identified involves maintaining a *distinct role* for peer support workers. This issue intersects with the "necessary tensions" noted above in that consumers need to maintain the principles associated with recovery-oriented practices and take care not to be socialised into the traditional way of working in mental health services.

In this final section the aim is to provide recommendations to those who aim to commence peer support groups, or improve those already underway. These recommendations address a number of the challenges noted. Below a set of

prescriptions (things to do) and proscriptions (things to avoid) are provided. This is written predominantly in the context of peer groups within or attached to a mental health system.

Recommended

1. *Clarify early and gain input from a range of people as the primary focus of groups*. That is, are they *remedial,* focussing on the personal processes of recovery, *interactional,* emphasising the interpersonal relationships and personal experience; or *social*- integrating the personal, interpersonal and political, which the authors refer to as social change and empowerment of oppressed populations.
2. *Clarify early and gain input from a range of people as to the advantages and disadvantages of each of the three main forms of peer support.* That is, are they (1) naturally occurring mutual support groups, (2) consumer-run services, and (3) the employment of consumers as providers within clinical and rehabilitative. It is also important to remember that any larger service may have a combination of these types of groups. Explicitly clarify the continuum of peer and non-peer involvement across the agency.
3. *Systematically seek to create "buy in" or ownership for peer services for all parts of the organisation.* This can be in the form of presentations at all staff forums, allocated time at staff meetings for personal stories on the effect of peer support. Multiple strategies that embed peer support such as: establishing work procedures and practices that reflect the values of peer support as an effective psychosocial rehabilitation offering; suitable training and support for peer workers, facilitators and educators; and implementation of peer supervision for peer workers. Strategies require realistic timelines for change to have the greatest opportunity to be embedded and succeed. Organisational change models should be considered.
4. *Use external influences including research, presentations of international best practice, organisational visits etc*. As outlined previously, whilst the discourse of many peer support initiatives is personal and political rather than medical, this in no way means it should not have the same rigour and scholarship supporting it. Some aspects of peer support groups may be similar to communities of practice or journal clubs, which include the sharing of ideas,

personal and other. In the U.S.A. consumer and consumer-supporter national technical assistance centres have been established to support such processes (Rogers, 2010).

5. *Set up organisational structures that allow discussion of the "necessary tensions" associated with peer support work*. For example, members of a peer support group may well question and explore difficulties with medical prescriptions. Hence, if a peer support worker is employed by a clinical agency, in this regard it would make little sense for them to be operationally reporting to a treating doctor. Whilst the individuals involved may manage the tension well, organisational structures, e.g. lines of reporting, should be designed to allow for these tensions to be addressed.
6. *As a general philosophy aim to keep groups and practices semi-structured, autonomous, non-hierarchical and non-bureaucratic.* This provides a challenge for many health services with their emphasis on quality or evidence base. They are not however necessarily opposing. Quality service provision and effective service provision does not necessarily require an a priori fully structured program. It is more likely to involve useful processes that have worked elsewhere that require tailoring to the context at hand.
7. *Examine ways for your agency to link with state, national and international efforts to certify and accredit peer specialists.* Well managed organisations will already be aware of policy initiatives in this regard and seeking to align their workforce and workforce development in line with these principles.
8. *Develop research programs around the peer support initiatives, particularly using methods and approaches consistent with the peer support movement.* For example, participatory action research and qualitative methods will likely be consistent with the aims and philosophy of many within peer support groups. These however are rigorous methods and will require technical support in the same way quantitative methods often require consultants to support.

Recommended to Avoid

1. *Do not use clinical staff members who have been with the service for many years to now lead peer support initiatives.* This would be neither peer led, nor likely to lead to system transformation aligned with peer support values.

2. *Do not employ peer support workers solely because they cost less at the moment than clinically trained staff members*. Whilst in the short term this may provide a useful strategy for having a greater number of peer support workers within a service, in the longer term it is not consistent with the non-hierarchical philosophy of privileging one discourse over another.
3. *Do not think of peer support initiatives simply as groups.* Peer support is a multifaceted phenomenon that may be spontaneous or planned. It may occur in a formal group setting or may represent an overarching culture underpinning the ongoing evolution of recovery oriented service provision. Health services should avoid viewing this solely as a personal or interpersonal process, and think of it also as a service and organisational transformational process, and also accept that much of it is occurring and will occur outside of the service system.

Conclusion

This chapter has provided an overview of key issues in peer support at a time when awareness and policy regarding peer support initiatives is growing in many western nations. Key recommendations have been provided about how to develop or improve peer support initiatives. We have argued for structures and processes to maintain the "necessary tension" between some of the philosophies stemming from the c/s/x movement that has underpinned peer support work with the traditional medical models that have dominated mental health service provision.

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