ImROC
Implementing Recovery through Organisational Change

A joint initiative from

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

Briefing

5. Peer Support Workers: Theory and Practice

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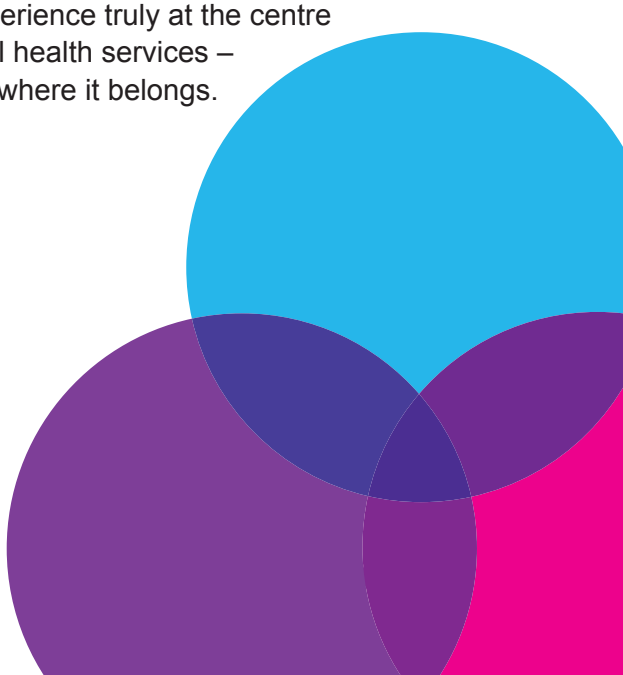
INTRODUCTION

Peer support is *"offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations"*. In this paper we will examine the concepts and principles of peer support and present examples from organisations which now have peers in their workforce.

The ImROC programme has recommended the use of peer workers to drive recovery-focused organisational change. ImROC recognises the value of a range of *different roles* for peers in all types of mental health services. Whether they are paid or voluntary, working in public, private or independent services, peer workers have a valuable role to play.

We have concentrated on the contribution of peers working inside mental health services because of the multiple benefits that they can bring. Working together, 'co-producing' services alongside traditional mental health professionals, they can offer a truly comprehensive and integrated model of care.

We also have to be concerned with maximising 'value for money' and we believe that peers – properly selected, trained and supported – can improve the quality of services at no extra cost, possibly even with cost reductions. This would put the voice of those with lived experience truly at the centre of mental health services – which is where it belongs.



ACKNOWLEDGEMENTS

Advances in recovery-focused practice arise from collaborative partnerships between individuals and organisations. The ImROC briefing papers draw upon this work. Each paper in the series has been written by those members of the project team best placed to lead on the topic, together with contributions from other experts. In this case, we particularly wish to acknowledge the contribution of those whose work on the theory and practice of peer support has led the field and inspired others. They are listed on the front cover. Without these pioneers, and others like them, we would have nothing to write about. In order to illustrate many of the points in this paper, we will use quotes from the Nottingham peer support worker project, *Final report for Closing the Gap, The Health Foundation*, (2012).

BACKGROUND

Increasing numbers of mental health services are developing peer worker roles and are faced with similar questions and challenges. As a result, a number of reports and recommendations have appeared over the last few years (Davidson *et al.*, 2012; Faulkner & Kalathil, 2012; Mead *et al.*, 2001; Mental Health Foundation, 2012). We want to try to bring together the collective learning from these publications, to examine some of the basic concepts and principles underlying the practice of peer support workers in mental health services and present them together with illustrative examples from organisations who have begun to train and employ peers as part of their workforce. This paper is accompanied by a second publication (*'Developing peer support workers in your organisation', in preparation*) which will cover the practical details of implementation in more depth.

For as long as people have used mental health services they have provided each other with friendship, shared coping strategies and supported each other through dark times (Davidson *et al.*, 2012). As the value of such mutual relationships have been recognised, so more formal peer roles have been created in mental health services across the western world. In the United States, 27 states have collaborated to create a scoping and guidance document for peer support (Daniels *et al.*, 2010). Peer workers have also been employed in various different roles and settings in Australia (Franke *et al.*, 2010), New Zealand (Scott *et al.*, 2011) and various parts of Europe (Castelein *et al.*, 2008). In the UK, peer support has long played a central role in voluntary sector and user-led services/groups (Scottish Recovery Network, 2011; Faulkner & Kalathil, 2012; Mental Health Foundation, 2012) but peer worker roles in statutory services have been slower to establish. The ImROC programme has specifically recommended the development of peer worker posts as a driver of recovery-focused organisational change (see Challenge 8 in Shepherd *et al.* 2010) and the growth of peer support of all kinds appears to have accelerated supported by a number of organisations. Prior to 2010, it would have been difficult to find a single peer support worker employed in mental health services in England, but in 2013 Nottinghamshire Healthcare NHS Trust employs 25 peer support workers, Cambridgeshire and Peterborough NHS Foundation Trust employs 32; Central and North West London NHS Foundation Trust employs 12. Many other trusts employ peers as trainers, in volunteer, bank and mentoring posts.

ImROC recognises the value of a range of different roles for peers in all types of mental health services. Whether they are paid or voluntary, working in public, private or independent services, peer workers have a valuable role to play. This is recognised in policy documents in England, Scotland and Wales. For example, in England the Department of Health papers on Health, Social Care and Volunteering all recognise the role that peer support can play in providing support, facilitating self-management, aiding prevention, improving public health and reducing health inequalities. They recognise the value of community based *"peer support services, user-led self-help groups, mentoring and befriending, and time-banking schemes, which enable service users to be both providers and recipients of support"* (DH, 2011, p.32) and recommend peer support as one of the *"roles of mental health organisations in implementing the mental health strategy"* (DH, 2012, p.51). The Joint Commissioning Panel for Mental Health also recommends the employment of peer mentors and patient experts to work on *'self-management, advocacy, training and mentorship programmes in order to improve personal understanding and responsibility for wellbeing'* (JCPMH, 2012, p.9). The recent Schizophrenia Commission (2012, p.35) specifically recommends that *"all mental health providers should review opportunities to develop specific roles for peer workers".*

WHAT IS PEER SUPPORT?

Peer support may be defined simply as *"offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations"* (Mead *et al.*, 2001). Thus, it occurs when people share common concerns and draw on their own experiences to offer emotional and practical support to help each other move forwards. This is well articulated by peer support workers from Nottingham.

"...They know I'm not the expert, they know we're just us, both trying to beat the same demons, and we're trying to work things through together.... I said to her, 'I've got my own experience of mental illness, I've been on the ward myself and so on,' and with that she sort of jumped up and gave me this huge hug."

Peer support encompasses a personal understanding of the frustrations experienced with the mental health system and serves to reframe recovery as making sense of what has happened and moving on, rather than identifying and eradicating symptoms and dysfunction (Bradstreet, 2006; Adams & Leitner, 2008). It is through this trusting relationship, which offers companionship, empathy and empowerment, that feelings of isolation and rejection can be replaced with hope, a sense of agency and belief in personal control.

"I wanted to be able to show people that however low you go down, there is a way up, and there is a way out... The thing I try to install is, no matter where you are, if you want to get somewhere else you can, there's always a route to get to where you want to be."

The shared experiences of peers in mental health settings are most commonly their mutual experiences of distress and surviving trauma. However, it is not always enough simply to share experiences related to mental health. Support is often most helpful if both parties have other things in common such as cultural background, religion, age, gender and personal values (Faulkner & Kalathil, 2012). For people who have experienced marginalisation and exclusion (such as those from minority ethnic groups) it can be important for the support to come from someone who shares these experiences of oppression and/or of facing structural barriers so that they can 'speak the same language'.

Relationships with others who share your experience are unlikely to be helpful if they are overly prescriptive, burdensome, or felt to be unsafe (in terms of trust and confidentiality). The peers from user-led groups interviewed by Faulkner and Kalathil (2012) also found that relationships were more supportive if both people were willing both to provide *and* receive support and had gained some distance from their own situation so that they were able to help each other think through solutions, rather than simply give advice based on their own experiences. For these reasons, training, supervision and support are all essential for peer workers employed in services.

DIFFERENT FORMS OF PEER SUPPORT

We can draw distinctions between three broad types of peer support: (a) 'informal' (naturally occurring) support; (b) peers participating in consumer, or peer-run, programmes alongside formal mental health services; and (c) employing people with lived experience within statutory services, irrespective of whether they are employed by the statutory organisation or by independent sector agencies.

These different forms of peer support also vary along a number of (not necessarily linear) dimensions. These include: the number of people involved, the level of choice involved, the rules governing the relationship, and the extent to which peers are at the same stage in their journey of recovery. These dimensions are summarised in Box 1.

Box 1: Dimensions of peer support

- **Group vs. individual:** Some forms of peer support, like peer run support groups and courses, offer only group support, although members may form individual relationships as a result of meeting through the group. Other forms, like informal friendships, buddy systems, co-counselling or individual interactions between peer workers (paid or unpaid) in services, provide more individualised support.
- **Extent to which both parties choose to enter the relationship:** Informal networks and friendships are entirely elective. Someone joining an existing group, or enrolling on a self-management course chooses to do so, but does not have choice over the other participants or the peer trainers. Someone entering a hostel, crisis or day service (whether user-led or not) may have some degree of choice about whether they enter the service and about the workers (paid or unpaid) with whom they engage, but the individuals using the service have little choice over who is employed there (although peers may be involved in staff selection).
- **The ways in which rules govern the relationship:** No relationships are entirely without rules or boundaries. Sometimes these are implicit, as in ordinary friendships while others are more explicitly stated, as in codes of conduct, for example in buddy and befriending arrangements. The most formal 'rules' are those contained in Job Descriptions which are usually set in a number of other regulations which govern employees of the organisation. Ethical guidelines differ in a similar fashion. In informal friendships they are implicit; in other relationships (e.g. peer support groups) they may be agreed by consensus or, again, formalised in codes of conduct for employment. These formal rules apply to all paid staff.
- **Extent to which the parties involved are in the same place in their recovery journey:** Everyone's recovery journey is different and each journey is usually far from linear. At different points in time one person may be further on, but then they experience a setback so reversing roles. Often in peer support groups there is a facilitator or organiser who may, at the time of fulfilling this role, have moved further in overcoming the challenges than those who are new to the group. Similarly, it might be assumed that peer trainers in self-management courses or paid workers in services will have moved beyond their most recent experience. Clearly these roles can change over time, but peer workers may experience setbacks and people currently attending services can and do move on to the role of trainers, co-ordinators and workers. Such is the dynamic nature of peer support.

DIFFERENT ROLES

There are many different ways in which peer workers can be employed within mental health services.

They may work in **dedicated teams**:

- responding to referrals for peer support from other teams (Repper & Watson, 2012)
- working across 'transitions', e.g. from specialist community teams to Community Mental Health Teams (CMHTs), or from inpatient wards to CMHT
- providing specialist consultancy advice regarding recovery-focussed practices such as WRAP (Wellbeing Recovery Action Plan), or other forms of Personal Recovery Planning
- providing service-wide functions, e.g. speaking at staff induction, reviewing policy documents, undertaking quality assurance exercises, providing mentorship for staff, etc.

Alternatively, they may be employed **in addition to staff in existing teams** (inpatient or community) to bring a specific focus on the needs of service users:

- Facilitating earlier discharge from inpatient wards, working across boundaries to engage with inpatients prior to discharge, spend time planning for life in the community and then supporting people after discharge by home visits, meetings with friends and community contacts, etc.
- Leading on personal recovery planning, using their own experience to help the person identify and prioritise goals, develop understanding, control and self-management strategies and to ensure that all of this is communicated to the professional staff team.
- Improving the value of follow-up appointments (e.g. outpatient consultations) helping the service user think through questions and concerns prior to appointments and how best to convey these to professionals. This can specifically help to establish the culture of 'shared decision making' (e.g. regarding medication management).
- Supporting learning in Recovery Colleges (Perkins *et al.*, 2012) working with staff to co-produce and co-deliver courses and facilitate productive engagement.
- Leading on social inclusion. As already indicated, peer workers often come from the same physical and cultural communities as the people they are supporting. They are therefore particularly well-placed to identify appropriate community resources and activities and to facilitate engagement by accompanying their peers until they are confident and comfortable to attend alone.

As will be evident from the above, the peer support role as an adjunct to existing staff roles has considerable overlap with non-peer support roles (e.g. Support, time and recovery 'STR' workers) and with peer advocacy. The difference is that peer support workers are specifically employed to use their personal experience to support others. But they cannot be expected to achieve this if they are left to work alone. In Recovery Innovations in the U.S. over half the mental health workers employed by the service are trained peers (See META Services Arizona in Shepherd, Boardman & Slade, 2008); and in Nottinghamshire the aim is for at least two peer workers in every team (see Nottinghamshire Healthcare Trust Recovery Strategy 2009-12, 2013-16). Some examples of peer worker roles are given in Box 2.

Box 2: Examples of specialist peer worker roles

Nottinghamshire Partnership Mental Health Intensive Care Unit (MHICU): The team leader had one 'Band 3' vacancy and was keen to bring lived experience into the team to promote a more recovery-focused ethos. The post was therefore converted to a peer healthcare assistant and three part time peers were recruited. They had all previously spent time in inpatient settings. The staff team spent a whole day learning about peer support, expressing their hopes and fears, generating ideas about how the peers might best use their experiences. Three months later all the peers say they are very happy working at the unit and feel they can make every aspect of their work recovery-focused whether it is serving meals, escorting patients or simply talking to them. They feel able to talk about their own experiences when appropriate and have day to day support from the team leader who encourages them to bring their insights and ideas to all team meetings.

Cambridgeshire and Peterborough NHS Foundation Trust – Integrated Offender Management (IOM) Peer Workers: In May 2012, CPFT appointed 5 peer workers to their IOM teams based in Peterborough, Cambridge and Huntingdon police stations. The role was very new and a lot of work was done to ensure that the peers worked out their roles in relation to the nurses also employed by the Trust in the IOM teams and with the police and probation staff who form the main staff groups. The peers are working in partnership with the trained nurses on the recovery needs of prolific offenders with mental health problems. They work with a number of external organisations, including drug and alcohol services, housing and adult education and have a particular role in training staff from other agencies (e.g. police) in relation to mental health issues. Due to the nature of the new role, a higher banding was required so that the peer workers could be more autonomous.

THE CORE PRINCIPLES

Whatever the form of peer support or the nature of the role, there are a number of core principles that peer support workers should aim to maintain. These are summarised in Box 3. They include: mutuality, reciprocity, a 'non-directive' approach, being recovery-focused, strengths-based, inclusive, progressive and safe. These principles can be used to guide training and supervision and to maintain the integrity of the peer role wherever they are located and whoever employs them (see below).

Box 3: The core principles of peer support

1. Mutual	The experience of peers who give and gain support is never identical. However, peer workers in mental health settings share some of the experiences of the people they work with. They have an understanding of common mental health challenges, the meaning of being defined as a 'mental patient' in our society and the confusion, loneliness, fear and hopelessness that can ensue.
2. Reciprocal	Traditional relationships between mental health professionals and the people they support are founded on the assumption of an expert (professional) and a non-expert (patient/client). Peer relationships involve no claims to such special expertise, but a sharing and exploration of different world views and the generation of solutions together.
3. Non-directive	Because of their claims to special knowledge, mental health professionals often prescribe the 'best' course of action for those whom they serve. Peer support is not about introducing another set of experts to offer prescriptions based on their experience, e.g. *"You should try this because it worked for me"*. Instead, they help people to recognise their own resources and seek their own solutions. *"Peer support is about being an expert in not being an expert and that takes a lot of expertise."* (Recovery Innovations training materials. For details see www.recoveryinnovations.org)
4. Recovery focused	Peer support engages in recovery focused relationships by: • inspiring **HOPE:** they are in a position to say *'I know you can do it'* and to help generate personal belief, energy and commitment with the person they are supporting • supporting people to take back **CONTROL** of their personal challenges and define their own destiny • facilitating access to **OPPORTUNITIES** that the person values, enabling them to participate in roles, relationships and activities in the communities of their choice.

5. Strengths based	Peer support involves a relationship where the person providing support is not afraid of being with someone in their distress. But it is also about seeing within that distress the seeds of possibility and creating a fertile ground for those seeds to grow. It explores what a person has gained from their experience, seeks out their qualities and assets, identifies hidden achievements and celebrates what may seem like the smallest steps forward.
6. Inclusive	Being a 'peer' is not just about having experienced mental health challenges, it is also about understanding the meaning of such experiences within the communities of which the person is a part. This can be critical among those who feel marginalised and misunderstood by traditional services. Someone who knows the language, values and nuances of those communities obviously has a better understanding of the resources and the possibilities. This equips them to be more effective in helping others become a valued member of their community.
7. Progressive	Peer support is not a static friendship, but progressive mutual support in a shared journey of discovery. The peer is not just a 'buddy', but a travelling companion, with both travellers learning new skills, developing new resources and reframing challenges as opportunities for finding new solutions.
8. Safe	Supportive peer relationships involve the negotiation of what emotional safety means to both parties. This can be achieved by discovering what makes each other feel unsafe, sharing rules of confidentiality, demonstrating compassion, authenticity and a non-judgemental attitude and acknowledging that neither has all the answers.

IMPACT OF PEER WORKERS

Although there has been relatively limited research into the effectiveness of peer support, the studies that have been published paint a positive picture of the benefits. These benefits can be considered from a number of different perspectives.

Benefits to the worker

Studies of the experiences of peer support workers report many challenges to the role which need to be identified and addressed (see below), but these are outweighed by the potential benefits. They feel empowered in their own recovery journey (Salzer & Shear, 2002) have greater confidence and self-esteem (Ratzlaff *et al.*, 2006) and a more positive sense of identity, they feel less self-stigmatisation, have more skills, more money and feel more valued (Bracke *et al.*, 2008). Being employed as a peer worker is generally seen as a positive and safe way to re-enter the job market and thus resume a key social role (Mowbray *et al.*, 1998).

"I work hard to keep myself well now, I've got a reason to look after myself better... It's made a real big difference to me, you know, contributing something to them. And hopefully changing their lives for the better".

Benefits to the people being supported

"Peer workers have the time and flexibility to listen. They always take the time to talk, whereas other staff members may get called away".

Research into the impact of peer support on the people being supported includes seven randomised controlled trials and many more observational, qualitative and naturalistic comparison studies (Davidson *et al.*, 2012; Repper & Carter, 2010; Bradstreet, 2006). Overall, these indicate that if peer workers are well trained and supported and employed in a recovery focused service where peer to peer supervision is available, they have the potential to bring a range of benefits to those receiving support, including:

- increased self-esteem and confidence
- improved problem solving skills
- increased sense of empowerment
- improved access to work and education
- more friends, better relationships, more confidence in social settings
- greater feelings of being accepted and understood (and liked)
- reduced self stigmatisation
- greater hopefulness about their own potential
- more positive feelings about the future.

Of course, not all studies show all these benefits and it depends a lot on how well the peer support workers are selected, trained and supported and how well the organisation is prepared. Nevertheless, the potential benefits are certainly huge and it seems that peer support workers can make a significant contribution to enhancing the *experience* of care (subjective quality).

In this country, an area where experience of care has consistently been shown to be very poor has been acute inpatient admission (Mind, 2012; Care Quality Commission, 2009; SCMH, 1998). Thus, it is particularly important to evaluate the effects of adding peer support workers to acute inpatient teams. In the USA, Recovery Innovations have found that, over time, the addition of trained peers can improve the subjective quality of the service, reduce coercion and the use of physical restraints (Ashcraft & Anthony, 2008). By selectively reviewing the evidence on this topic we have found that adding peer support workers to the acute pathway can also shorten lengths of admission and reduce re-admission rates leading to significant cost savings (Trachtenberg *et al.*, 2013). This is clearly an important area for further study.

Benefits to the teams in which they work

"I just stand back and watch him work his magic. Not just with the patients who come in here so frightened and hopeless, but with staff too. He can help them see things in a completely different way."

The introduction of peer workers is a powerful way of driving forward a recovery-focused approach within a team. Just as peer workers provide hope and inspiration for others experiencing mental health problems, they challenge negative attitudes of staff and provide an inspiration for all members of the team. Peer workers also facilitate a better understanding between the people providing the service and those using it (Repper & Watson, 2012). As this team leader said:

"Peer workers have significantly changed the recovery focus of our team, they challenge the way we talk about people from a problem and diagnosis focus to one of strengths and possibilities" (Politt *et al.,* 2012).

Benefits to the organisation

"The values and leadership of consumers are driving the shift from a system focused on symptom reduction and custodial care to self-directed recovery built on individual strengths..." (SAMSHA 2005).

Peer workers can also use their personal experience to influence organisational policies, procedures and behaviours. The fact that they have found ways of recovering a contributing role challenges some of the beliefs that underpin the system. For example, if an organisation is to employ peer workers, then human resources departments will need to reconsider general recruitment and selection policies and the use of Criminal Records Bureau (CRB) checks. Similarly, the recruitment of peer workers may highlight the need for occupational health procedures to be strengthened in relation to staff with health work problems arising from mental health issues. Thus, processes for supporting staff and improving wellbeing may be improved not just for peers, but for the whole workforce (Perkins, Rinaldi & Hardisty, 2010).

Where peer workers are active in decision-making bodies throughout the organisation they can challenge negative assumptions, counter risk-aversive behaviour and point out discriminating language and excluding practices. Finally, peer workers stand as a living testimony to the potential of everyone with mental health problems to recover and to contribute in a significant way to the services they receive. They demonstrate the role that services can play in this if they can make the right opportunities available. The employment of peer workers in itself therefore drives change towards more recovery-focused organisations.

MAINTAINING INTEGRITY

The ImROC programme has been particularly concerned with the establishment of peer support workers in paid posts within formal mental health services (e.g. in the NHS and other provider organisations). This is because of the multiple benefits to this approach described above. However, this approach has also been criticised for 'professionalising' the peer role, with risks of over-controlling the natural and spontaneous relationship that is at the heart of the helping process (Faulkner & Kalathil, 2012). This is clearly a danger. But there is also a danger in *not* formalising the role. When people are employed in large, bureaucratic organisations, there are perhaps even greater dangers of the role being blurred and people being exploited as 'cheap labour'. The trappings of formality – job descriptions, managers, individual review – thus provide safeguards as well as risks.

The most effective way of retaining the essence of peer support is to identify its core values and ensure that these are upheld through recruitment, training and supervision. Of course, formal processes do not guarantee that the role will be allowed to develop in a creative and sensitive way, but they do provide a framework within which this is possible and within which distortions – should they occur – can be clearly identified.

A number of other organisational challenges have been identified which can potentially get in the way of peer support workers being able to make their maximum contribution. These include:

- engaging managers to support and understand the role
- treating peer workers as staff colleagues, not 'patients'
- enabling peer workers to meet organisational demands such as administration and record keeping
- ensuring that peers take appropriate responsibility for their own wellbeing
- placing peers appropriately so that they are not put in positions which are too stressful or isolated
- allowing peers to work to their full potential by utilising both lived experience and life skills
- ensuring that peers have the support, skills and confidence to challenge poor practice in an appropriate manner
- ensuring that peer workers have the training and ongoing support to disclose personal information appropriately
- supporting peers to negotiate 'reasonable adjustments' in the workplace so that they can work to their full potential
- ensuring that all staff have access to the same support for their personal wellbeing as peers do.

This is a daunting list, but it reminds us that although the introduction of peer support workers can have enormous benefits for organisations, but it is also difficult and complex and easy to get wrong. The key to integrity remains the commitment to our core principles: mutuality, reciprocity, non-directive, recovery-focused, person-centred, strengths-based, community-facing and safe. It is these that we must aspire to maintain.

CONCLUSIONS

We have argued strongly for the value of establishing peer support roles to promote recovery in mental health organisations. Peers bring unique experience and a unique set of skills which can be deployed across a range of settings to provide hope, inspiration and influence for staff and service users alike. Their potential contribution is now recognised by policy makers and governments across the world. The research base is also growing and confirming that peers, appropriately recruited, trained and supported can have multiple benefits, for those providing the service, for those receiving it and for the organisations themselves. There is even beginning to be some evidence that peers, working alongside traditional professionals, can be highly cost effective and reduce demands on other services. However, we have also noted that the establishment of peer support roles is not without significant difficulties and it is easy to make mistakes. How can some of the practical difficulties of establishing peer support workers be addressed? This is the topic for the next paper, to be published this summer.

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Peer support workers: theory and practice

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For more information on the current work of ImROC, please visit **www.imroc.org**.

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Centre for Mental Health

Centre for Mental Health is an independent national mental health charity. We aim to inspire hope, opportunity and a fair chance in life for people of all ages with or at risk of mental ill health. We act as a bridge between the worlds of research, policy and service provision and believe strongly in the importance of high-quality evidence and analysis. We encourage innovation and advocate for change in policy and practice through focused research, development and training. We work collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

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Mental Health Network NHS CONFEDERATION

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors. The MHN works with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

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