34 Empowerment and Inclusion: The Introduction of Peer Workers into the Workforce

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History and Background

The idea that people with mental health problems may receive support from others who share their experiences has a long history in mental health services (Davidson et al. 2012). For example, Davidson notes how Pinel and his colleagues, working in the Bicetre hospital in Paris at the end of the eighteenth century, were convinced that a major factor in the reform of mental health care must be the employment of people with '*lived experience*'. '*As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest and humane*' (Jean Baptiste Pussin in a letter to Pinel, 1793, quoted in Davidson et al., p. 123). With the advent of more medical models of mental illness, the use of peer support in hospitals declined in the later part of the nineteenth century as the mental health professionals – medical, nursing, psychology, social work – established themselves. It made a reappearance in the 1960s and 1970s in the therapeutic community movement, with a renewed emphasis on the potential of peers to help one another (Campling 2001). Now peer support is popular again, with more than half of the US states making it billable under Medicaid and trained peer workers being employed in many countries all over the world (Repper 2013a; Slade 2009).

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In the UK, peer support has long played a central role in voluntary sector and user-led services/groups (Basset et al. 2010; Mental Health Foundation 2012; Scottish Recovery Network 2011, 2012) but peer worker roles in statutory services have been slower to develop (Rinaldi and Hardisty 2010). Nevertheless, the English Department of Health has recognised that peer support can play an important role in providing individualised support, facilitating self-management, aiding prevention and reducing health inequalities (Department of Health 2010, 2011). It also recommends peer support as a potentially important route whereby people with mental health problems can participate in paid employment. The recent Schizophrenia Commission report (2012) specifically recommends that, '*all mental health providers should review opportunities to develop specific roles for peer workers*' (p. 35).

What Is Peer Support?

Before going any further, we should define what we mean by '*peer support*' and review the different types of peer support that have been developed. 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. Peer support encompasses a personal understanding of the frustrations sometimes 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 dysfunctions (Adams and Leitner 2008; Bradstreet 2006). 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*' (*Peer support worker*, *Nottingham Healthcare*).

The shared experiences of peers in mental health settings are most commonly their mutual experiences of distress and of surviving trauma. However, it is not always enough for them simply to tell their stories. Support is often most helpful if both parties have other things in common such as cultural background, religion, age, gender and personal values (Faulkner and Kalathil 2012). The peers from user-led groups interviewed by Faulkner and Kalathil 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 essential for peer workers employed in services (see section "Characteristics of effective peer support" below).

There are several different ways in which peer workers can be employed within mental health services. For example, they may work in *dedicated peer support teams*, responding to referrals for peer support from clinical teams (Repper and Watson 2012). In this arrangement they are likely to be used as a source of specialist advice for the local mental health service regarding recovery-focused practices such as WRAP, or other forms of personal recovery planning. They may also contribute to 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 *alongside traditional staff in existing teams* (inpatient or community) to bring a specific focus on the needs of service users. In inpatient settings they may facilitate early discharge, using their experiences to help the person identify and prioritise goals and develop their own control and self-management strategies. Working closely with the professional staff team can help ensure that the person does not spend any longer in hospital than they need to and is best prepared for managing their own condition on discharge. Peer workers are also in a good position to work flexibly across boundaries, liaising with staff in community teams, to help the person engage with follow-up supports. For example, they may improve the benefits of outpatient appointments by helping the service user think through their questions and concerns prior to the appointment and how best to convey these to the professional thus facilitating a '*shared decision making*' approach (SAMSHA 2010; Torrey and Drake 2009). One of the most important roles for peer workers in community teams is to facilitate social inclusion by using their personal knowledge of the local community to identify resources and activities which might help the person and then supporting them to engage by accompanying them until they are confident to attend alone (Repper and Watson 2012).

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 34.1. 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.

Effectiveness and Cost-Effectiveness

Despite considerable interest in introducing peer workers into the workforce in recent years, the evidence for their effectiveness is limited. There have been few randomised controlled trials those which have been performed often evaluate very different forms of peer support. Not surprisingly, meta-analytic reviews which restrict themselves to randomised controlled trials tend to come up with rather negative results (Pitt et al. 2013; Evans et al. 2014). However, other reviewers who have also considered non-RCT evidence, including '*grey*' as well as published literature, present a more positive picture (Davidson et al. 2012; Repper and Carter 2011; Trachtenberg et al. 2013; Warner 2009). Not surprisingly, because of the variable quality of the evidence and the use of different samples, different

Box 34.1: The Core Principles of Peer Support (From Repper 2013a, Reproduced with Permission)

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.
Reciprocal	Traditional relationships between mental health professionals and the people they support are founded on the assumption of an expert (professional) and a nonexpert (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.
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, 2007)
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.
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 flourish. 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.
Inclusive	Being '*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.
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.
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 nonjudgemental attitude and acknowledging that neither has all the answers.

reviewers come to slightly different conclusions. Nevertheless, a number of consistent findings do emerge.

- In no study has the employment of peer support workers been found to result in worse health outcomes compared with those not receiving the service. Most commonly the inclusion of peers in the workforce produces the same or better results across a range of outcomes.
- The inclusion of peer support workers tends to produce specific improvements in patients' feelings of empowerment, self-esteem and confidence. This is usually associated with increased service satisfaction.
- In both cross-sectional and longitudinal studies, patients receiving peer support have shown improvements in community integration and social functioning. In some studies they also bring about improvements in self-reported quality of life measures, although here the findings are mixed.
- In a number of studies when patients are in frequent contact with peer support workers, their stability in employment, education and training has also been shown to increase.

As indicated, some of these findings are not replicated across all studies and the overall methodological quality of the evidence is limited. Nevertheless, the general findings of an increased sense of empowerment and positive benefits in terms of social inclusion are consistent.

Regarding cost effectiveness, Trachtenberg et al. (2013) examined a sample of outcome studies ($n=6$) which aimed to evaluate whether the introduction of peer support workers into community crisis teams or acute inpatient wards reduced the use of hospital beds either by preventing or delaying admissions to a hospital, or by shortening the length of inpatient stays. Across the studies, the average benefit/cost ratio (taking into account sample size) was more than 4:1. Thus, the estimated financial value of cost savings in terms of reduced inpatient bed days consequent upon introducing peer workers was very significant. This was a small study, but the results provide preliminary support for the proposition that adding peer support workers to existing mental health teams result in cost savings. This conclusion is echoed in a recent review commissioned by the UK charity Rethink (2014) from the Personal Social Services Research Unit, led by Professor Martin Knapp, at the London School of Economics. They suggest, '*An approach which may also in time offer the biggest scope for cost savings in mental health care is to promote and expand co-production, drawing on the resources of people who are currently using mental health services, for example in peer support roles*' (p. 6).

In addition to these benefits for people receiving this kind of support, there is also evidence of benefits for the peer workers themselves. They feel more empowered in their own recovery journey and have greater confidence and self-esteem and feel more valued (Mowbray et al. 1998; Repper and Carter 2011; Salzer and Shear 2002). They also acquire a much more positive sense of identity. As one of the peer workers in the ImROC programme said, '*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, just contributing something, to them. You know and hopefully changing their lives for the better'.

Finally, our recent experience with the ImROC (Implementing Recovery through Organisational Change) programme is that the introduction of peer workers is a powerful way of driving a more recovery-focused approach within the whole organisation (Shepherd et al. 2010). Just as peer workers provide hope and inspiration for service users, so they challenge negative attitudes of staff and provide an inspiration for all members of the team. They provide a living example that people with mental health problems can make a valued contribution to their own and others' recovery if they are given the opportunity (Repper and Watson 2012). As this team leader said, '*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*'. This specific impact on organisations is common among services where peer workers are introduced but, to our knowledge, it has not been formally investigated. We shall return to this theme later.

To summarise, there is reasonably good evidence to support the idea that the introduction of peer workers, alongside other traditional mental health staff in the workforce, may have significant benefits in terms of increasing feelings of empowerment and social inclusion both for those receiving the service and for those delivering it. Furthermore, there is some evidence that the introduction of peers into the workforce may be highly cost-effective. There is also evidence that there are benefits for the organisations in which they operate in terms of inspiring a more positive, '*recovery-oriented*' approach. Of course, these kinds of benefits do not happen automatically. They requires a high quality implementation of the intervention and there is still considerable variability in what kind of support is provided. This lack of standardisation of the '*independent variable*' undoubtedly accounts for some of the variability in outcomes. So, can we specify in more detail the nature of effective peer support?

Characteristics of Effective Peer Support

As part of the ImROC programme, we now have experience in supporting the development of more than 300 peer posts (Shepherd in press). On the basis of this experience we can begin to identify some the key characteristics of effective peer support. (This section is based on one of the ImROC Briefing papers, Repper (2013b) and this text is reproduced with permission).

When developing peer worker posts, it is useful to think of four sequential phases. The first involves *preparation* – of the organisation as a whole, of the teams in which peers will be placed and, obviously, of the peers themselves. The second involves *recruitment* of trained peers to the posts that have been created. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, this whole process needs careful support. Thirdly, there is the safe and effective *employment* of peer workers in mental health organisations. Finally, the *ongoing*

development of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. These different phases are summarised in Box 34.2 below.

Box 34.2: Developing Peer Worker Posts: 4 Phases (Reproduced from Repper 2013b, with Permission)

1. Preparation
   - Preparing the organisation
   - Preparing the teams
   - Defining roles
   - Common myths and misperceptions
   - Preparing the peer workers (training)
   - Developing job descriptions and person specifications
2. Recruitment
   - Advertising
   - Benefits advice
   - Applications
   - Interviews
   - Occupational health
   - CRB checks
   - Supporting people who are not offered posts
3. Employing peer workers
   - Selecting placements
   - Induction/orientation
   - Supervision and support
   - Staff myths
4. Ongoing development of the role
   - Career pathways
   - Training opportunities
   - Wider system change

Preparation

The development of peer worker posts must begin with consideration of the context in which they will be employed. A local project/steering group therefore needs to be established and its membership should include representatives from the various parts of the organisation that will be affected – e.g. HR, management, professional groups, communications, etc. It is also important to include people who use the services, their family and friends and members from relevant local partner organisations.

This group then needs to work through a number of critical issues, beginning with the fundamental questions, '*Why do we want to employ peers*?' and '*What*

differences do we hope they will make?' In the current climate, it is particularly important to be aware of the danger of creating peer support roles for the sole purpose of saving money, or simply to carry out tasks that other staff are unwilling to do. The vision for peer workers needs to be communicated to all relevant departments and teams with an invitation to find out more, or to get involved for those who are interested. A variety of communication methods will be necessary to achieve this, including workshops, information days, staff briefings, newsletters, etc. Potential peer workers should be involved directly in all these initiatives. Once committed, the organisation then needs to address a number of key organisational processes.

(a) *Human Resources* (*HR*) – At the heart of establishing successful peer support worker programmes will always be the support of HR departments (indeed, some of the most successful schemes have been led by HR professionals). Ensuring that HR colleagues understand the aims and philosophy of peer support workers and are in a position to offer their guidance regarding recruitment, job descriptions, interviewing, supervision, etc. is therefore essential. If people are to be employed in '*proper*' jobs, then they will need '*proper*' job descriptions and person specifications. These should be developed locally.
(b) *Workforce Planning* – Predicting the future balance of traditional professionals and peer workers is a key problem. No one believes that peers could – or should – replace *all* professionals, but there is an issue of balance to be resolved. What should this be? Local services need to agree local targets and prepare to work towards them. In Nottinghamshire Healthcare Trust (England) the aim has been expressed in terms of at least two peer workers (not necessarily full-time) in every clinical team. This may require a process of consultation with local trade unions to help them see the benefits for staff inherent in these new developments.
(c) *Occupational Health* (*OH*) – Occupational health services have a critical role to play in providing advice regarding appointments of new staff (peers) and return-to-work plans for peers who have periods of absence due to recurrence of illness. Although the same rules should apply to peer workers as to other staff, OH clinicians may be particularly anxious regarding fitness and '*return-to-work*' issues when the person is known to have had mental health problems and is returning to work in a mental health service setting. They may also be unfamiliar with the concept of '*reasonable adjustments*' to the workplace as applied to people with mental health issues (*see* Perkins et al. 2009). Members of the project team will therefore have to ensure that OH colleagues are fully involved in the project from the outset and that their continuing input is secured.
(d) *Facilities* – Peer support workers will need their own base for meeting, peer supervision, informal support and to complete records. This should be close to their workplace but not necessarily based in the clinical teams.

(e) *Finances/Management* – If new posts are to be created, or existing posts redefined, this may have financial and other management implications. Funding needs to be identified to cover basic salary and '*on-costs*', recruitment, training, peer-led advice/supervision, relief cover, travel, administration and equipment costs. If comprehensive costs are not identified at the beginning of the project they will inevitably return to haunt the project team at a later date.
(f) *Involving Staff* '*Learning and Development Units*' – The employment of peer workers may create new opportunities for learning and development departments to work collaboratively with peers in developing and delivering training to a variety of staff groups (and groups outside the organisation, e.g. police, GPs, etc.).
(g) *Developing Relationships with Local Social Services Departments and Non-statutory Partners* – Peers' roles may usefully cross over boundaries between services, so any steering group is likely to need to include relevant partner organisations. For example, social services departments may provide funding for joint training; local peer-led or voluntary sector organisations might be involved in the preparation, training and supervision of peers. This is particularly important in the early stages of the project as user-run organisations may have considerable existing experience relating to the topic and may be able to provide advice, support and active collaboration regarding training and supervision. However, if not handled sensitively, it may also give rise to conflicts.

Once established the Project Group then needs to develop a clear plan, within the identified financial envelope, with specific actions, accountabilities and timescales. Of course, this will change as the project evolves, but clear planning at this stage is essential to keep the project '*on track*'. It may be assisted by having some external monitoring of progress.

If the introduction of peer workers is to be successful then the teams where they are to be placed have to be prepared. The whole team must understand and (hopefully) own the process and in several pilot studies it has been reported that they are less likely to be successful or effective in teams that are not already working in a recovery-focused manner and not committed to engaging with peers as team members (Repper and Watson 2012; Scottish Recovery Network 2011). Therefore, it is strongly recommended that teams in which peer workers are placed have already accessed training in recovery-focused practice and have a commitment to making the service more recovery focused (e.g. have used the '*Team Recovery Action Plan*', Repper and Perkins 2013).

In practical terms, it is most helpful if the team is given an opportunity to try out working together. This can be done in a training day in which everyone meets and considers the role of peer support and how it differs from other roles in the team. Team members also need the opportunity to hear the experience of peer workers and mental health practitioners from other teams where they have been successfully introduced. They should be encouraged to discuss their hopes and concerns honestly and to develop a sense of collective ownership of the relative roles and responsibilities of peer workers in their own, specific, team context. In these meetings it is

helpful if senior managers can also attend (at least partly) to provide reassurance, answer questions and confirm that there is a commitment to these developments from the '*top*'.

Next we must consider the training of workers. '*The Peer Support Training took me on a massive journey of discovery about myself and gave me an appreciation for my strengths. Through it came to realise that all those scary places I had been during my time of being unwell, were going to allow me to hold up a torch for others during their dark times and help them on their road to recovery – it wasn't wasted time*' (cited in Pollitt et al. 2012). Although peer worker training has been developed and delivered in several different countries and settings, there is a reasonably high degree of consistency across the content of the course the style of teaching and intended learning outcomes. The core skills required are active listening and problem solving, clarity about how to facilitate recovery and the role and relationships of the peer worker. Courses therefore generally cover communication skills (particularly active listening), mutual problem solving/solution focused skills, WRAP, managing challenging situations, valuing difference, code of conduct and ethical considerations, team working and managing personal information/telling your own story. Most courses are very much '*strengths based*' and also place emphasis on students learning from one another how to support recovery using an interactive format. Marked differences exist in the intensity ('*depth*') of the teaching and length of courses (from a few days to several weeks). Some courses are linked to formal accreditation with local Colleges of Further Education, some are not. With such a wide range of training it is not surprising that the outcomes of peer workers have often been highly variable. However, at the moment, there are no empirical grounds for deciding between different training options.

Recruitment

Recruitment begins with advertising. There is no simple answer regarding how best this is done. Prospective peer workers who are not in active contact with specialist mental health services are unlikely to read professional journals and may not access newspapers, so other options for local publicity may need to be considered (e.g. direct communication with local user groups). But simply contacting local user groups may exclude many people who have experience of mental health problems, who have not chosen to join a local group. These processes of how and where to advertise therefore needs careful consideration and a relevant local strategy developed accordingly. Whatever the advertising strategy decided upon, local '*orientation sessions*' for prospective candidates are a useful way of providing information. They can also be used as part of a '*preselection*' process.

Whatever the recruitment process it is important to provide financial advice for potential applicants in terms of the possible effects of employment on their social security pensions. The benefits system is usually complicated and highly individual, so it is important for applicants to get an expert, personal '*back to work*' calculation. If this is not provided, many good candidates may be significantly deterred from applying.

Because of the nature of the likely applicants, it is also necessary to consider how best to support them in the recruitment process. Some applicants may have been out of employment for some time and will lack the confidence and skills to apply. Applications can be particularly challenging for people who have spent time in the hospital, homeless, or in prison. The process usually assumes familiarity with IT, an ability to explain interruptions in employment and housing, and to answer questions about criminal history. All of these can be very off-putting and may constitute a real barrier to the very people who could be most helpful peers – those having most in common with the average person using services. Support for prospective applicants can be provided either within the organisation or delivered by a partner agency specialising in employment support.

Given the complex and sensitive nature of the role, applicants need to be interviewed to assess their baseline communication skills, their understanding of recovery and their ability to share constructively their own journey and what helps them to stay well. These interviews can be conducted on an individual or group basis. They can take the form of role play interviews which allow relationship and communication skills to be observed.

In most countries peer support workers – like any other new employee – will need to complete some kind of check regarding possible criminal record (CRB). Criminal record checks can be very stressful for peer applicants and they may need help to complete the relevant forms. In England the NHS is clear that it cannot employ people who have a serious criminal history, but it is not unusual for applicants to peer posts to have a record of minor crime and some discretion is given to the appointing authority. The challenge for the service is therefore to assess the risk involved in employing this particular person and to make judgments about the likelihood of criminal acts being repeated. This has to be undertaken on a case-by-case basis and the decision needs to take into account the seriousness of the offence, when it occurred, and its potential relevance to the role. Some decisions will be easy, some will not. Where the incidents are clearly related to periods of mental ill-health, it is easier to put safeguards in place to prevent reoccurrence. However, where the incidents are more serious, more frequent, or unrelated to periods of mental instability, then it may be more difficult to identify triggers and develop effective safety plans. The employing organisation therefore needs to be clear at the outset how these decisions will be taken and by whom.

If the person is then offered a position in a local service then, in England, occupational health colleagues need to come back into the process to ascertain if the successful applicant requires any '*reasonable adjustments*' under the provisions of the '*Disability and Discrimination Act*' (HMG 1995, 2005). In this context, '*reasonable adjustments*' might include:

- Specifying work hours to take account of particular problems with early mornings, rush hour traffic, or side effects of medication
- Offering support with aspects of the role that are particularly difficult due to nature of mental health challenges (e.g. sealing envelopes may be difficult for people who feel compelled to check)
- Increasing feedback to people who tend to repeatedly worry over possible mistakes ensuring that they are thoroughly debriefed at the end of each shift.

These kinds of simple changes may be crucial to helping people with psychiatric disabilities function in these new roles.

Finally, we need to consider how best to support unsuccessful candidates. Following an intensive training programme, people will naturally feel despondent and their confidence will drop if they are unsuccessful in their job interview. It is therefore very important to discuss thoroughly with the person the reasons for not appointing and to explore alternative options. For some this will take the form of further interview practice, for others a period working as a peer volunteer, or doing some courses in the recovery college might be more appropriate.

Employment

So, we come to the phase of actual employment, again a number of elements need to be considered. First, the choice of initial placement: where there is a choice, peers can be allocated according to their personal attributes, experiences and preferences. Certainly, at least in the beginning, it is sensible to place peers in teams that already actively support recovery and are keen to welcome these new colleagues. It is not a good idea to choose the most difficult place to start.

It is also worth thinking more broadly than simply matching people in terms of the peer's mental health problems with the peers to be worked with. By placing a peer with a specific diagnosis on a unit that specialises in this particular set of difficulties, there is a danger of perpetuating a narrow diagnostic categorisation. Of at least as much value is the placement of a peer in a team that has identified a gap in certain skills or interests that the peer can fill (e.g. membership of a particular age or ethnic group). Wherever possible peers should be placed in groups of at least two per team, with some overlapping working hours. This will help prevent isolation, provide support and help create a greater impact on the team culture.

There are specific issues if the peer is placed in a team that is currently providing her mental health support or has done so in the recent past. There are advantages (e.g. she/he can be an inspirational role model for other peers and staff) and disadvantages (e.g. she/he is seen as '*special*' and not like other patients). These issues need to be discussed with the peer worker and the staff together and a joint decision reached.

In terms of induction for new peer workers, it is helpful to allocate a staff mentor to each peer (possibly the team recovery champion) to provide information, support and to give informal tips about routines and informal procedures ('*how we do things around here*'). The mentor is also then in a good position to help set up an induction plan. Many peer workers – just like other staff – find adjusting to the demands of a new and complex organisation quite stressful. *'Returning to work was a daunting issue in itself and it became clear that peers need tailored support during this period. Even though I described processes such as sickness reporting, how to apply for annual leave, using information systems, whereabouts sheets, client records, etc.*

many times; for some peers embedding this into their everyday working life proved very difficult. Even basic tasks like organising telephones and computer access and how to obtain diaries, keys, 'pigeon holes', etc. was time consuming and the team would have benefitted from a slow induction period to ensure that each peer was fully confident and familiar with these processes before they started working' (Peer support team coordinator, Nottingham).

Once they have begun to settle in, the questions of supervision and support then need to be addressed. Supervision and support is vital for peers – just as it is for other staff – and, ideally, this should be provided through a combination of '*managerial*' supervision (from the team leader or a care coordinator) and '*professional*' supervision (from a senior peer or through contact with a group of peer workers). Individual and group supervision offer opportunities to model and practice the principles of mutuality: sharing strategies, challenges and successes, developing skills, knowledge and expertise in the group and creating confidence that difficulties are not unique and can be overcome.

The value of bringing all peer workers together for group supervision and mutual support cannot be overestimated. Once together, peers become more confident about sharing their hopes, fears, their personal stories and challenges. As a group they gain strength and solidarity, they can support each other effectively and solve problems together. Even when peers are working in separate parts of the service, it is a good idea to bring them together from time to time so that they can continue to develop their identity and retain clarity about their distinctive contribution.

There are some aspects of peer working that need particular attention. These are specific to the role and do not lend themselves to clear rules or '*black and white*' solutions. First, there is a big difference between telling your own story in the classroom setting and using your experience to build a relationship with someone who you are supporting. Peer workers often need additional support in the early days to clarify their own boundaries and develop a personal account or narrative that feels safe. The second challenge lies in their double role and identity as both a '*practitioner*' (staff) and a '*patient*' (service user). Peers may be accustomed to relating to mental health workers as '*the expert*' (sometimes the '*enemy*') but not as a colleague with whom they can work as equals, in a relationship based on mutual respect. Similarly, they are more used to relating to service users as friends, rather than peers, so it can be challenging for them to maintain professional boundaries.

While peer workers can find it difficult to separate their role as practitioner from their role as '*patient*', staff seem to find this even more difficult. Too often the challenges reported by peer workers focus on their problems gaining the respect of staff. In some instances staff are reluctant to refer to peers, unclear about what peer workers offer, lacking in confidence that peer workers can cope with people who might present complex challenges. Staff will have many said and unsaid fears and anxieties about the introduction of peers and these have to be addressed. Some of the common myths and misinterpretations are shown in Box 34.3.

Box 34.3: Common Myths and Misperceptions About Peer Workers (From Repper 2013b)

Myth #1 – Peer support is just a way of saving money.

Myth #2 – Peers will be too fragile, they are likely to '*break down*' at work.

Myth #3 – Peers cannot be expected to conform to usual standards of confidentiality.

Myth #4 – There is no difference between Peer support workers and other staff who have personal experience of mental health problems.

Myth #5 – The presence of peer support workers will make staff worried about '*saying the wrong thing*'.

Myth #6 – The only way to be sure of getting a job these days is to say you have a mental health problem.

Myth #7 – Peers get to do all the nice things – talking to patients, taking them out, going home with them – the rest of us have to do the boring admin and medication, handing out meals, making beds etc.

Myth #8 – Peers don't know the difference between friendships and working relationships.

Myth #9 – Peers will be subversive, they will be '*anti-psychiatry*' and '*anti-medication*'.

Myth #10 – Peers will take up so much time that traditional staff roles will be made much harder, not easier.

Myth #1 – Peer support is just a way of saving money. As indicated earlier, this is where many of the debates about peer support workers generally begin. We have argued elsewhere that promoting recovery requires a great deal more than traditional therapeutic approaches (Repper and Perkins 2003: Shepherd et al. 2008). Providing hope, helping people make sense of their lives, finding meaning in what has happened, helping people take control over their destinies and manage the challenges of everyday life: these do not require professional expertise. Those who have faced similar challenges are often far better equipped to support these endeavours. To extend the domain of professionals to span all facets of life both deskills everyone else – friends, families, carers – it is also wasteful of the considerable resources involved in training and employing specialist professionals. The use of peer support workers is simply an attempt to complement these '*professional*' skills with '*life experience*' so as to ensure that both are provided (hopefully in at least equal measure) in the most cost-efficient way. It is clearly *not* simply a case of '*saving money*'.

Myth #2 – Peers will be too fragile, they are likely to 'break down' at work. People with lived experience of mental health challenges have long been employed in mental health services in a variety of positions from clinicians to managers, it is just that they seldom disclose this fact. Does this mean that all these workers are '*too fragile*' and '*likely to break down*'? The evidence actually suggests that, if provided with appropriate support, employees with mental health challenges may take *less* time off sick than those without (Perkins et al. 2000).

Myth #3 – Peers cannot be expected to conform to usual standards of confidentiality. Anyone working in a mental health service – from statutory to voluntary to peer-led will be required to observe formal rules relating to confidentiality. Peer workers are no different. Indeed, because of their lived experience, peer workers are often particularly sensitive to issues relating to confidentiality. Indeed, our experience is that issues of confidentiality have been more frequently raised by peer workers complaining about other staff breaching confidentiality by chatting about the clients with whom they work outside the workplace.

Myth #4 – There is no difference between employing peer support workers and employing other staff who have personal experience of mental health problems. Peer workers are employed *because of* their personal experience of mental health issues in the belief that with proper training and support they can use these experiences to help others. A psychologist, or a psychiatrist or a nurse with their own lived experience is primarily employed because of their professional qualifications and experience – although their personal experience will, hopefully, help to improve their professional role. Introducing peer workers into the workforce does, of course, raise the issue of how best to support people in traditional professions who have their own lived experience. They often fear discrimination and exclusion if they disclose their history. However, acknowledging their additional experience is not only '*healthy*' in terms of recognising the reality of human experience for both staff and service users, it can also enhance the quality of the service by encouraging traditional mental health staff to use this experience to inform their work.

Myth #5 – The presence of peer support workers will make staff worried about 'saying the wrong thing'. Everyone, peer or professional, has, at some time, said or done something that they later regret. Without the capacity for humility – and the courage to accept and accommodate feedback to reflect on our behaviour – any relationship, whether it is between partners, friends or the providers of services, is likely to break down. Thus, the willingness to reflect and learn from our behaviour is a key process for improving the quality of interactions and most groups have some mechanisms (formal or informal) for reflecting on these problems as they arise. As indicated, opportunities for supervision and reflection on practice are therefore an essential and necessary aspect of good practice.

Myth #6 – The only way to be sure of getting a job these days is to say you have a mental health problem. Within mental health services many types of expertise are required: professional expertise, expertise resulting from experience outside the mental health arena, and the expertise of lived experience of mental health challenges, trauma and recovery. To date, pride of place in mental health services has

been accorded to professional expertise at the expense of the other two. Therefore there is a continued need to break down barriers and actively value the expertise and insights that experience of mental distress brings. It is not the case that this is the only thing that is important, but it should be valued and not be a source of stigma and discrimination.

Myth #7 – Peers get to do all the nice things – talking to patients, taking them out, going home with them – the rest of us have to do the boring admin and medication, handing out meals, making beds etc. In any relationship, group or service there are tasks that have to be done. What distinguishes peer relationships is not what is done but the nature of the relationship: '*peer to peer*' rather than '*expert to non-expert*'. Peer support can thus occur in the course of any activity whether it is making a bed, going for a walk or just sitting and talking. Thus, it is not the case of peers getting to do all the '*nice things*', it is simply that peers may have greater opportunities to use their relationships productively. The key question this raises for staff is actually how to engage in the '*nasty things*', while preserving positive relationships.

Myth #8 – Peers don't know the difference between friendships and working relationships. There are many differences in the relationships between peer support workers and peers and those of friends, particularly in terms of self-disclosure, the degree of choice involved and the explicitness of '*rules*' (conventions of behaviour). But formal rules don't obviate the need for judgement and sensitivity. Peer support worker relationships therefore do involve more judgements than friendships – when and what to disclose, when and what '*rules*' to obey, etc. These judgements need to be considered as part of the training of peer support workers and reinforced by careful reflection and supervision.

Myth #9 – Peers will be subversive, they will be 'anti-psychiatry' and 'anti-medication'. The essence of peer support is not to prescribe what others should think, feel or do. Thus, peers should not be telling people whether or not to take medication, or to use conventional services, complementary therapies, etc. Rather, peers should be aiming to help people explore different ways of understanding, ways of coping and growing that make sense to them. Such exploration may involve challenges to orthodox views, but orthodox views are nearly always limited by the attempt to generalise from the performance of a group to the experience of an individual (e.g. in large scale treatment trials). Individual exploration is facilitated by the diverse narratives of others who have faced similar challenges.

Myth #10 – Peers will take up so much time that traditional staff roles will be made much harder, not easier. As indicated earlier, peer support workers may require additional employment support, particularly when the roles are being established. But these should not be different from any other worker. Peer workers may then make the jobs of other practitioners easier by relieving them of aspects of support that do not require their specialist professional expertise. This potential is clearly there if the problems are properly addressed at the outset. If peer workers are simply '*thrown into the mix*' then they will save neither time nor money.

Development of Peer Worker Roles

Once in post, just like other staff, peers should be given regular opportunities to review their role and consider if they wish to pursue avenues for career development. As they gain experience they will become clearer about the sort of training they might need to qualify for more specialist peer roles (e.g. in supervision and/or peer management, peer training or peer research). These positions are likely to attract higher remuneration. Peer workers may even decide to apply for training to equip them to enter traditional professional roles (e.g. counselling).

Regarding the development of new peer worker positions, given appropriate training, support and supervision, they will be their own best advocates. As indicated earlier, staff soon come to value peer posts and recognise the unique and complementary skills that they can bring to a service. There is therefore a demand for new posts to be created or converted and numbers grow. For example, in Nottinghamshire Healthcare the service chose to review all suitable vacancies as they arose and consider the possibility of converting them into peer posts (for example, converting a healthcare assistant posts into peer/healthcare assistant post – doing the same things in a different way).

The employment of peer workers also drives forward positive changes across the whole organisation. As already described, it becomes necessary to review recruitment, occupational health, management and supervision and career progression for *all* staff. Once in post, the peers themselves will begin to challenge policies, procedures and familiar assumptions about the work performance of people with mental health problems. This may have significant implications for members of staff who are employed in traditional professional roles, but also have their own '*lived experience*' of mental health problems. These challenges to existing practices are part of the cultural change that having peers employed inside services can bring.

But, they may also have other effects on the organisation. Let us begin to explore these as we try to understand the processes which underpin the effects of peer workers on individuals.

A Theory of Change Based on Stigma Reduction

We have seen already that support from peer workers is consistently associated with feelings of increased empowerment and improvements in various aspects of social inclusion (employment, education, community involvement, etc.) for those receiving this kind of support. But, how do these changes occur? What are the underlying mechanisms? We believe that they are specifically linked to reductions in self-stigma and stigmatising attitudes in staff in the organisations in which the peer workers are located.

The stigma associated with mental illness is pervasive. It is perhaps the most important social consequence of mental illness and may persist long after symptoms have subsided. Stigma takes two forms, '*external*', where the focus is on the effects of stigmatising attitudes on the part of neighbours, workmates, employers, etc., and

'*internal*', where the focus is on processes of '*self-stigmatisation*'. Most of the research has concentrated on attempts to measure – and to change – external stigmatising attitudes (Thornicroft 2006), relatively less attention has been paid to the alleviation of '*self-stigma*'.

Self-stigma refers to '*an internalisation of negative beliefs about the self*, *which are largely based on shame*, *the acceptance of mental illness stereotypes*, *a sense of alienation from others*, *and consequent low mood*' (Henderson et al. 2014). These authors note that self-stigma is usually negatively correlated with empowerment, i.e. it is a state *dis*empowerment. Corrigan and his colleagues have developed a progressive model for the effects of self-stigma in people with serious mental illness (Corrigan et al. 2009, 2011; Rusch et al. 2010). They suggest that it arises from three related processes: (i) an *awareness* of the stereotypes regarding mental illness, (ii) an *acceptance* that these stereotypes are largely '*true*' and (c) a subsequent *application* of these ideas to the self (internalisation), together with an assumption of personal responsibility. These beliefs lead to feelings of disempowerment, reductions in self-esteem and loss of hope, which in turn lead to a reluctance to engage in positive activities which might help the person pursue their life goals. Corrigan et al. call this the "why try?" effect. Hence, the person asks themselves, '*Why should I even try to get a job? Someone like me – someone who is incompetent because of mental illness – could never successfully meet work demands …. Why should I even try to live independently? Someone like me is just not worth the investment to be successful…. Why should I pursue education?*' (etc.).

In an earlier paper (Corrigan and Watson 2002) also note that some people with serious mental illness may be aware of the stereotypes but reject their '*truth*' and reject the notion that these stereotypes apply to them. These people may then become justifiably angry ('*righteous anger*') at what they see as simple, unwarranted prejudice. They are most likely to be active in pushing for change in mental health system and, indeed, in society more generally. Thus, what might sometimes seem to be militant, irrational rhetoric may, in fact, be more accurately viewed as a perfectly rational response to an unfair situation.

Is it possible to change these processes of self-stigmatisation? The research cited earlier on effective methods to reduce external stigma (e.g. Thornicroft 2006) suggests that effective anti-stigma programs need to contain three key components:

1. Attempts to *combat ignorance* through the provision of accurate information about mental health problems, their prevalence, what is known about causes and precipitating factors, effective treatments, etc.
2. *Addressing prejudice* (negative emotional reactions) through engineering direct contact between members of the group who hold the prejudiced attitudes and those they are prejudiced about which is of sufficient duration, and is managed in such a way, that the groups can explore their prejudices and (hopefully) conclude that, faced with the evidence of real people, they are not possible to maintain.
3. *Reducing discrimination* by continually monitoring and challenging discriminatory behaviour.

Applying these conclusions to the context of peer support, this implies that:

(a) If people are provided with *information* about what can be achieved by peers (for example, through the use of personal narratives and stories) then this may help them question negative stereotypes. It may help inspire hope as they realise that it may be possible to pursue their personal recovery goals after all.
(b) If they then have the opportunity to meet with others with whom they can identify, who are coping in positive ways, then they may be helped to *re-examine their negative emotional reactions to themselves* (i.e. their prejudice towards self) and, in this way, improve self-esteem and confidence. Specifically, the person can begin to see that what they felt most ashamed of in themselves (the stigma of mental illness) is actually an experience which might be extremely valuable and might be used to help others. Thus, the negative effects of self-stigma are '*turned on their head*'.
(c) Finally, if they are given *ongoing support to monitor and challenge* '*self-discriminatory behaviour*' this might overcome the "*why try*?" effect. Their negative cognitions are challenged and they should feel more willing to take up opportunities which will help them purse their personal recovery goals. This combination of exposure to contradictory beliefs and emotional support from others it is possible to identify with, seem a potentially powerful combination to increase feelings of empowerment and move people towards a state where they can begin to engage with their own recovery.

This formulation is consistent with the findings of a recent study by Corrigan and Sokol (2013) which showed that self-stigma was directly reduced through participation in mutual help programmes, particularly where the person identified with other members of the group. This model needs much further work and testing but, if correct, it highlights a number of ways in which peer support might be made even more effective and might have even more far-reaching benefits.

The same model can also be applied to the processes of organisational and cultural change that we noted earlier in relation to the effects of peers. Thus, it has already been shown that stigmatising attitudes are common *within* mental health services as well as outside (Henderson et al. 2014). They are more common in younger, less experienced staff and are undoubtedly reinforced by the biased sample of service users which staff tend to see (i.e. '*sick*' people, rather than those that are doing well). Hence, the presence of peers in the workforce who can talk about positive personal stories provides staff with living examples which challenge negative stereotypes. They can also get to know these people, over extended periods of time, in formal and informal settings, and (hopefully) this will reduce prejudiced attitudes and increase expectations. Finally, the provision of this counter-attitudinal information, and a chance to address prejudice, should challenge discriminatory behaviour. Staff should then think twice before saying things like, '*You will just have to accept it….. I am afraid that you are stuck with your condition for life…..You will never get completely better……You will always have to take medication …..I wouldn't think of trying to live on your own / get a job / maintain a relationship (etc.)*'.

This explains why the introduction of peer workers can have a powerful effect on changing the culture of mental health organisations and driving forward a recovery-oriented approach by challenging stigmatising attitudes among staff. 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…….. 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*' (Pollitt et al. 2012).

Conclusions and Future Directions

We have seen how the provision of support from suitably trained and managed peer workers is consistently associated with increases in feelings of empowerment, self-efficacy and hope for the future. There is also evidence that this leads to positive behavioural changes in the direction of increased social inclusion. These changes can be achieved in ways that are cost-effective and seem best understood in terms of the reduced self-stigma and contact with living examples of people who contradict low expectations and stigmatising attitudes in the workforce. We have argued that, in a similar way by challenging stigmatising attitudes, the presence of peer workers in mental health organisations may be a powerful mechanism for increasing hope and expectations among staff, making it more likely that they will support peoples' recovery.

However, much remains to be done. As indicated earlier, most of the available outcome data on the effectiveness of peer support is based on simple, prospective follow-up studies or matched control designs; there are few randomised controlled trials. To conduct meaningful randomised controlled trials we need to know more about the key ingredients of effective peer support and be able to '*standardise*' – at least make replicable – the intervention itself (the '*independent variable*'). We have made some suggestions about what we consider to be some of the essential ingredients based on our experience, but these ideas need to be empirically investigated. In addition, the theoretical model proposed here, based on stigma reduction, particularly the reduction of self-stigma, needs much more rigorous testing. This could be done in conjunction with further outcome trials.

We believe that this research is important. If peer support can be shown to be effective in the ways described above and if it works for the reasons suggested, then we might have a highly cost-effective intervention, with far-reaching effects, which is both cheaper and better. This would be a very exciting prospect for the future.

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