Chapter 6
Peer Support and Open Dialogue: Possibilities for Transformation and Resistance in Mental Health Services

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> I AM grief for hire, a Poetess – not PTSDs marauded Duchess, nor the Black Dog's mistress. I used to be the clinical Countess of Distress! …
>
> I HOPE to enter your white wonderland chamber, but your syntactical activist tongue SHIPWRECKS my lips, until I'm trembling and sick.
>
> I LOVE that you said poetry is both confession and exorcism – so we should Houdini out of the syntax straight jacket by sticking it to big pharma!
>
> I am GRIEF FOR HIRE. Tell seclusion and restraint I want ceasefire.

(Alise Blayney, 2016, Poet and Peer Support Worker. Extract from 'Grief for Hire'.)

When we speak of peer support, we speak of a discipline that represents a potential revolution in how communities respond to human distress, and in care practices within contemporary mental healthcare services. Peer support workers (PSWs), unlike in other healthcare professions, openly and purposefully bring to their work knowledge and wisdom gained through lived experience of emotional distress and/

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or extreme states of mind (distress/extreme states), and/or contact with mental health services, to establish connections with others. PSWs are paid to be experts by experience. Peer support can be transformative in its rejection of individualistic, reductive and pathologising metanarratives of distress/extreme states that medicalise or psychologise human experience and subordinate lived experience perspectives. Instead, peer support advocates for solidarity, mutuality and power sharing, and exploration of multiple explanatory frameworks for distress/extreme states, including socio-political and relational aspects (Mead, 2010; Mead & Hilton, 2003). Peer support is resistant to 'thin' narratives of recovery that silence and marginalise alternative ways of living that justify restrictive and pathologising practices, and can be used as grounds for cutting support services (Beresford & Russo, 2016; Wade, 2016). Yet, all too often, the transformative power of peer support is curtailed, limited by conventional health service cultures that are resistant to change and continue to privilege biomedical responses to distress/extreme states, while drawing power from statutory mental health legislation, which safeguards risk-averse, coercive and controlling treatments and practices that violate human rights (United Nations, 2017).

Open dialogue (OD) represents an altogether different kind of revolution in mental health services. OD is a social network–based approach to mental healthcare that uses a distinct form of therapeutic conversation (Olsen, Seikkula, & Ziedonis, 2014). Originally developed in Finland, it came out of a reorganisation of psychiatric services pioneered by clinical 'psy' (psychiatric and psychological) disciplines. It radically challenged clinicians to put aside their disciplinary expertise, diagnoses and clinical judgements, to see distress/extreme states in a relational context rather than as an individual illness, to explore how people language their experience and co-create communicative relationships with people and their networks (Seikkula & Olson, 2003). The primary aim of OD is to generate dialogue with a person in distress/extreme states, as well as the important people in their social network. Practitioners strive to privilege all voices, including that of the person experiencing distress/extreme states, and dialogue is viewed as transformative for all involved. OD practitioners aim to be adaptive to the needs of a person and their social network, to make care decisions in a genuinely collaborative way and to tolerate their own uncertainties about care decisions without any attempt to rush towards resolution or provide expert advice.

Although marginalised in biomedically dominated mental health services, the implementation of OD has nonetheless transformed practice in some parts of the Finnish healthcare services and it is now implemented in mental health services worldwide, including Australia. In its initial conception, OD did not include a specific peer support role. However, PSWs and OD practitioners across the world are beginning to explore ways to work together (see Bellingham et al., 2018).

This chapter explores the histories and possibilities of peer support and OD, and the potential for transforming responses to human distress/extreme states, as well as care practices in mental health services, by the pairing of the two. It uses a co-production framework, which aims to yield new forms of knowledge through a collaborative, exploratory and reflective process of interaction between people with lived experience and researchers (Filipe, Renedo, & Marston, 2017). We, the

authors, are people with an interest and/or practice in OD. We are also PSWs, mental health consumers, academics—including consumer academics—and mental health professionals who work alongside PSWs. Through an ongoing, iterative dialogue, we sought to understand what peer support and OD, in combination, may have to offer. We believe there are important possibilities held at the intersection of these two approaches, so we would like to offer you our insights and thoughts, which, in the spirit of peer support and OD, are tentative and unfinished.

Peer Support

Mutual support between people experiencing distress/extreme states has probably occurred for as long as notions of self and madness have existed, and people marked as different have been marginalised, socially excluded and exposed to oppressive and discriminatory practices. In contemporary Western society, peer support exists on a continuum from informal, mutual relationships of connection and support, to more 'formal' relationships where someone is employed to provide peer support based on their lived experience of distress/extreme states (Bradstreet, 2006; Davidson, Chinman, Sells, & Rowe, 2006). However, to have a critical understanding of contemporary peer support, and how it came to be, it is necessary to engage with the history of the consumer/psychiatric-survivor/ex-patient (C/S/X) movement and appreciate its roots in broader fights for freedom.

The C/S/X movement first appeared in discourse in the late 1960s, at a time of radical restructuring of the US mental health system, which included deinstutionalisation—a move away from large-scale hospitalisation (asylums) to community-based mental health services—and the introduction of modern psychotropic drug treatments (Everett, 1994; Tomes, 2006). The C/S/X movement grew out of the lived experience of former 'patients', particularly their dissatisfaction with psychiatric treatments and anger at psychiatric abuse (Chamberlin, 1978). It was also informed by the radicalism of other burgeoning social movements, such as the civil rights and women's rights movements, as well as the intellectual critiques from 'anti-psychiatry' proponents and political philosophers, such as Thomas Szasz, R. D. Laing and Michel Foucault (Tomes, 2006). Despite epistemological differences—with psychiatric survivors being more radical and rejecting medical models than consumers—C/S/X were united by a desire to end coercive psychiatric practices, and to promote alternatives to harmful psychiatric treatments (Chamberlin, 1978), and they developed their own knowledge, organisational structures and methods of communication (Adame & Leitner, 2008; Everett, 1994).

During the late 1970s, the C/S/X movement gained momentum and shared knowledge, links and tactics with other social movements including civil, women's, disability, Indigenous peoples' and lesbian, gay, bisexual, intersex, queer (LGBTIQ) rights movements, which had common experiences of oppression and the quest for self-determination (Chamberlin, 1978). These movements also shared a critical perspective of society and psychiatry, born of direct experience of stigma, discrimina-

tion and oppression. It was around this time that ex-patients, Morton Birnbaum and Judi Chamberlain, coined the terms ‘sanism’ (Perlin, 1992) and ‘mentalism’ (Chamberlin, 1978), which made visible the social division between those considered normal and those considered mad, linking this to the prejudicial treatment and systematic subjugation of people with lived experience (Poole et al., 2012).

A complete history of the C/S/X movement is yet to be written, and the links between peer support and C/S/X movements are still obscure (Chamberlin, 1990). However, mental health consumers are looking back, performing an archaeology of their own history and finding that elements of peer support have always run through the C/S/X movement, and, likewise, the politics of the C/S/X movement has shaped peer support. Historically, activism was demonstrated through the peer support activities of the Alleged Lunatics’ Friend Society, established in England in 1845 by ex-patients with lived experience of abuses in the private ‘madhouses’ (Podvoll, 1990). The group actively supported patients trapped within asylums, influencing legislative change and raising public consciousness of asylum practices that threatened civil liberties (Hervey, 1986). Perhaps the origins of more formal peer support can be traced back to France in the 1780s, when psychiatrist Jean-Baptiste Pussin employed people with lived experience as attendants in the Bicetre Asylum (Weiner, 1979). The asylum attendants formed connections with ‘patients’, and it was noted that they were less likely than others to be abusive to the people in their care (Weiner, 1979). This early example not only highlights how mental health systems have long recognised and valued the skills and capabilities of people with lived experience but also how psychiatric systems may incorporate peer support to maintain psychiatric practice rather than as a way of fundamentally transforming service provision.

More contemporary examples of peer support are ‘We Are Not Alone’ (WANA), formed in the 1940s by a group of ex-patients to support people transitioning from institutional care back into the community (Usar, 2014). Well-known support groups of the 1970s and 1980s include the Insane Liberation Front, Portland Oregon; the Mental Patients’ Liberation Project, New York; and the Scottish Union of Mental patients, UK; which tended towards more explicit activism, expressing deep dissatisfaction with psychiatric treatment (Bluebird, 2010; Usar, 2014). Probably the most widely known example of peer support is Alcoholics Anonymous (AA), which in 1937 was the first of many fellowships within the sphere of substance use and addictions. There are also stories of individuals who mustered interest in the plight of those in asylums. For example, Elizabeth Parsons Ware Packard secured her own release from an asylum and founded the Anti-Insane Asylum Society in 1968 to work for the release of others (Chamberlin, 1990). These groups and individuals explored and developed alternative responses to human distress/extreme states, pioneering approaches that were non-medical, relational and often community-based (Chamberlin, 1990). For example, the Hearing Voices Movement positioned itself outside of the mental health framework, recognising extreme states of mind as a common, natural and meaningful variation of human experience (Hayward & May, 2007).

While some of the history of resistance, activism and peer support by people with lived experience may be lost, this salvaged history informs peer support prac-

tice, as well as the developing academic discipline of 'Mad Studies', which combines activism and a community development ethos with radical social and political critiques of dominant psychiatric paradigms (LeFrancois, Mezies, & Reaume, 2013).

Change, Exploitation and Resistance

Sherry Mead (2010), who developed a model of 'intentional' peer support (IPS), argues that the main tasks of contemporary peer support are about creating meaning and connection through mutual, transparent and transformative dialogue. PSWs view people in distress/extreme states not as the containers of illness or disease, and themselves as containers of healing, but as equal partners in a peer relationship, exploring together the multiple explanatory frameworks for distress/extreme states, including wider socio-political factors (Adame & Leitner, 2008; Mead, Hilton, & Curtis, 2001). Owing to their lived experience, PSWs know first-hand the hierarchy and power imbalances of mental health systems, and engage in meaning-making to reclaim their voice (Mead, 2010). Peer support does not aim to 'do to' but aims to 'be with' and sit with the 'discomfort of a difficult situation' in non-expert, 'not-knowing' position, trusting that there is potential 'learning' in this discomfort and that sitting with risk is essential for promoting dignity (Mead, 2010, p.5; Scott, Doughty, & Kahi, 2011).

In recent years, the size of the peer support workforce has rapidly expanded (O'Hagan, 2011). Peer support is practised in a wide variety of ways and settings. It occurs one-to-one or in groups within statutory mental health services, non-governmental organisations and consumer-operated services such as Brook RED (2019) in Brisbane and consumer-operated resource centres such as Our Consumer Place (n.d) in Victoria. PSWs provide support for people in crisis (e.g. emergency departments and inpatient facilities), as well as community support with housing, education and employment, and can also support access to cultural and social activities. In addition to the discipline of peer support, lived experience roles span education, research, advocacy and activism.

Being met by a PSW as a whole human being, rather than a list of symptoms or diagnoses, can be a novel and transformative experience for service users in modern mental health services (Repper & Carter, 2011). The emerging evidence base suggests that peer support benefits service users in various ways, including increasing social networks, service engagement, well-being, employment and housing opportunities (Davidson, Bellamy, Guy, & Miller, 2013; Grey & O'Hagan, 2015), as well as reducing hospital readmissions (Sledge et al., 2011). Recent research suggests that service users who engage with PSWs have better, or at least equivalent, scores on outcome measures as those who received a conventional approach (Dark, Patton, & Newton, 2017; Davidson, Chinman, Sells, & Rowe, 2006; Repper & Carter, 2011). Peer support also provides service users with the opportunity to share a common experience and language (Repper & Carter, 2011). For example, sharing experiences of stigma and discrimination can be key to developing new insights and

analyses, which may prove to be highly protective against individualised feelings of alienation and isolation.

The increased number of peer support roles in health services is linked to the increasing strength of local consumer movements, service user dissatisfaction with mental health services (Adame & Leitner, 2008) and the focus on recovery-oriented care in health reform policy and statutory mental health services (Repper & Carter, 2011). However, there is considerable critique regarding the co-opting of peer support and C/S/X notions of recovery to justify restrictive and pathologising practices (Beresford & Russo, 2016; Repper & Carter, 2011; Wade, 2016), and PSW report experiencing direct and indirect stigma from mental health clinicians. This can take place indirectly, through the use of negative language and views about service users, and directly through patronising attitudes and devaluing of peer support (Byrne, Roper, Happell, & Reid-Searl, 2016; Vandewalle et al., 2016). Clinicians, with the power and status of formal education, can perceive the deliberately informal approach of peer support to be unprofessional (Vandewalle et al., 2016). Clinicians can police 'professional boundaries', by positioning peer support as low status or non-essential (Asad & Chreim, 2016; Collins, Firth, & Shakespeare, 2016; Repper & Carter, 2011), and PSWs can find themselves being treated like patients rather than valued colleagues (Gill, 2018).

Stigma towards PSW has been linked to a lack of understanding among clinicians of what peer support is and what PSWs do (e.g. Kemp & Henderson, 2012; Vandewalle et al., 2016). However, the concept of stigma may serve to problematise the person with lived experience, rather than illuminate the discriminatory practices within health services (Thornicroft, Rose, Kassam, & Sartorius, 2007). Poole et al. (2012) argue that discrimination is rooted in 'sanism', which, like racism, can lead to outright exclusionary practices, as well as 'multiple, small insults and indignities' or 'microaggressions' (Kalinowski & Risser, 2005, p.1). Yet, less apparent in the discourse around peer support and mental health reform are broader cultural and historical influences, such as the continued dominance of psy knowledge systems that regulate notions of self and madness and shape practice in health services (Rose, 1998). As Poole et al. (2012) note, the privileging of biomedical ways of knowing guarantees the dominant position of psychiatry and supports a negative attitude towards people with lived experience. It creates a hierarchy of clinical relations among various disciplines, with PSWs being in the subordinate group. Indeed, patronising, prejudicial attitudes and bullying of PSWs are reportedly more common within biomedically oriented services (Bennetts, Pincehes, & Paluck, 2013; Byrne, 2013; Vandewalle et al., 2016), and can become a 'normal part' of peer support (Byrne et al., 2016). PSWs who 'call out' medicalising or dehumanising language are particularly likely to find themselves caught up in claims of discrimination or disciplinary action (Mancini, 2018).

Wider statutory mental health legislation also compromises the role integrity of peer support. Mental health legislation structures, sanctions and safeguards coercive and restrictive practices, including human rights violations towards people with lived experience, and health services, in fear of legal reprisal, have low tolerance for risk (Byrne et al., 2016; United Nations, 2017). As Poole et al. (2012) argue, 'offen-

sive and injurious practices are integrated into everyday procedures to the point where we no longer recognise them as discrimination' (p.2). PSWs risk being re-traumatised when witnessing practices they have personally experienced as harmful, such as involuntary treatments for people sanctioned by mental health legislation.

PSWs also risk becoming a new class of exploited worker in neoliberal health services, which divest themselves of care costs through withdrawal and underfunding of state supports, and increased work expectations (Carney, 2008). PSWs experience job shortages, high workloads and under-resourcing of their roles (WAPSM, 2018), poor remuneration and limited opportunity for career growth (Chapman, Blash, Mayer, & Spetz, 2018). Under-resourced, undervalued and under pressure in health services, peer support practice more easily shifts at the whims of neoliberal and managerial dictates, and can be 'colonised' by psy perspectives. Stripped of liberation politics, PSWs are often used to serve the labour force needs of biomedically oriented services, particularly when non-peer support managers determine their roles and responsibilities (Daniels et al., 2010; Rebeiro Gruhl, LaCarte, & Calixte, 2016).

The current—less than ideal—positioning of peer support is not necessarily fixed. It is historically and situationally informed and has altered, and will continue to alter, over time in different contexts. In many locations, peer support has held to its radical roots and continues to resist discrimination, sanism and clinical hierarchies, as well as coercive practices (e.g. ourconsumerplace.com.au). Peer support has promoted care practices based on emancipation and self-determination and has challenged metanarratives of distress/extreme states, continuing to expose the need for recovery from iatrogenic harm and restrictive treatments (Bellingham et al., 2018). Relations between healthcare disciplines and mental health services/organisations have also shifted over time in different settings. Some organisations actively support lived experience perspectives and diverse recovery principles (Vandewalle et al., 2016). Many clinicians report positive working relationships with PSWs (Gates & Akabas, 2007), valuing their ability to build rapport, model recovery and challenge the low expectations for service users held by healthcare professionals (Cleary, Raeburn, West, Escott, & Lopez, 2018). Some have reported that PSWs are 'a living, breathing reminder' of diverse recovery perspectives (Gates & Akabas, 2007), although the idea that gainful employment is somehow indicative of 'real' recovery aligns more closely with neoliberal values of productivity than the C/S/X movement and peer support values of self-determination (Voronka, 2017).

Perhaps more shifts are possible. The practices and knowledge embodied in peer support could serve as an invitation to clinicians working in traditional mental health roles to liberate themselves from the narrow confines of accepted and acceptable sources of professional knowledge, expertise and practice, and become allied with peer support. Together, they could actively reject reductive and pathologising narratives of distress/extreme states and open up possibilities for practice based on emancipation, self-determination and meaningful collaboration; explore multiple explanatory frameworks for distress/extreme states, including relational and sociopolitical factors; and peer support principles and safe environments for peer support

practice could be actively promoted. In the next sections, we explore OD practices and how they align with peer support practice, and consider how the pairing of the two might support revolutionary transformation and resistance in health services.

Open Dialogue

OD is an approach to care that also resists traditional ways of 'doing' mental health, and seeks to transform mental health services. However, OD has had an altogether different genesis and reception in health services to that of peer support. OD originated within psy disciplines in Western Lapland, Finland, during the 1980s, at a time when the incidence of distress/extreme states was high and disillusionment with traditional psychiatric practices was widespread (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007). A rapid shift away from agrarian economies to city-based employment had led to high rates of poverty and unemployment in Western Lapland and a corresponding escalation in rates of distress/extreme states (Haarakangas et al., 2007). Following a period of deinstitutionalisation, psychiatric services struggled to meet the needs of people and families in crisis or to engage them in psychiatric treatment, which was viewed as impersonal and dehumanising (Seikkula & Olson, 2003).

Jaakko Seikkula and colleagues resisted medical and pathologising accounts of distress/extreme states, and developed OD as an alternative approach to mental healthcare. OD draws on concepts from the Milan, systemic model of family therapy, which explores interactional dynamics in families that contribute to distress/extreme states (Seikkula et al., 2006), as well as the 'need-adapted' approach of Alanen and colleagues, which emphasises rapid, flexible and case-specific interventions in mental health services (Seikkula et al., 2006; Seikkula & Olson, 2003). OD also translates into practice the dialogical principles articulated by Mikhail Bakhtin, a Russian philosopher and literary scholar, who posited that meaning and the self are not fixed, but socially constructed and continuously emergent through relational dialogue (Seikkula et al., 2006). The OD approach was extended beyond the family context to incorporate a person's private and professional social networks (Bellingham et al., 2018).

In the 1990s, seven key principles of OD were articulated. The principles represent aspirational goals aimed at integrating health system change and therapeutic techniques rather than manualised instructions for care (Bellingham et al., 2018). The key principles include the following: (1) *immediate help*: a commitment to respond timely and rapidly to the acute needs of a person in distress/extreme states, and their social network; (2) *social network perspective*: the inclusion of a person and their social network based on the underlying notion that families and social groups are generative in terms of insight and psychosocial resources; (3) *flexibility and mobility*: a creative and adaptive response to distress/extreme states that avoids rigid thinking and supports diversity of individual and social circumstances; (4) *responsibility*: the ability to respond (respond-ability) to a person in distress/extreme

states. The health professional who responds assumes accountability for connecting the person experiencing distress/extreme states to a treatment team; (5) *psychological continuity*: establishing and providing continuity in the relationship between the person in distress/extreme states, their social network and the treating team to promote mutual knowing and connection; (6) *tolerance of uncertainty*: help is offered with an attitude of tentative uncertainty about what the 'help' might actually be. Resources and authority for decision-making sit with the social network, and no attempt is made to rush to agreement or provide expert advice. Treatment options and issues of risk are openly discussed; and (7) *dialogism*: generating dialogue with a person and their social network is the primary aim of OD. It involves sitting together (usually in a circle) and creating dialogue with a person in distress/extreme states and the people in their social network. OD practitioners facilitate the network meeting, ensuring that all voices are heard and responded to, exploring how people language their experience, and listening in an appreciative, non-judgemental, present-moment-focused and non-directive way. New meanings about a crisis and the experience of distress/extreme states, not previously voiced, are able to emerge (Gergen & McNamee, 2000).

The Transformative Power of Open Dialogue

The idea of sitting in a circle and dialoguing is neither revolutionary nor unique to Finland. Indigenous peoples around the world have used dialogue circles with different protocols for conducting conversations (Bessarab & Ng'andu, 2010). In Western Australia, Nyoongah people use the term 'yarning' to describe a process of meaning-making through relational dialogue, where connection, history and knowledge are exchanged (Bessarab & Ng'andu, 2010). Yarning has also been used in therapeutic contexts to support the health and well-being of Aboriginal peoples (Burke, 2007). However, OD is revolutionary in the sense that dialogical processes become 'ordinary' in clinical practice. Like peer support practice, OD challenges the status quo in health services. Distress/extreme states are viewed as meaningful and located within family/social interpersonal dynamics rather than the individual, and medications are used judiciously if at all. There is a shift in focus from individualised, inpatient care aimed at 'stabilising' the person in crisis with psychotropic medicines, to community-based care aimed at generating dialogue with the person and their social network at the time of crisis (Seikkula, Alakare, & Aaltonen, 2001).

Having originated in psy disciplines, OD has arguably possessed greater power to shape health services than peer support, which has often been co-opted within them. OD transformed mental health services in Western Lapland, and has now moved well beyond the Finnish context to potentially transform health services in other Scandinavian countries, Germany, the UK and the USA, and, more recently, Australia (Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016; Rosen & Stoklosa, 2016). Research indicates that OD is a welcome alternative to conventional mental health practices (Buus et al., (2017) that reduces medication use and rates of hospi-

talisation, and supports service users to live in their communities and to pursue vocational and education goals (Gromer, 2012; Seikkula et al., 2001; Seikkula & Olson, 2003). OD provides a framework for organising mental health services that radically improve communication and connection between service providers, service users and their social networks (Jackson & Perry, 2015). Nonetheless, implementation studies indicate that tensions between OD principles and psy discourses in health services can lead to considerable organisational and professional resistance to OD (Brottveit, 2013; Søndergaard, 2009), and it remains peripheral to dominant psy approaches.

Peer Support and Open Dialogue

During its introduction to contexts outside of Finland, there has been considerable variation in how OD has been adapted to fit with local needs (Buus et al., 2017; Gordon et al., 2016). In some places, such as the UK and the USA, an important adaptation to OD, which was not an aspect of its Finnish genesis, has been the inclusion of peer support (Bellingham et al., 2018; Razzaque & Stockmann, 2016; Sykes, 2015). The pairing of peer support and OD has arguably occurred due to the strength of local grass-roots consumer movements in advocating for alternative approaches to mental healthcare, as well as increasing emphasis on recovery-oriented practice in health services (Bellingham et al., 2018; Trivedi, 2010). It is also the case that core tenets of peer support resonate with key principles of OD. Peer support, and IPS in particular, is similarly a dialogical approach, whereby PSWs and service users build new understanding through mutually transformative dialogue (Adame & Leitner, 2008; Mead et al., 2001). Both OD and peer support practices are concerned with varied meanings of distress/extreme states and exploring relational factors (Mead & MacNeil, n.d.; Adame & Leitner, 2008), although peer support, conversant with C/S/X perspectives, contains a sensitised and embodied critique of socio-political power (Bellingham et al., 2018). Both approaches emphasise collaboration and democracy as well as accountable and transparent decision-making (Mead, 2010). Moreover, the OD principle of 'tolerating uncertainty' is not entirely different to peer support principles of 'not knowing' and 'dignity of risk', which support self-determination and seek to avoid risk-averse practice (Mead & Hilton, 2003; Repper & Carter, 2011; Scott et al., 2011).

Models of peer support and OD have been developed; these include peer-supported OD (POD) in the UK National Health System and IPS-need adapted OD in the US Parachute NYC program of the New York Department of Health and Mental Hygiene (Bellingham et al., 2018; Razzaque & Stockmann, 2016; Sykes, 2015). Published accounts of the peer support role in OD meetings are scarce. However, Razzaque and Stockmann (2016) report that PSWs in the POD model have acted as OD practitioners as well as support persons outside of network meetings. Potential models of peer support and OD have been explored within Australian mental health services. Bellingham et al. (2018) proposed six configurations of peer

support in OD, which range from PSWs acting as support persons outside network meetings, or as members of a person's social network, to PSWs being OD practitioners alongside clinicians or other PSW. However, to date, little is known of the benefits and challenges of these six proposed peer support and OD configurations.

Possibilities for Transformation and Resistance in Services

This brings us to our question, what transformations might the pairing of peer support practices and OD achieve in contemporary health services? Previously documented benefits of this union include psychosocial benefits for service users that may lead to improved health outcomes (Bellingham et al., 2018); promoting democracy and disrupting clinical hierarchies in health services (http://apopendialogue.org); humanising health services and fostering greater understanding of peer support/lived experience perspectives (Stockmann et al., 2017); and expanding role opportunities for PSWs (Bellingham et al., 2018).

The notion of a combined peer support and OD model promoting democracy and challenging clinical hierarchies is appealing. OD attends to dialogue from multiple perspectives and attempts to privilege all voices, which would necessarily include the voices of service users and PSWs. OD also asks practitioners, including psychiatrists, to relinquish the 'expert' position and practice from a place of 'not knowing' (Anderson, 1990). PSWs are well acquainted with this position. Indeed, providing peer support has been described as the ability to be 'expert at not being expert', which 'takes a lot of expertise' (Repper & Carter, 2011). PSW could potentially support clinicians to give up the authoritarian role, lean into the discomfort of uncertainty, tolerate risk (Scott et al., 2011) and facilitate spaces to discuss treatment openly and democratically.

However, sitting with uncertainty is not a trivial thing, and OD is not a panacea for medico-legal frameworks that sanction discriminatory, coercive and restrictive practices. Yet, both peer support practice and OD do support transparent and collaborative decision-making that can resist and potentially mitigate some of the impacts of legislative agendas. PSW can also bring a lived experience perspective of the trauma of restrictive practices into the space of collaborative decision-making of OD, and may increase team capacity to bear uncertainty (Haarakangas et al., 2007) and withstand coercive practices that can be traumatising for service users, PSWs and others.

Peer support and OD could potentially lead to more humane health services. OD asks clinicians to reflect on their own lived experience and to bring more of themselves into their practice (Olsen et al., 2014; Stockmann et al., 2017). Clinicians, previously trained in objective and impersonal ways of practicing, may have much 'unlearning' to do in terms of deep-seated assumptions about themselves, professional practice and service users (Putman, 2015; Shotter, 2015), and PSWs may play a key role in supporting the clinicians' unlearning process. PSWs do not share the discipline-specific training and systemic culturalisation of clinicians and are

well versed in the intentional use of lived experience, as well as having a more critical and nuanced understanding of recovery that can inform care practices. PSWs may also open up space in OD for clinicians to sit with difficult feelings, and to improve their understanding of service users' negative encounters with sanism and discrimination in health services.

The coming together of peer support and OD may not necessarily be straightforward in practice. For example, PSWs are likely to bring highly sensitised and embodied analyses to their work, offering nuanced critiques of power that may be resisted by other OD practitioners (Bellingham et al., 2018). PSWs also hold a less privileged position in services and may continue to find themselves as victims of ingrained discriminatory practices that are overlooked by other OD practitioners. On the other hand, working within a peer support–OD framework, with a shared language and democratic practices, may embed cultural change within organisations and, if not transform awareness, at least support resistance to sanist, or other discriminatory ideas. In such a context, PSWs may be able to enact a central tenet of the C/S/X movement adopted from the disability movement 'nothing about us without us' and provide a space for critical understandings from the C/S/X movement to be voiced, via principles of transparency and dialogue enacted in a network meeting.

Similarities in the origins of OD and peer support, with each resisting traditional and pathologising approaches to care, may assist peer support to retain its radical roots in C/S/X perspectives. OD specifically aims to respond to human distress/extreme states rather than to serve psychiatry, and actively pursues and supports multiple perspectives rather than promoting psy ways of knowing. As such, OD is well positioned to champion and assist peer support practice to retain its connection with core tenets, and resist being colonised by psy perspectives. This is perhaps crucial in the shift from a tradition of peers informally supporting each other to a more formalised provision of peer support in mental health services, and the professional standards, accreditation and associations that come with the professionalisation of a discipline.

Other transformational possibilities of combining peer support and OD may include broader engagement with a person's social network. In the context of OD, PSWs can have dual roles as network members or practitioners (Bellingham et al., 2018). In a network role, PSWs can provide social support for a person with reduced social connections, and support service users to expand their social network. However, Bellingham et al. (2018) argue that sitting in the practitioner role may represent a move away from the peer support principle of mutuality to a less symmetrical relationship of 'giver and receiver of care' (Repper & Carter, 2011). On the other hand, PSWs frequently work in parallel with clinicians in competing or conflicting discourses, and OD may offer PSWs new opportunities to work more collaboratively with clinicians, and expand their roles in health services (Bellingham et al., 2018).

It is early days for peer support and OD, and it is hard to consider them in concert when a lack of understanding about both approaches exists. Healthcare cultures comprise discipline-specific traditions and hierarchies, with systems and ideologies

that situate particular clinical practices and therapeutic work within specific disciplinary domains. Tensions around the province of psychotherapeutic work can exist, and psy clinicians are powerfully positioned in a space where the peer support role and lived experience perspectives are not yet fully understood and accepted. Nonetheless, OD practice requires interdisciplinary collaboration and the possibility of working in teams without emphasising prescribed roles, to value ever-changing knowledge and understandings, and to ensure all voices are heard and respected (Brown, Kurtti, Haaraniemi, Löhönen, & Vahtola, 2015). OD, then, could have a positive role to play in advancing peer support as a distinct and adjunct discipline in the mental health landscape. Yet, teaming up with OD will not solve many of the issues faced by the peer support workforce identified in this chapter, such as its under-resourcing.

Arguably, OD has much to learn from peer support, C/S/X movements and Mad Studies scholars. These groups have pointed to the intersections between social structures and distress/extreme states, contending that particular groups of people suffer more, not because they are predisposed to suffer, but because the sociopolitical system creates and sustains poverty, racism, sexism, displacement, domestic violence, colonisation, detention, homophobia, transphobia, etc. (Beresford & Russo, 2016; Wade, 2016). In other words, humans are relational beings in sociopolitical contexts, and social systems are 'crazy making' for those worse off and subjugated, marginalised, violated, incarcerated and impoverished. Also crazy making is the lack of recognition for the unequal distribution of distress/extreme states, and the reframing of these states as individual, or even family/social network issues (Wade, 2016). OD may need exposure to this knowledge, to avoid being complicit in putting responsibility for care back to family and community, or in the increasing rationalisation of services and under-resourcing of peer support.

Co-producing a Critically Informed Model of Peer Support and Open Dialogue

To facilitate the power of peer support and OD to co-transform and co-resist conventional practice in health services, we propose that a more critically informed model/s of peer support–OD is now required. Such a model would move beyond simply pairing the two approaches and deliberately consider a framework that attends to the strengths of both peer support and OD.

Disciplinary power in OD warrants greater critique. It is not sufficient that OD practitioners purport to privilege all voices, as this may not necessarily influence the flattening of clinical hierarchies. There needs to be an explicit critique of disciplinary hierarchies, and exploration of how some clinical voices are more advantaged than others, receiving greater social recognition and remuneration. Disciplinary power affects relationships both within and outside network meetings, and can be linked to the devaluing and under-resourcing of the peer support role. If OD practi-

tioners, including PSWs, are to be equal in the network meeting and other organisational structures, solidarity between disciplinary groups is required, and there must be action to redress power imbalances through resource sharing, and active support for equal pay and meaningful career progression. Additionally, to preserve the distinct qualities of each discipline and to avoid these being lost, or co-opted by dominant clinical professions, there needs to be meaningful dialogue about the values, practices and responsibilities of each discipline, including the unique insights of peer support (Byrne, Roennfeldt, & O'Shea, 2017).

Furthermore, it is not enough that OD lays claim to being a social movement simply because it provides an alternative to conventional psychiatric treatment (Buus et al., 2017). Just as we cannot work with a person's mind in isolation from body and context, equally we cannot regard social networks as being separate from the same systems of power that negatively impact on persons in distress/extreme states, while potentially blinding others to their own privilege. We need to understand how power operates in network meetings, so that OD includes transparent recognition of socio-political causes of distress/extreme states, in real time, to avoid augmenting those states. Critical peer support–OD model/s could be informed by peer support and the C/S/X knowledge, as well as knowledge from civil rights, women's, disabilities, indigenous and LGBTIQ movements. This would provide explicit critiques of privilege and power, including sanism discrimination, and understanding of the intersections between social structures and distress/extreme states.

A critically informed peer support–OD model would also explicitly address the diverse and alternative narratives of recovery, avoiding clinician-centred definitions that support sanist ideas of normalcy, and 'chokehold' psy practices and legislatively sanctioned deprivation of human rights (Wade, 2016). Finally, we need to look for ways to promote wider socio-political change rather than expecting a person to manage their distress/extreme states solely through models of care and psychotherapeutic techniques. As Samuels (2001, p.21) argues, 'the world is making people unwell; it follows that, for people to feel better, the world's situation needs to change'.

We end by proposing two practical methods that could enable continued critical reflection with an explicit focus on power differentials. Both methods privilege the embodied knowledge arising from peer support, C/S/X perspectives and Mad Studies scholarship. The first is co-production, which aims to build new forms of knowledge through a collaborative, exploratory and reflective process between people with lived experience and researchers (Filipe et al., 2017). Co-production deliberately seeks to redistribute power amongst partners, giving those with less power in the partnership more space to contribute and more influence than they would have in usual circumstances (Roper, Grey, & Cadogan, 2018). Importantly, in the context of developing co-produced models of critical peer support–OD, harnessing C/S/X perspectives and Mad Studies scholarship may ensure critical reflection on important issues that may otherwise be overlooked. For example, at a structural level, co-produced methods could ensure that overt and tacit stigma and discrimination, and the effects on the peer support workforce and service users were not over-

looked, and that service impacts such as restrictive practices would not be discounted. Additionally, co-production at the practice level would consider what can be learnt from the embodied knowledge of PSWs arising from lived experiences of distress/extreme states, and/or mental health services.

The second method for redressing power differentials within a critical peer support–OD model could be the development of a supervision discipline by PSWs. Supervision led by PSWs is essential to retain the unique values, identity and practice of peer support, and to resist being colonised by psy perspectives, and neoliberal work cultures. Supervision led by PSWs has many potential positive functions. For example, PSWs could facilitate co-produced reflective practice spaces where PSW/clinician teams can deeply engage together in deliberations about, for example, power, intersectionality and ethics through the lens of peer support principles, C/S/X perspectives and Mad Studies scholarship. Such groups would also be modelling the co-produced methods they espouse.

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