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POINT OF VIEW

Developing a Strategy to Embed Peer Support into Mental Health Systems

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Abstract
Globally, health care systems stakeholders have encouraged health systems change that reflects recovery oriented practice. The implementation and integration of Peer Support Workers is one such strategy. Yet, what factors should be considered in the implementation of these roles? How can services be integrated effectively? Recent literature will be reviewed to explore current knowledge about peer support, and offer considerations for effective implementation of peer supports into current health care systems.

Keywords Peer · Peer support · Mental health · Recovery · Implementation

Introduction

Mental health and substance use disorders are considered to be the leading cause of disability worldwide (World Health Organization 2014). While formal mental health supports play an important role in mental illness management, achieving a state of positive mental health requires more than the management of symptoms of mental illness, it requires recovery. Recovery refers to a deeply personal process where an individual develops meaning and purpose in their life and grows beyond the illness experience. It is a way of living a "satisfying, hopeful, and contributing life, even with limitations caused by illness" (Anthony 1993, p. 15). Health care systems globally are recognizing the need for health care practices that encourage and support the recovery process, and the World Health Organization has incorporated recovery throughout the 2013–2020 Mental Health Action Plan (World Health Organization, N.D.). Integrating concepts of recovery requires that health care systems grow beyond a model of illness management, and implement a model of care that embraces a recovery orientation.

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Recovery-oriented mental health practices are intended to support the processes involved in recovery, including connectedness, hope, identity, meaning, and empowerment (Leamy et al. 2011). Peer support is a recovery-oriented practice that can serve as an essential component of recovery-oriented and effective mental health programs. Yet, little focus has been directed toward strategies for implementation, despite the complexity of the task. The effective implementation of peer services requires both philosophical and instrumental support (Mancini 2018). It is the aim of this paper to review the current literature regarding the philosophy and the practice of peer support, and suggest strategies for the effective implementation of peer support services.

Current Knowledge

Peer support references a relationship between two people with shared experiences. Support may be provided by one or both individuals. While common in the mental health literature, peer support is not unique to mental health. It has been seen in health promotion, disease prevention, and illness management strategies, and has been used to facilitate support groups, telephone and online interventions, and 1–1 encounters (Dale et al. 2008). Within the field of mental health, peer support has been founded on respect, shared responsibility, and mutual agreement (Mead et al. 2001).

Peer support services run along a continuum that includes both informal and formal supports. Informal support may

include spontaneous relationships including family relationships and friendships, and/or relationships developed within a self-help context. These relationships are generally characterized as mutual and voluntary. Formalized peer support is intentionally developed, and can be implemented as a stand-alone service, in specific settings such as a workplace or community, or in traditional mental health or hospital based systems (Sunderland and Mishkin 2013). Peer services have been provided in a variety of program areas within the mental health system, including employment development, assertive treatment, primary care, group formats, outreach formats, treatment formats, and as part of crisis management (Davis and Pilgrim 2015). Peer support workers are frequently integrated into Assertive Community Treatment (ACT) teams. ACT is a model of care that offers an intensive and integrated community service for individuals experiencing enduring mental illness with associated functional impairments or disability.

While there are potential benefits to the peer support role, the evidence regarding the effectiveness of peer support interventions is mixed. As a formalized practice, peer interventions support personal recovery and promote hope, empowerment, self-esteem and self-efficacy (Mancini 2018; Repper and Carter 2011; Sheehan et al. 2017). Peer support interventions, alone or in combination with traditional or other models of care such as ACT, have been associated with reduced hospitalizations, enhanced social functioning, social support, and quality of life, improved outreach, and enhanced staff attitudes of mental illness (Dark et al. 2017; Dixon et al. 1997; Mead et al. 2001; Repper and Carter 2011). Peer workers can also benefit from their role. The role of helper can be healing (Gates and Akabas 2007), and peer workers have experienced enhanced social support and an increasing sense of personal empowerment and self-esteem (Asad and Chreim 2016; Repper and Carter 2011).

In a systematic review of 18 Randomized Controlled Trial (RCT) studies, Lloyd-Evans et al. (2014) concluded that there was little to no evidence that peer support interventions impacted key illness measures, including hospitalizations, symptoms, or service satisfaction, although there were some positive effects on hope, recovery, and empowerment. Similarly, a Cochrane Review of 11 RCT studies described as moderate to low quality, found that services offered by consumer-providers of care achieved outcomes that were no better or worse than mental health professionals employed in similar roles (Pitt et al. 2013). Yet, the quality of the studies reviewed, and recent evidence, suggests that more research is warranted. O'Connell et al. (2018) conducted a RCT study that compared the impact of a peer support intervention combined with standard care, against standard care alone. Participants assigned to the peer mentor group experienced greater overall improvements, including reduced substance use and hospitalization rates. Additionally, Thomas et al. (2018) conducted a systematic review of person-oriented recovery constructs over time using mixed quantitative studies, and found that recovery-oriented services improved person-oriented recovery outcomes. Significantly, collaborations between mental health professionals and peer providers may work the best to enhance recovery, through the use of recovery-oriented practices such as psychoeducation, and enhancing self-management skills and self-determination.

In their review of the evidence of peer support, Davidson et al. (2016) argued that initial studies of peer support have focused on the feasibility of training and hiring people with lived experience, and identifying if peer workers could function at least as well as the status quo in conventional roles. The current wave of research has begun to identify if, and how, peer support workers perform unique roles and functions. Davidson et al. (2016) indicated that peer workers can engage effectively with clients, and enhance recovery-oriented outcomes such as hope, self-care, and belonging. A clearer understanding of the roles, functions, and unique mechanisms underlying the peer support model is needed to determine the most effective use of peer supports in mental health systems.

Implementation Considerations

Researchers have explored the factors that influence the implementation and integration of Peer Support Workers (PSWs) into mental health roles. The data, which is primarily qualitative in nature, can be used to develop an understanding of the perspective of peer workers and the teams they work with. Their perspective, their wisdom, and their struggles can serve as a beginning roadmap, illuminating factors to consider when implementing peer support roles.

Core Components of Peer Support

A PSW will explicitly use their personal experiences of recovery from mental illness to help others with similar experiences. Watson (2017) believed that PSWs occupy a "liminal space" (Scott et al. 2011) as they have experienced the roles of a service user, and a care provider, and can identify with both perspectives simultaneously. This understanding helps them role model recovery to their clients, and to the mental health professionals they work with. The peer relationship is valued for the reciprocity arising in the relationship. While formalized peer roles may have a lesser degree of mutuality than informal roles, this characteristic continues to be an integral component of the peer relationship, along with trust, empathy, and acceptance.

Peer Support Workers have the capacity to inspire others and confront stigma. In their qualitative review of the role of peer supporters, Austin et al. (2014) argued that

peers are able to work with others in a reflexive manner. By drawing on their own recovery experience, peer workers are able to acquire distinctive knowledge and awareness of the recovery journey, and use this knowledge to help peers with their recovery. Davidson et al. (2012) characterized the relationship as the use of empathy combined with "conditional regard", which refers to the peer worker's belief in and expectations of the client's capability to engage in a recovery process. Peer workers may have greater expectations of recovery, which can be inspiring and motivational. Further, by sharing this unique perspective within the team setting, the peer worker's experience can help to transform cultures of care to reflect more recovery-oriented perspectives that recognizes and honors the voice and capabilities of the client.

Focus

Peer workers' emphasis on *presence* has been recognized as a great strength that serves as an important focus for a role that is not adequately explained through a task-oriented job description (Paulson et al. 1999; Repper and Carter 2011) Peer workers may be able to work with clients to address broad healthcare needs, partly related their unique perspectives and empathy (Corrigan et al. 2017), yet peer workers traditionally emphasize quality of life indicators as opposed to diagnostic criteria or symptom reduction goals. A peer worker will offer practical and social support while emphasizing the strengths and capacities of the individual (Watson 2017). This practice has been described as *role modeling* of self-care skills and "street smarts", helping the client better negotiate daily struggles, such as managing with little income, or negotiating service systems (Davidson et al. 2012).

Role and Scope

According to Kuhn et al. (2015), the perception that one's supervisor understands the peer role is a critical factor influencing peer specialist satisfaction. Indeed, confusion and conflict within the role have frequently been cited as barriers to effective peer support implementation in mental health systems (Asad and Chreim 2016; Gates and Akabas 2007; Mancini 2018; Repper and Carter 2011; Vandewalle et al. 2016). Role confusion may arise from poorly defined jobs. While it is important to recognize that it is the peer worker's unique approach that warrants the development of distinct roles (Gates and Akabas 2007; Repper and Carter 2011), a clear delineation of expectations is an essential goal when implementing PSW roles.

Role definitions can vary based on the type of team that a peer worker may be involved with. Asad and Chreim (2016) described that peer workers had different experiences of role definitions on ACT-type versus non-ACT teams. On an ACT team, the peer worker had a clearer definition of their role. All ACT team members, including peer workers, functioned in a 'generalist' role for most of the day which included "providing assistance with tasks of daily living, service coordination, and symptom management" (p. 769). Simultaneously, they were recognized as offering highly specialized and individualized supports to the clients. Conversely, peer workers on non-ACT teams had the experience of fulfilling roles which were not clearly described (Asad and Chreim 2016). The perspective of filling a "generalist" role can lead to an impression that peer workers do not themselves have specialized knowledge or the opportunity for autonomy. It is a valid concern that if peer worker's roles are subsumed into the arena of generic casework, peer worker's effectiveness can be significantly diminished (Slade et al. 2014). A generalist role may lead peer workers to feel they must act in the role of a professional (Vandewalle et al. 2016). Yet, a generalist could be considered to be a role that recognizes and supports the central place of the client, and the client's environment, in their recovery, and allows the worker to act in a collaborative manner with the client.

Decisions related to role definition, and the degree of overlap between the "classic" mental health worker role versus a clearly defined and separate role for the peer support worker, can significantly impact the extent to which the peer support worker role replicates the role of the team, versus offers a unique service to clients (Gillard et al. 2015), and deserves careful consideration prior to implementation.

Team Integration

An important factor to consider is the degree of integration of the PSW within a mental health setting. Consumer involvement can be viewed along two gradients, according to Dixon et al. (1997). The first gradient is related to the degree that the role is a peer support role, versus a traditional role that may include traditional task functions. The second gradient is related to the degree that the peer supporter's work is integrated into the mental health setting. Vandewalle et al. (2016) has indicated that the team's values of recovery and peer support are foundational to the integration of PSWs on the team. Peers will benefit from integration into a team who shares recovery-oriented values. If a peer will not be integrated into a recovery-oriented team, they may experience increased job stress, and less role satisfaction. According to Davis and Pilgrim (2015), physical proximity and integration into the team has led to increased utilization of the peer support worker, increasing both referrals and consultation by the rest of the team.

Boundaries

In a clinical relationship, boundaries are an essential component of practice. Boundary violations place clients at risk of abuse or domination (Williams et al. 2006). Boundary crossings, while potentially harmless, place the practitioner at risk of future boundary violations. Knowledge of boundaries also helps the practitioner reduce the risk of burnout. For peer workers, the act of self-disclosure is a boundary crossing that is a necessary component of good care. Yet, this act can place both the practitioner and the client at risk. PSWs have identified that the development of effective boundaries is an issue that is challenging for workers (Repper and Carter 2011). The development of boundaries with an individual is an ethical issue that necessitates careful assessment of the context of care as opposed to the development of rigid guidelines (Gillard et al. 2015; Repper and Carter 2011; Williams et al. 2006). Possible strategies include adequate training on healthy boundaries, boundary crossings, and boundary violations; adequate clinical supervision, and the development of opportunities for peer staff to articulate questions and concerns regarding boundary crossings that are a regular component of the PSWs day-to-day life.

Gates and Akabas (2007) noted that role confusion can be caused by a blurring of boundaries between PSWs, and other staff who may provide direct support (i.e., counseling) services to the peer worker. A potential solution to this situation may include having the client work as a PSW outside of the arena where supports and social networks are traditionally obtained. Additionally, Repper and Carter (2011) suggest utilizing peer training and supervision, and providing group supervision.

Professionalism

Mancini (2018) and Vandewalle et al. (2016) articulated that professionalization has been an issue for PSWs. There is a need for ongoing professional development, and a need for enhanced professional standards. Peer workers may be motivated toward professional development to gain acceptance from the health care team. Yet, concerns have been raised related to the risks inherent in professionalization, in that role confusion may arise and staff could become integrated as a general worker in the institution, which may diminish the value of the peer worker.

Power is also an issue related to professionalism. Power dynamics can arise from the formalization of peer support. Power differentials between the client and peer can exist even if minimized, and can impede the development and practice of the PSW role if not addressed (Repper and Carter 2011). Adequate supervision and peer support may help the PSW navigate these concerns.

Training

Education and training is an essential factor to consider when implementing PSW positions. Possible training topics could include the role of the PSW, communication, social skills training, crisis intervention, risk factors, illness and/or relapse prevention, professionalism, and boundaries. (Mancini 2018; Nemeth and Kolozsi 1999; Repper and Carter 2011; Sheehan et al. 2017). Surprisingly, despite the push toward professionalization of the role through certification programs, Gillard et al. (2015) articulated that there are significant benefits to the provision of locally developed roles and training programs for PSWs. Local training allows for the development of specialized knowledge that caters to the needs of the PSW and the clients they are working with. There is also a need to consider training in the implementation stage of peer support integration. What training resources are available in the region that the PSW will have access to? Are there opportunities to dialogue with peers or supervisors, and identify training needs?

Organizational Factors

PSWs have worked both in voluntary roles and roles where remuneration is provided. Peer workers have indicated that the manner in which the role is implemented can send a strong signal with respect to its perceived value. PSWs risk job instability related to limited term projects. Inadequate remuneration or inadequate workplace resources can leave PSWs with the impression that their skills are not valued (Vandewalle et al. 2016). Yet, flexibility of employment and the opportunity to work limited hours may be of interest to individuals at certain stages of their recovery. If a role is adequately defined, role flexibility, including flexible hours of work, may be perceived as a benefit.

Summary

Peer support workers offer a unique perspective and culture within mental health service systems that can enhance the development of a recovery oriented culture, and positively impact health outcomes. Mental health services have begun to utilize peer support services, yet questions arise regarding strategies to effectively implement and integrate these services in current mental health systems. Recognizing the core components of a peer support role is an important first step. Other factors to consider include: the potential role, scope, and focus of the PSW; the healthy use of boundaries; expectations of professionalism; training and support needs; and organizational factors. Clear supervisory direction and support, and adequate team support, are strategies that can

be used to develop and plan for successful peer support implementation.

Compliance with Ethical Standards

Conflict of interest No conflicts of interest have been identified.

Research Involving Human and Animal Participants This article does not contain any studies with human participants or animals performed by the author.

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