

Peer workers in mental health services: roles, research & methodology

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Who do we mean by peer workers?

Peer support is 'just what people do when they recognise a shared experience of adversity and are motivated to support each other'
(Pinto da Costa et al 2019)

- What happens when peer support is taken from the real world and is transplanted into mental health services as a way of providing care?
- Emergence of 'peer workers' as a new role in the mental health workforce
- People employed and trained to provide peer support on the basis of their own experiences of mental distress (and of using mental health services)

Why now?

- Rationale (recovery + economics)
 - Peer support workers, role-modelling living well with mental illness and embodying hope in the future for others, improve the 'recovery focus' of mental health services (Repper and Carter 2011)
 - Economic solution - reflects wider shift in HICs away from professional workforce
- UK Mental Health Workforce Plan (2018)
 - 'growing more peer support worker roles' among 8000 new non-traditionally qualified jobs by 2021
- Globally, peer support seen as untapped resource in LMICs (Puschner 2018) to address 'treatment gap' between size of population and size of economy

Benefits of peer support

- Strong qualitative evidence base for the impact of peer support on
 - Empowerment and strength of social networks (Ochoka 2006)
 - Hope in the future (Davidson 2006)
- Observational and pilot studies suggest that peer support might impact on
 - Hospitalisation rates (Sledge et al 2011)
 - Community tenure (Min et al 2012)
 - Engagement with community services (Craig et al 2004)
 - and therefore cost?

Evidence for the effectiveness of peer support

- Ambivalence!
- Systematic reviews of trials indicate that peer support is, on the whole, 'no better or worse' than similar support provided by 'non-peers' (Lloyd-Evans et al 2014) once results are pooled
- And that what peers do, and how it is different from what other mental health workers do, is not explained (Pitt et al 2013)

Crisis in evaluation?

	Trials 27	Comparison group studies 18
One to one 27	Improved outcomes 13 'No better or worse' 13 Poorer outcomes 1	Improved outcomes 9 'No better or worse' 9
Group 12		
Online 4		
Mixed 2		

Improved outcomes: 'recovery' 12; symptoms 7; service use 5; QoL 3.

Where is the evidence base currently taking us?

- Recent review of trials (King & Simmons 2018) indicates peer workers were most often delivering case management, working as healthcare assistants, tasked with improving medication adherence or delivering psychological therapies
- Peer worker as para-clinician!
- Successful new trials evaluating 'peer supported self-management' (Bellamy, Schmutte & Davidson 2017)
- Responds to an chronic illness model of mental health
 - reflects an individualised, deficit model of recovery

Are we actually evaluating peer support at all here?
Or is it peer workers that are being scrutinised?

- If we are asking peer workers to do what other mental health workers are already doing...
- ...why would we expect to see any difference?
- Plenty of qualitative research that shows that peer support is diluted where peers are not asked to do something distinctive (Schmidt et al 2008; Gillard et al 2015)
- And there is a whole management literature that indicates that the adoption of new roles fails where distinctiveness is not maintained (Bach & Della Rocca 2000; Dierdorff & Morgeson 2007)

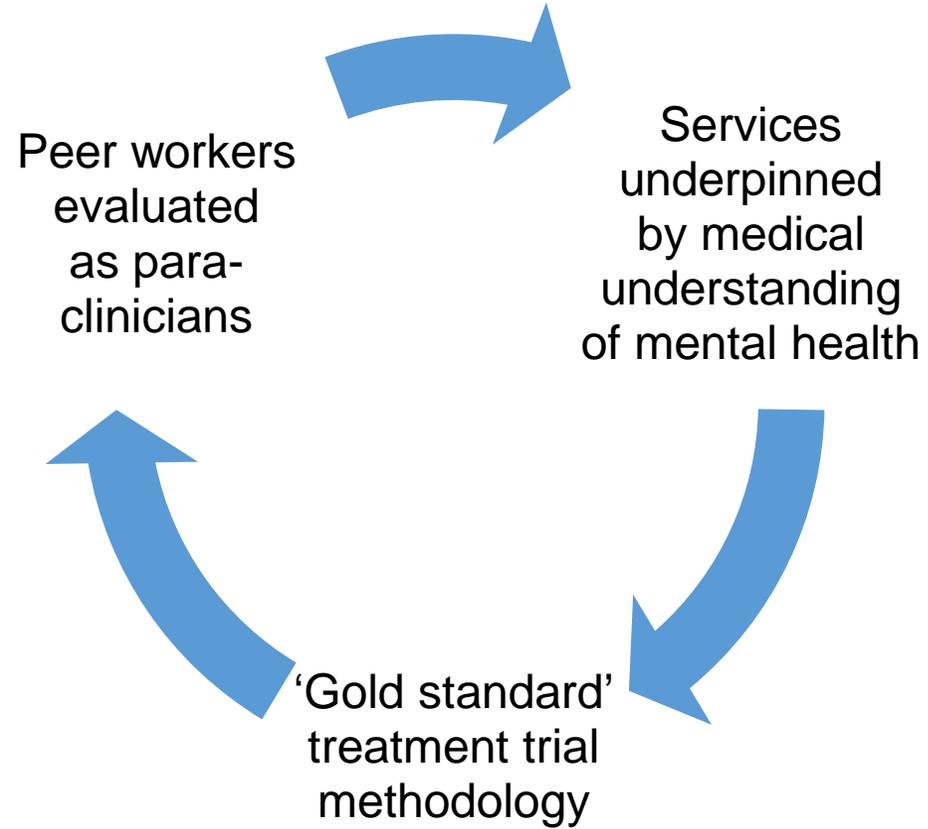
Raises a number of methodological questions...

- Are we measuring the right things?
 - Do we know how peer support brings about change?
 - Or are we just measuring what we've asked peer workers to do?
- If peer support is fundamentally about human relationship...
 - ... can we really randomise people to peer support (Corrigan & Salzer 2003)?
 - ... control for other peer support (Craig et al 2004)?
 - ... and allocate people to a relationship (O'Hagan et al 2011)?!

Underlying problem

- Clinical trial as a methodology developed to measure 'treatment effect'
 - Known physiological disease mechanism resulting in poor health state
 - Treatment 'intervenes' in disease mechanism and health improves
- A peer support trial borrows the assumption that
 - Mental ill health is internal to the individual
 - Peer support - as an 'intervention' - changes something at an individual, internal level (and mental health improves)

Circular logic...



Evidence deficit...

- Peer support is evaluated on its success in facilitating an essentially medical model of care
- With the evidence telling us that if you ask peers to fulfil a clinical function they will do it as well as anyone else
- But is that really what we want peers to be doing?
- And if it isn't, how should we evaluate peer support in mental health services?

Distinctiveness of peer support

- Intentional Peer Support (Mead & Filson 2017)
 1. both parties 'invited to learn and grow'
 2. creative rather than problem-based approach
 3. focus on relationship and community rather than individual change alone
- O'Hagan et al (2009)
 1. equal power relationships (choice and control over peer support at individual and organisational levels)
 2. identification with each other (sense of mutuality, reciprocal roles of helping and learning)
 3. holistic understanding of madness (strengths rather than illness focussed, confirming the validity of personal experience)
- Those values are challenged when implemented in inflexible and highly standardised organisational cultures (Stewart et al 2008; Scott 2012)

So if peers bring experience-based knowledge to their work (not learnt, medical knowledge)...

... and if what peers do together is about relationship (beginning with the peer support relationship itself), not about 'fixing' the individual

1. ... where is the social/ relational dimension to the peer worker role that seems key to the values and principles of peer support?
(Largely absent from academic literature)
2. ... and what are the research methodologies that will enable us to evaluate a social model of peer support?

Options!

1. Can we use trial methodology to evaluate what peer workers do as a distinctly social – rather than clinical – intervention in mental health services?
2. And/ or should we be using other methodologies to evidence the effects – if not the effectiveness – of peer support?



Enhanced discharge from inpatient to community mental health care (ENRICH): programme of applied research to manualise, pilot and trial a Peer Worker intervention

5 year programme of research funded by UK National Institute of Health Research

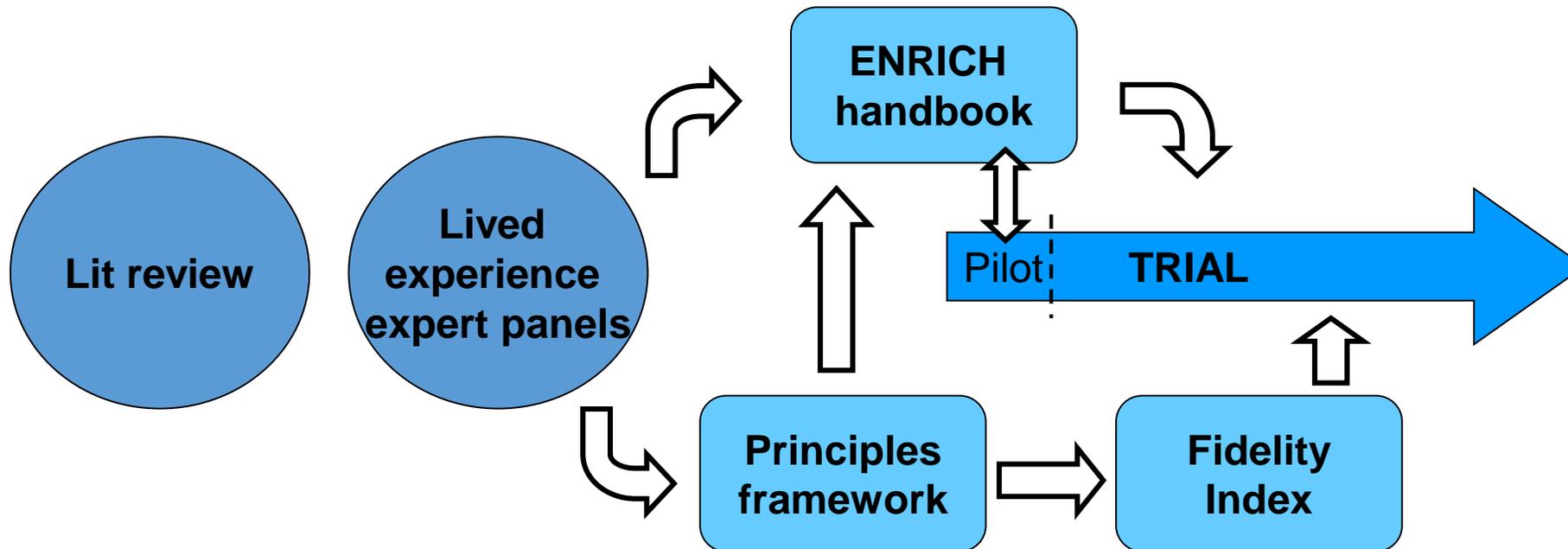
- 590 participants across 7 sites randomised to peer support for discharge or usual community follow-up
- *Trial hypothesis*
Peer support for discharge will reduce readmissions in the year post discharge compared to care as usual
- Secondary outcomes include:
 - Hope, stigma, strength of social connection, therapeutic relationship
 - Time to readmission, type of admission, length of stay, DNAs, use of CRHT/ A&E
- Peer workers begin working with people on the ward and for 4 months post-discharge, initially weekly stepping down to fortnightly for the final 6 weeks
- ENRICH peer support training provides peer workers with a kitbag of strengths-based skills and tools focussing on connecting people to community



Evaluating peer support as a social intervention in mental health services

- Lived experience in the investigator team
- Service user researchers working at all study sites
- Local and national Lived Experience Advisory Panels
- Development of peer support intervention and evaluation process informed by Principles of Peer Support framework
- Principles-based fidelity index to ensure it is peer support that is being evaluated
- Process evaluation asking, if it works, how does peer support work?

Developing the intervention



Developing the principles



ENRICH Peer Support Principles

The development, implementation and evaluation of peer worker roles in mental health services should:

1. Support the building of **safe, trusting relationships** based on **shared lived experience**
2. Ensure that the values of **mutuality** and **reciprocity** underpin peer support relationships
3. Promote the validation and application of **experiential knowledge** in the provision of peer support
4. Enable peers to exercise **leadership, choice and control** over the way in which peer support is given and received
5. Empower peers to discover and make use of their own **strengths**, and to build and strengthen **connections** to their peers and wider communities

In delivering on all these principles, peer support should respect and support the full **diversity** of experiences, language, culture, identity and background that people bring, enabling peers to build connections and relationships, and access resources and strengths found in the range of communities with which they identify and belong.



Using the Principles to develop the ENRICH training

Sharing lived experience					
Working with boundaries & relationships					
Keeping well at work					
Working with risk and safety					
Understanding the discharge transition & mental health services					
Local & individual 'asset mapping'					
Discussing difficult issues					
Cultural competency & understanding diversity					
Using communication skills					
Using strengths-based approaches					
Competencies					
Principles	1. Safe trusting relationships built on the sharing of lived experience	2. Mutuality & reciprocity	3. Applying experiential knowledge	4. Leadership, choice & control	5. Non-directive, strengths-based approach

Using the Principles to develop a fidelity index

Criterion	Indicator	Sub item	
1. Support the building of safe and trusting relationships based on shared lived experience as fundamental to peer support			
1.1 Peer worker and supported peer make an informal agreement about how they will work together	<p><i>At the beginning of the peer support relationship the peer worker and I reached initial agreement about how we would work together (e.g. where to meet, when, how we'd work together / decide what to do / boundaries and expectations)</i></p> <p><i>1: Didn't agree OR way of working together wasn't discussed OR peer worker imposed what would happen.</i></p> <p><i>2: Some discussion and agreement.</i></p> <p><i>3: Thorough discussion and agreement.</i></p>	1.1SP	
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1.2 Peer worker and supported peer are able to talk openly and constructively about things that are difficult and challenging	<p><i>When we work together we are able to talk openly and constructively about things that are difficult and challenging</i></p> <p><i>1. Don't talk openly or conversation is unhelpful</i></p> <p><i>2. Able to talk openly on some topics but not all.</i></p> <p><i>3. Able to talk very openly and constructively.</i></p>	1.2SP	



Current progress

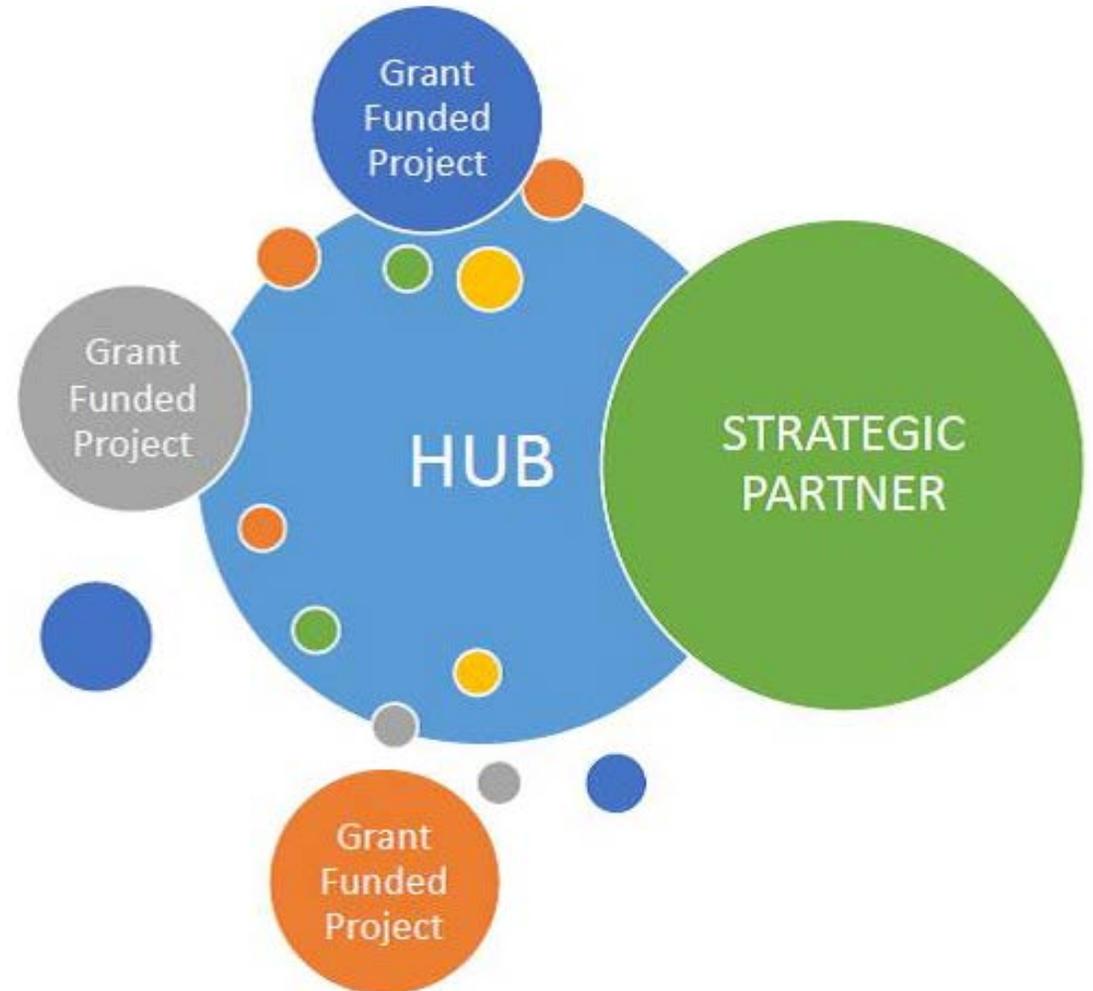
- 451 participants recruited
(on target to close recruitment by end of Feb 2019)
- Fidelity measure tested on 18 peer support projects outside of ENRICH
- First of four rounds of fidelity interviews complete
 - 2 participants; 2 peer workers; peer worker coordinator in each site
- Second round underway
- Process evaluation designed with service user researchers and Lived Experience Advisory Panel
- In-depth interviews with 5 participants at each site (35) and all peer workers (28)



Improving mental health through peer support

Side by Side

- Charity funded programme of peer support
- 45 projects across England
- Mix of group, 1-to-1 and online peer support
- Included projects that were:
 - Activity or arts based
 - Condition specific
 - Culture or gender focussed
 - Befriending or mentoring
 - Training focussed





Improving mental health through peer support

The challenge

- Peer support took all different forms (we weren't evaluating a single 'intervention')
- Peer support was open access (we couldn't randomise)
- Taking place in environments where lots of other peer support was available (we couldn't control)

1. An RCT would not be possible

PLUS

2. We were interested in how people's choices about engaging in peer support – when, why and how much? – were related to outcome



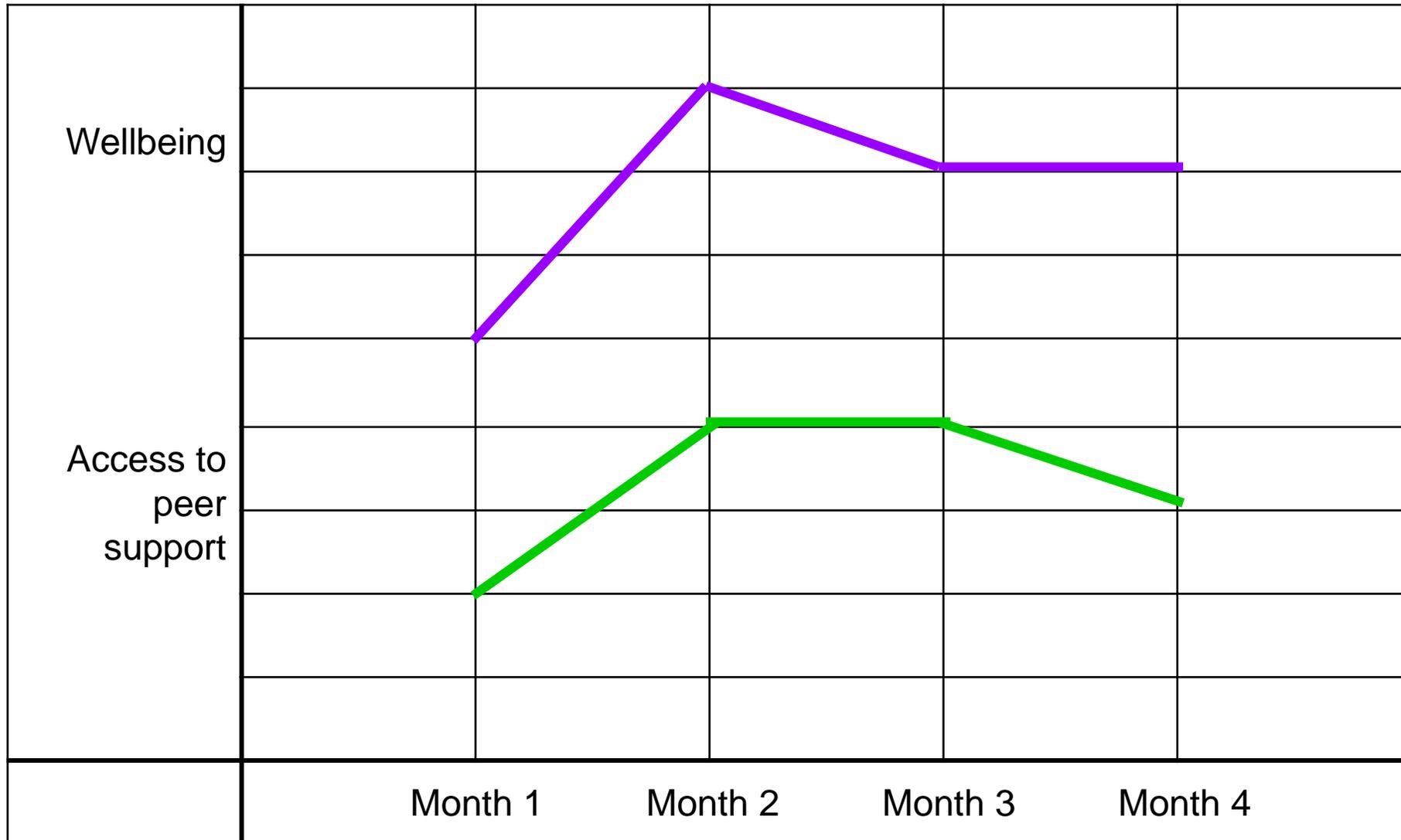
Improving mental health through peer support

‘Self-controlled’ case series design

- People complete a monthly ‘peer support log’
 - Amount of different types of peer support people access
 - Wellbeing, sense of hope in the future, self-efficacy and social contacts
- Compares change in outcomes between months where people access more peer support with months where they access less



Improving mental health through peer support

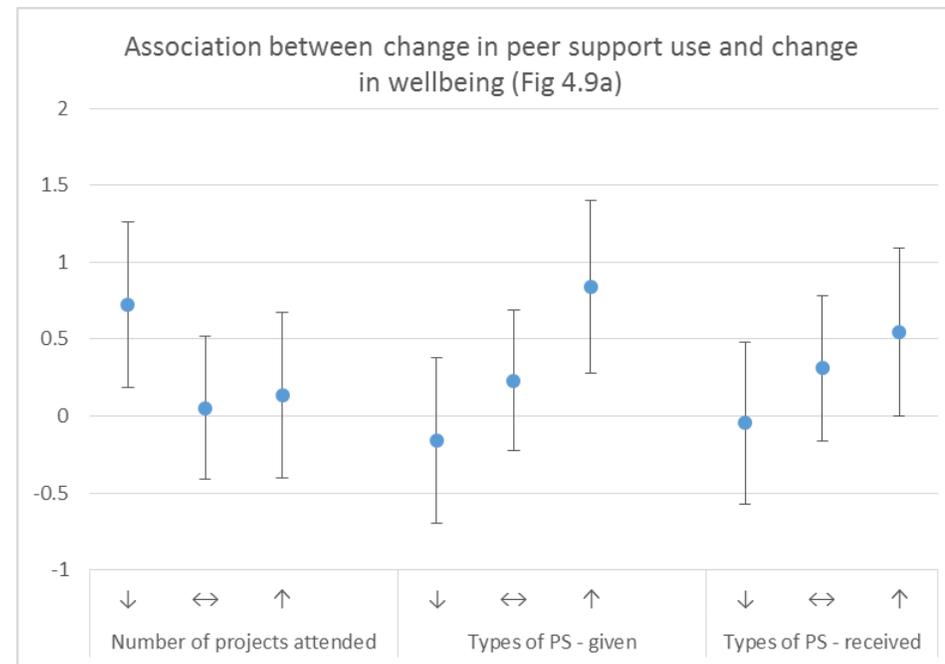




Improving mental health through peer support

What did the log tell us?

- People accessed less peer support as their sense of wellbeing and general health status increased, and as they had more contact with family and friends
- People who increased the overall number of types of peer support they were **giving** reported increases in their levels of wellbeing and hope in the future

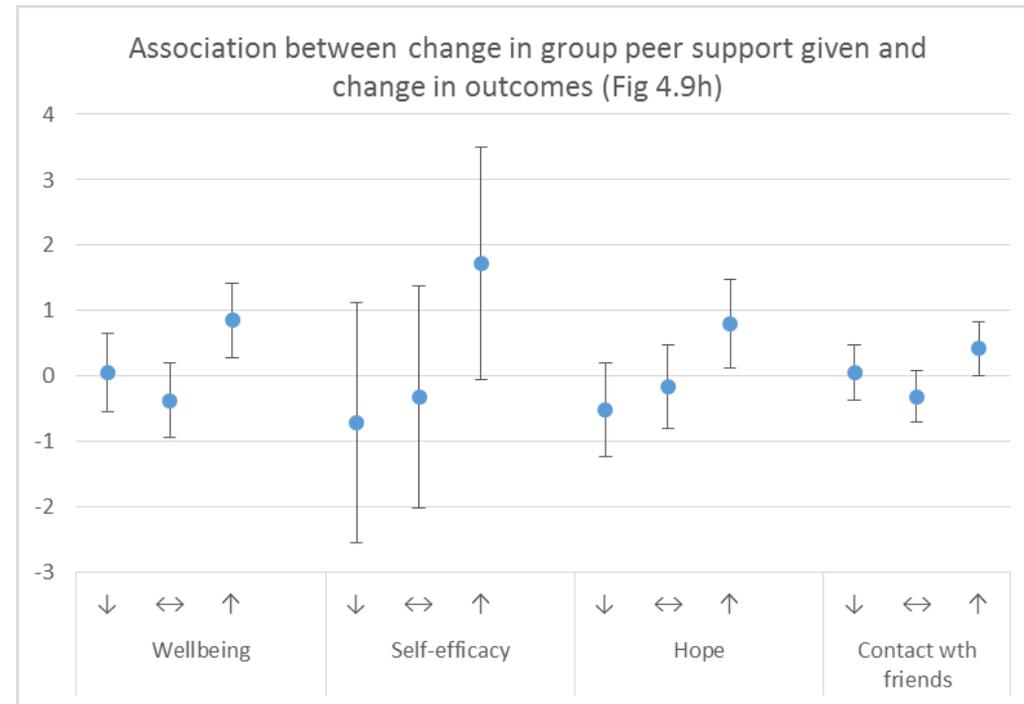




Improving mental health through peer support

Change in outcomes vs change in types of peer support

- People who increased the amount of group-based peer support they gave reported improvements in wellbeing, hope, self-efficacy and increased contact with friends
- Suggests a sense of agency is an important aspect of the way people benefit from peer support



Reflections

- So, what might this all mean for the future of peer worker roles in mental health services?
- And how we might best evaluate peer support?

The peer support trial?

- The distinctiveness of peer support, defined by values and principles, should underpin what peer workers do and how that is evaluated
- In the context of mental health services, there is a rationale of peer workers delivering socially-focussed peer support interventions at crucial transition points in services
 - where those transitions are a source of disruption for people's live and social connectivity is an important risk factor for people
- And if we are to have a peer support workforce those peers workers need tried and tested *peer support* practice at their disposal

The peer support trial?

- BUT the trial as a methodology still involves randomisation, allocation and control
- This can be done but is challenging and anathema to some of the values underpinning peer support (and therefore potentially undermines the peer support we are trying to evaluate)
- New 'virtual control' methodologies are emerging that use big data sets
- These have their own ethical issues around information and consent
- But offer a potential alternative if and when research funders and health service commissioners are convinced of the value

Alternative methods?

- Our individually-controlled method was much more closely aligned to values of peer support
 - Reflect the choice and control integral to peer support
- Offers an understanding of outcome in a way that relates to how people do peer support (and not to service delivery targets)
- Good in context of open access - real world - peer support
 - could work with support provided by peer workers but challenges health services culture of intervention (prescribed at a particular dose for a specific period of time)

Alternative methods?

- But, repeated measures hard to do, asks a lot of participants
 - e- and m-health approaches to service delivery and evaluation will make this easier (i.e. online platform comprises both intervention and data collection)
- Doesn't tell us about the effectiveness of specific interventions
 - only how individuals benefit from doing peer support
- Will be a challenge to get funders and commissioners respond to this sort of evidence...

Peer worker roles, research & methodology

Where next?

- The way that much research about peer support in mental health services is currently being done is leading us to conclude that:
 - Peer workers might be most effectively employed in a para-clinical capacity delivering existing healthcare interventions
 - But the evidence for this isn't strong, we just keep doing equivalence trials by default
- The distinctiveness of what peer workers can actually do – i.e. peer support as a social, rather than clinical resource – needs to explicitly underpin what peer workers are asked to do
- And research, including trials, needs to be designed to test the social, rather than clinical mechanisms of peer support

Many thanks to:

- ENRICH
- Side by Side

research teams and participants