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A critical discussion of peer workers: implications for the mental health nursing workforce

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Essays and Debates in Mental Health

A critical discussion of Peer Workers: implications for the mental health nursing workforce

Introduction

The Partners In Recovery (PIR) programme is a recent Australian national policy initiative that employs Peer Workers (PWs) who have a lived experience of mental health problems in a variety of roles. A key aim of the programme is to improve the coordination between services for those people with severe and enduring mental illness. Many PWs working in PIR do so in a consultancy capacity and have their positions defined by their employing organization, with a consequent lack of consistency and clarity towards their key roles. However, PWs have been identified as being important role models of hope for consumers and can also offer direct interventions aimed at helping consumers meet their at times complex needs (Department of Health and Ageing, 2014). This paper explores the recent literature on the efficacy of PWs, as well as discussing the mechanisms influencing those roles such as the therapeutic relationship. Emergent from that exploration is that while being fragmented and uncertain toward agreeing on PWs efficacy, studies mainly suggest PWs can positively contribute to the well-being and recovery of people with mental health challenges. However, the lack of clarity surrounding PWs efficacy is arguably a contributing factor to clinician resistance reported in the literature. This paper forwards that mental health nurses (MHNs) who often work closely with PWs need to engage in critical discussions around the potential implications for the mental health workforce as PWs become an increasingly established component of the workforce.

Context

In the Australian mental health service setting, specific policies are in place to support both recovery-orientated services generally (Department of Health and Ageing, 2009; Australian Health Ministers Advisory Council, 2013a) and PIR more specifically (Department of Health and Ageing, 2014). The national framework for recovery-orientated services specifically identified a lived experience workforce as being essential. Despite the strong policy direction of growing the PW role, Australia along with Japan is identified as lagging behind compared to other parts of the world (Chiba et al. 2011, Mental Health Commission of New South Wales, 2013). In contrast, Scotland is well advanced in embedding recovery into their mental health service delivery, inclusive of advancing PW roles (Scottish Recovery Network, 2012). In England, the PW role has been closely aligned to supporting consumers through the mental health system (The Schizophrenia Commission, 2012) and New Zealand has also been building workforce competencies around recovery and PWs for some time (New Zealand Mental Health Commission, 2001). Within the North American context, the development of recovery-orientated services has been in part driven by those in PW like roles influencing both nurses and researchers to realign their work to be more supportive of recovery principles as well as directly supporting consumers (Rivera et al. 2007, Caldwell et al. 2010).

The recent report from the National Mental Health Commission (2014) in Australia called for an expansion of the PW workforce and for more formalized and structured frameworks to be placed around their roles, capability training and support systems within the workplace. Interestingly the report directly places PWs and MHNs together within the same recommendation that seeks improved productivity and access to both these workforce populations, suggestive but not explicitly so, that future policy may be constructed from a view that PWs and MHNs share roles and have a closer relationship to each other than other workforce groups. The integration of PW lived experience expertise with the capabilities of all mental health clinicians is identified as being cen-
central to transforming service delivery (Australian Health Ministers Advisory Council, 2013b) with MHNs being most numerous and proximal of these clinicians to PWs, and are hence central to creating recovery-orientated environments (Department of Health and Ageing, 2009).

Arguably, these PWs are being propelled into an Australian mental health system that is a fragmented, uncoordinated and complex network of care settings and service providers with mixed and overlapping responsibility for service delivery, funding and expenditure (Mendoza et al. 2013). Additionally, there appears to be minimal critical consideration of the ramifications of adding a new workforce population to the mental health services, a lack of consensus on their key roles and a patchy evidence base explaining what they are achieving and importantly how achievements are being made.

From a wider perspective, PWs are in many cases entering a culture characterized by ritualized health care delivery that has evolved as a system of sick care in which societal members are acculturated to defer the responsibility for their health to western medicine in a powerful process of medicalization (Illich 1975). This culture includes a professional class who determine what is sickness and health, and how to deal with each of these. Illich (1975) invokes the metaphor of the priest and their acolytes in the church to elucidate the place different professionals have taken. This metaphor is consciously selected as pre-medicalization, wherein the church housed many of the rituals of self-care. Healing attempts outside the regime of this professional class were and still are demonized with the aspirations of self-care and healing within the contexts of individual, family and community responsibility for this has been replaced by professional treatment.

The recovery model to which PWs are intrinsically linked and in which the PIR programme is embedded (Cook 2011) has been an effort at re-focussing this vision, but an effort operationalized within a medico-centric system of health care. Hence a concern for the PWs initiative and the wider recovery approach is that attempts to break down medicalization of mental health service structures have been arguably subsumed by counter narratives to its dominance (Grant & Mills 2000). In effect, the experience of being unwell is now potentially being professionalized, with little recognition that this in itself is a tacit admission of failure by modern psychiatry. PWs are potentially being positioned to be another, albeit ill defined, layer of professionals to be consulted with and deferred to in decisions of care, but also to offer a dimension of non-medicalized care founded on empathy and experience, rather than medical treatments. Arguably such processes are being undertaken with minimal clarity as to how effective PW interventions are for consumers or their families and carers.

**PW efficacy**

There is a lack of quantitative empirical evidence that unambiguously supports the positive impact and efficiency of PWs (Lloyd-Evans et al. 2014), although as indicated in the recent National Mental Health Commission (2014) report, the majority of research that is undertaken largely ignores social and recovery-based outcomes. Additionally, the lack of homogenous workforce functions and the poorly articulated professional identity of PWs make it difficult to extrapolate meaningful measures from those studies that have been undertaken.

Pitt et al. (2013) conducted a Cochrane review of the efficacy of employed peers within government mental health services. Their search from 1950 to 2012 sought comparative outcomes between peer and clinician delivered services and/or mental health services with and without peer input. Their findings, drawn in part from the Randomised Control Trial studies examined by Lloyd-Evans et al. (2014), were heavily slanted towards North American contexts and again within diverse populations and a limited range of studies. Their analysis showed minimal differences between services, including peers and those without peer involvement, other than peer providers spent more time with consumers and that there was a small decrease in use of crisis services by consumers. While no adverse outcomes were identified between PWs and clinician-led services, it is important to note that their respective roles differ.

Doughty & Tse (2011) showed findings from their integrative review that PW-led services can offer better recovery outcomes across emotional and social domains and that quality of life factors such as employment and education can also be better than traditional services. Importantly these findings partially draw from the experiences of consumers of PW roles. Repper & Carter (2011)
offer a useful recent overview of the literature on peer support within Australian, United Kingdom and United States of America-based studies from 1995 to 2011. The review was, as with previous noted reviews, limited by the diversity of methodologies, outcomes measured and approaches undertaken, but within the context of these limitations it was argued that reduced readmissions to hospital-based care were a key difference between peer and clinician delivered services. However the precise roles of the PWs and the level of acuity of the consumers involved with the PWs, in achieving these outcomes are again unclear in this review. Indeed, many PW studies are community based and the PW roles within in-patient settings are often focused around supporting consumers, as distinct from offering clinical interventions, rendering direct comparisons between PW and clinicians outcome problematic (Bouchard et al. 2010).

Other studies reported in the literature described outcomes from PW-led interventions and services as including decreased use of coercive interventions (Frost et al. 2011), lowered service delivery costs (Trachtenberg et al. 2013), fewer rehospitalizations (Sledge et al. 2011), improved crisis planning (Cook et al. 2010) and better engagement with services (Davidson et al. 2012, Coulthard et al. 2013). However to echo Lloyd-Evans et al. (2014), the heterogeneity of PW focussed studies makes cross comparison impossible, an issue compounded by many of these studies having minimal controls in place to discern the effect of PWs. Arguably the strongest conclusion to be drawn is that where collaboration exists between MHN clinician and peer service delivery, some consumers have experienced improved outcomes.

Implications for MHNs

Given that there can be some confidence around PWs supporting positive consumer outcomes within the context of inconsistent scopes of practice, there is worth in MHNs critically considering the wider workforce questions around the inclusion of PWs into existing services, where nurses are the most numerous of the mental health disciplines. A key implication for nurses is that they will need to critically consider the nature of the relationships PWs have with consumers and how that may or may not impact upon traditional MHN understandings of therapeutic relationships. Nurses will also have a pivotal role in contributing to workplace cultures that directly support PW personal recovery, as well as cultures that promote recovery principles more generally. Central to achieving this will be how nurses ensure that any resistances to PW roles are respectfully constructed around achieving consumer benefit, rather than being covert sabotage of these new workforce roles.

The lived experience of mental illness by the PWs is arguably one of the most influential mechanisms upon how they engage with consumers. As earlier identified within the policy strategies, PWs potential capacity to provide role modelling of hope and recovery is a powerful factor that can be argued as being a new addition to the mental health workforce. PWs are uniquely placed to offer consumers genuine and direct empathy through shared lived experience and as such have the building materials of a relationship that would otherwise not be possible between consumer and MHN clinician (Davidson et al. 2012, Lewis et al. 2012, Byrne 2014). The limiting factor in the policies to this point in Australia is that there is little direction in the nature of the role within which this empathetic connection can occur. With reference to a scope of practice there is also little definition of where in the illness journey the contact is able to take place. A further confounding factor to consider is the huge variance within the experiences and understandings of mental illness. This variance of what mental illness is (and what it is not) is superimposed upon the natural community variance in human experience founded on family, community and cultural lines. This naturally occurring variance is compounded by the variance within what we label as mental illness. The variance challenges underpinning assumptions that a shared connection will naturally exist based on the foundation of a lived experience of mental illness.

Identification of a causal link between this empathic relationship and the PW outputs reported above appears to be missing in the literature, however mental health nursing has long celebrated its own identity and contribution to consumers from precisely such foundations (Dziopa & Ahern2009). What is contestable is whether this relationship between PW and consumer is a therapeutic relationship, in the absence of any defined preparation to do, or claim that PWs provide, therapy. If so, what does this mean for mental health nursing that identifies the form-
tion and maintenance of such a relationship as being their particular and identifying intervention (Lakeman et al. 2014). Dziopa & Ahern (2009) in their examination of the MHN literature on the therapeutic relationship suggested that the MHN engaged in a therapeutic relationship would be conveying Rogerian conditions as well as providing support, and maintaining clear boundaries. By comparison the principles supporting PW relationships underpin sharing, companionship, mutuality and solidarity, as distinct from maintaining boundaries (National Survivor User Network, 2010). Of critical importance however is whether the process or characteristics of the relationship determine whether it is therapeutic, or whether it is the outcomes that relationship seeks. If the latter, the PW principles of building hope, focussing on strengths, empowerment and stigma reduction are not on the surface, incongruent with those of many MHN clinicians (National Survivor User Network, 2010; Browne et al. 2014).

This dual identity of PWs can also be identified as being an influential mechanism impacting upon the outputs of PWs and the roles of MHNs in particular. PWs are consumers and paid employees of services, the very foundation of their capacity to form unique relationships with their consumers (Berry et al. 2011). Additionally, and arguably unlike most but not all MHN clinicians, they also occupy their roles to move forward in their own recovery, as well as the recovery of others. Walker & Bryant (2013) in a metasynthesis of qualitative studies, Moran et al. (2012, 2013) through in depth interviews and Salzer et al. (2013) through survey all identified perceived improvements in the psycho-social experiences of PWs gained through their work. However, they are also vulnerable to risking their own recovery (Singer 2011) predominantly through having poorly articulated roles (Kemp & Henderson 2012) and where service leaders failed to offer recovery focused (Bradstreet & Pratt 2010, Cook 2011) structural and interpersonal support (Wolf et al. 2010). It is these latter points that MHNs need to be cognisant of when sharing work environments with PWs with a view to minimize the negative impact of these structural deficiencies (Byrne 2014).

A key finding with the grounded theory study by Byrne (2014) was that where recovery was embedded into the service and where other supportive factors were in place, PWs were described as being more effective and hence creating greater beneficial outcomes for the consumer, carer and themselves. Interestingly non-government services with fewer MHN and medical discipline staffs were reported by PWs as being more willing and more successful at integrating recovery principles into their service delivery than government-led services. Bennetts et al. (2011) highlighted the belief that there is considerable resistance to PWs by mental health staff of all disciplines, but especially by those MHNs strongly wedded to the medical model. Such resistance is also described by Cleary et al. (2011) in their exploration of the mental health workforce where professional staff inclusive of MHNs were reported as overtly and covertly rejecting and sabotaging PWs. Loumpa (2012), Moran et al. (2013) and Lewis et al. (2012) all reported similar instances of MHN and other mental health discipline workforce resistance and opposition, often with adverse health outcomes for PWs through having their own experiences negated and/or through occupying compromised and isolative work roles.

However, the framing of reluctance as resistance in the papers referred to above bears some critical consideration by MHNs. Resistance, as defined in the Australian Oxford Dictionary, in the negative implies a refusal to comply. It is worth considering the route of resist in the word, as this gives an understanding that the act is one of stopping the course of progress or prevention of penetration (Moore 2004). In the positive resistance refers to the ability to withstand adversity or adverse conditions. Given the lack of clarity around the PW role, resistance may actually in some cases be the responsible action of MHN clinicians if interpreted as a lack of willingness to go along with the integration of an ill-defined role that has risk for the incumbent, and potentially those under their care. This is particularly the case if a well-defined scope of practice does not exist and support mechanisms have not been established.

As a word resistance can create a reading position of wilful obstruction based on less honourable intent. Such language can create a reading position (Kress 1985) of the inherent good of the PW role, because it involves consumers, and detract from a critical consideration of the merit of the approach taken thus far. It may frame what in some cases plausibly may be responsible MHN professional behaviour as a negative act, thus in effect silencing reasonable concern. Consequently, MHNs must
construct a position of supporting PWs both directly and in-directly (through supporting recovery principled services) whilst simultaneously voicing concern where emergent ramifications of PW role ambiguity may be in tension with their professional assessment of consumer need.

Situating MHN resistance to PWs as being grounded within a co-constitution of decisions and support directed toward achieving best consumer outcomes strengthens possibilities of wider changes within the relationships between mental health services and consumers. Scott & Wilson (2011) highlight that while it is ideal that consumers assume self-determination and responsibility for their own mental health wellbeing that many are not yet socially placed to achieve that desired outcome. PWs in partnership with mental health services are well positioned to support this consumer population within recovery approaches, whilst also drawing upon the expertise of mental health clinicians as required. PWs can hence position themselves as an important step within the fragmented stepped care approach of Australian services, as well as to be creating communities of support between consumers still striving toward total autonomy of their own well-being (Scott & Wilson 2011). PWs would arguably need to also show resistance, however in their case this resistance would be against being incorporated into medicalized roles within the service structures. Positioning PWs within such an approach most accurately reflects the range of consumer recovery journeys that encompass both autonomous self-management and supported self-management and which services struggle to respond to effectively (Bilsker et al. 2012).

Conclusion

That PWs are entering the mental health workforce is unambiguous, however questions remain as to whether they are being integrated into that workforce and what the ramifications of this are. Integration suggests a planned blending of complimentary workforce components into a system that is primed for such an intervention. However, coalescing the values of recovery to the medico-centric health care system is an ongoing task (Jaeger & Hoff 2012) and the lack of a homogenously articulated PW identity contributes to the healthcare system being at least wary of, if not resistant to their roles. The available evidence within which PW practice might be grounded remains fragmented and unless care is taken risks overstating the impact of PWs, leaving them vulnerable to impossible expectations and constructions of perceived failure. What evidence there is suggests that collaboration between PWs and MHN clinicians generates some consumer benefit, but that the mechanisms generating this are unclear.

It also remains unclear what the ramifications of greater PW participation on the MHN discipline are, with MHNs being proximal to PWs and who share in part strong values toward the relationships they have with consumers. PWs unlike nurses will relate to consumers non-therapeutically, but rather will relate through powerful empathic understandings based upon sharing lived experiences of disrupted recovery. While close co-working will offer consumers access to differing but arguably equally enabling styles of relationship, nurses also need to be aware that the wide variances in lived experiences may minimize the impact the PW empathy-based relationship. Nurses will also need to be aware of the PW recovery journey can be challenged by the very roles they undertake and find ways to minimize such vulnerabilities, whilst also voicing resistance when advocating for best consumer outcomes. This positioning requires the MHN to be empathic to the PW and yet assertive in voicing their professional responsibilities. It is incumbent on MHNs to critically consider existing PW programmes and clearly articulate concerns in a solution focussed manner to shape the programme for the benefit of consumers and the PWs themselves. Engagement is required to prevent a silencing of the nursing voice when it does arise, in the true psychiatric tradition of resistance.

Achieving positive consumer outcomes through a partnership of PW, consumer and services arguably builds the relationships and cultures required to not simply minimize resistance but to actively build mutual trust. Within the contexts of the fragmented Australian mental health systems and ambiguous PW roles described earlier in this paper, successful partnerships between PWs, consumers and services will be episodically rather than systemically achieved in the short term.

Future research

There is a need to better understand the impact, and character of, collaboration on the PW role, as
it is this that appears pivotal within the contexts of relationships with health providers, MHN clinicians and consumers. Additionally, once a more homogenous PW scope of practice is established through frameworks and training, there will be greater opportunity to empirically evaluate the impact of the role with particular emphasis needed to explore consumer experiences of PWs and how effective the PW role is in helping better meet their needs. Finally, mental health nursing needs to consider the ramifications of greater PW participation in the workforce to see if opportunity exists for nurses to take on new roles.

References


