Evaluation of a training scheme for peer support workers

Louise Gerry and colleagues describe how service users can work alongside healthcare providers to help their associates recover.

Summary
This article is based on focus group reports on the experiences of people with mental health problems who have undertaken training to be peer support workers in mental health services. In focus groups, trainees stated that the completed training programme empowere them to help and support their peers, and led them to explore wider issues in the mental health services. The professional involved also benefited from the programme. The authors suggest that adequate guidance and support from the Department of Health and local trusts may establish peer support as a welcome and effective component of recovery-oriented mental health services.

Keywords
Peer support, mental health services, recovery

IN MENTAL health services, peer support involves people with experiences of mental health problems supporting others with similar experiences. Peers can help with groups, including self-help groups, drop-in, day, crisis and employment services, or can offer service users internet or telephone support (Solomon 2004). The need for such service-user involvement in mental health services has been emphasised by the Department of Health (2006, 2007).

Peer support workers benefit from having an identity other than 'service user'. They are often mindful of the specific problems faced by service users (Solomon 2004).

Despite the ability of these workers to offer empathic services, however, uptake of peer support in mental health services has been slow (Davidson et al 2006).

This may be because of little evidence of its usefulness, although peer-provided services have been found to be as or more effective than professional-led services (Solomon and Draine 1995, Chinman et al 2000, Deegan 2003). In addition, peer support has been associated with reductions in hospital admissions and use of crisis services (Klein et al 1998, Clarke et al 2000), and the inclusion of peer support workers in discharge processes has been associated with improvements in patient outcomes (Felton et al 1995, Chinman et al 2001).

Peer support workers often benefit from the training they receive and employment opportunities they are offered. They tend to be admitted to hospital less often than other people with mental health problems (Sherman and Porter 1991) and there is evidence that they experience more self-efficacy and self-esteem, a greater sense of empowerment and hope, and an improved quality of life. Research suggests, moreover, that peer support workers can build their own support systems and deal with the stigma associated with mental health problems (Manning and Suire 1996, Humphreys 1997, Salzer 1997, Mowbray et al 1998, Salzer and Shear 2002, Solomon 2004, Akbas and Kurzman 2005).

In addition, peer support can be beneficial to mental health service providers, most obviously by reducing costs associated with hospital and crisis services (Sherman and Porter 1991, Solomon 2004).

There is also evidence that service providers who employ peer support workers are less likely to exhibit discriminatory attitudes toward people with mental health problems (Cook et al 1995, Dixon et al 1997) and may even experience improvements in their general health and wellbeing (Solomon 2004).
This article outlines the development and training of peer support worker roles in the Sussex Partnership NHS Foundation Trust. Although the role is subject to local interpretation, this description will be useful to any mental health service provider that is considering its introduction.

In February 2008, Sussex Partnership NHS Foundation Trust and the Sussex Recovery Alliance commissioned Recovery Innovations, a training and consultancy company based in Phoenix, Arizona, to lead the development of a training programme for peer support workers. The trust also commissioned an evaluation of the programme.

At the heart of the programme is the process of recovery, which has been described as ‘a deeply personal, unique process changing one’s attitude, values, feelings, goals, skills or rules. It is a way of living a satisfying and hopeful life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability’ (Anthony 1993).

The two-week training programme consists of nine modules (Box 1, page 24). In completing these, trainees can progress along their own recovery journeys while developing the skills they need to help others along their recovery journeys. Recovery Innovations refers to graduates of the programme as ‘peer support specialists’, and participants used the same term to describe themselves during the evaluation process.

Of the 20 people who undertook the programme, which was situated at a local university campus, 17 agreed to take part in one of three focus groups so that their opinions of peer support and working with the trust before, during and after they had undertaken the training programmes could be recorded. Each of the 17 focus-group participants received an invitation letter, consent form, and a description of the purpose and areas of interest of the evaluation, and information on their right to withdraw from the evaluation at any time. The focus groups were organised by the first author and a co-ordinator of the trust’s recovery action plan.

The participants’ contributions to the focus groups were recorded, transcribed verbatim and analysed thematically by the first author. The second author then reviewed the themes to ensure that the content of the transcripts had been represented accurately. The training process was masked to both authors.

Findings

Recovery One notable finding of the focus groups was that, as participants progressed through the programme modules, the concept of recovery became more meaningful to them.
Participants said that, before they started the programme, they had thought that recovery was part of a government drive to minimise service use and, therefore, expense. Asked to describe their opinions of recovery before they had started the programme, two participants said:

'It was just a meaningless term that was about cutting services.'

'I felt it was government-led because if everyone recovered, they get off the books, and it is therefore cheaper.'

Participants also suggested that 'recovery' is synonymous with 'cure', which they see as unavailable to some people. When asked for their opinions on the meaning of recovery, some said:

'I wanted to see the difference between cure and recovery.'

'Recovery means being classified as having a normal mental state, if there is any such thing.'

'I thought recovery meant that people who had a period of depression or anxiety could recover. I did not think recovery was for people with bipolar, like myself.'

Participants became less sceptical about the concept of recovery as they were encouraged to consider their own recovery journeys and the incorporation of recovery approaches into mental health services. They also came to understand recovery as a process that is open to all, rather than a discrete event open only to a few.

Comments on recovery by participants who had started or completed the programme included:

'I am more positive about recovery in the long term and I am not as cynical. It is possible to live in a recovery model.'

'Back then I thought recovery would not be possible for certain people but from our course, it looks as if everybody is capable.'

The programme Trainees described the programme as 'a battle', as well as 'exhausting', 'hectic', 'intense' and 'overwhelming', but they believed that such intensity and hard work was necessary for their recovery to progress.

One participant suggested that the programme would be less exhausting if it took place over a longer period of time. Comments on the overwhelming nature of the programme included:

'That fortnight was hell.'

'In the first days it was quite overwhelming. It got to the point where I actually screamed.'

'The course was exhausting practically, emotionally and mentally, but it was one of the best things I have ever done.'

'I knew it would be hard work but it was very worthwhile.'

Learning skills Participants who had completed the programme said that they were able to apply their new skills when they experienced mental distress, and that this allowed them to continue their recovery journeys. Comments on the skills acquired during the programme included:

'It has given me tools to deal with my own symptoms as and when they occur.'

'It has certainly enabled me to start on the process of some other aspects of recovery.'

'What we have learned is completely priceless and can be used in every single area in every personal environment. It plays a part in all parts of life.'

Confidence Participants who had begun the programme reported that they had become more confident when being interviewed for jobs, for example, or in their relationships with care team members, friends, family members and work colleagues. They had also developed strategies for dealing with other people in distress, and said that seeing other people recover helped them to understand why they behave in certain ways. Comments included:

'I tended to stay away from things that would upset me, but now my confidence is much better and I actually think I can do things.'

'You suddenly start using the skills you have gained, not just in work but with friends and family.'

'The way I was with other people, when I came across their strengths: I was aware of that change happening in me. I could see, okay, people are doing that because that is what they need for themselves.'

Communication Participants undertaking the programme also reported an increased awareness of aspects of communication. Comments on this aspect of the programme included:

'It helps me talk to friends, family and to be a bit more understanding.'
'By asking more open-ended questions, I have noticed a language change.'

The trust's approach When participants were asked about mental health care services at the trust, they perceived a lack of recovery-oriented practice. For instance, some said:

'There is no recovery within the system.'

'It is not a recovery environment that we work in.'

'It almost needs the whole thing turned over to start a different system.'

Participants also suggested that the trust's care programme approach (CPA) conflicted with its recovery agenda. One said:

'CPA is all about difficulties and problems. There is no space to say: 'Well, I am actually good at doing this!'.

Although participants recognised the potential difficulties of challenging trust structures that could impede their recovery, some hoped that peer support specialists could be catalysts for change. One said:

'I have more hope for services as a whole now than I had before.'

Some participants highlighted the different approaches to recovery adopted by peer support specialists and mental health staff. One commented:

'The peer support approach is perhaps at one extreme and the approach of other people is at the other extreme. So there is a bit of work to do in terms of moderating the ethos.'

Participants perceived a lack of support in the trust for continuing the focus groups after the programme had been completed.

Comments included:

'I am very disappointed that we have not been supported to meet together yet.'

'The trust does not understand the commitment of the group. I have grave concerns.'

However, despite participants' apparent desire that the trust should organise and support group meetings, many were adamant that they were independent of the trust and that they could use their skills in other organisations with or without the trust's assistance. Comments included:

'This group could be independent if we so choose and if the trust does not meet our expectations.'

'As a unit we have enormous power to change the system.'

The peer support specialist role Members of all three focus groups doubted that peer support specialists would be accepted as full and equal members of the NHS workforce due to a lack of understanding of recovery and the peer support specialist role among staff.

Commenting on the perceived resistance to the peer support specialist role among healthcare professionals, such as community psychiatric nurses (CPNs), participants said:

'Clinicians will have to take on board that it is the people that are using services that are saying something, so they have to listen.'

'We are something completely new and psychiatrists and CPNs, and whoever else might be involved in the CPA, might not be happy about it.'

'They are taught to not get involved whereas we sort of mix with each other or other people like ourselves.'

When asked what else may prevent healthcare professionals from accepting the peer support specialist role, participants said:

'There is a culture of thinking among clinicians and people who are in a profession that, if you are a service user, you do not amount to very much. There needs to be a shift in thinking although I think that would be very difficult.'

Participants said that peer support specialists are unique in that they have self-awareness derived from lived experience and can promote choice, focus on strengths, honour the service user's role as experts, and provide a safe environment for the open and fair negotiation of risk. They can also preserve the independence and flexibility of peers, who can 'dip in and out' of services.

Participants suggested that peer support specialists can be integrated into mental health services more easily if staff are provided with additional information and training on their role. But, for them to be fully integrated into teams, a commitment to recovery practices is needed at every level of the workforce. One participant said:

'I would like to go back to the resistance of the staff. They need to have good information.'

Discussion Analysis of the participants' contributions produced six themes relating to the personal experiences of trainees, and to the implications of the training programme for the trust and mental health services generally.

The increasing confidence of, and development of inter- and intrapersonal skills by, participants in the programme is supported by evaluations of earlier peer support programmes by, for example, Klein et al (1998) and Chinman et al (2000).

Participants' claims to have experienced personal growth, increased self-esteem and confidence, a sense of empowerment and hope, and an improved quality of life, reflect the findings of research by Humphreys (1997), Mowbray et al (1998), Salzer...
and Shear (2002), and Solomon (2004). Meanwhile, their reported inability to combat stigma, and their perception that the trust’s lack of involvement in their professional growth immediately after the training programme has impeded their initial attainment of career goals, reflect the findings of Manning and Suire (1996), Salzer (1997), and Akabas and Kurzman (2005).

The descriptions of the pathway to recovery and the training experience as being exhausting and intense battles are novel, and may reflect participants’ emotional experiences of personal growth. They may also indicate that service providers should take seriously the suggestion that the programme could be run over a longer time period.


The gap between policy and practice has been identified nationally, both in relation to recovery and social inclusion (Newbigging 2001, Bertram and Stickley 2005, Slade and Hayward 2007), and to service-user involvement and choice (Perkins and Repper 1998).

Of the barriers to peer support specialist employment identified by the participants, negative attitudes from other professionals are also identified by Davidson et al (1999) and Kling et al (2008); role ambiguity by Dixon et al (1994), Mowbray et al (1996), and Salzer and Shear (2002); and a lack of infrastructure or job definition by Dixon et al (1994) and Mowbray et al (1997).

Solomon (2004), meanwhile, has warned that all of these barriers can undermine peer support specialists and ultimately reduce their effectiveness.

The participants did not think that they had been involved in the development of strategies for integrating peer support specialists in the trust and indicated that, if necessary, they would consider peer support specialist roles outside the trust. There is too little research to ascertain whether peer support specialists’ difficulties in finding employment are localised or part of a wider structural problem. A strategy for overcoming these barriers is outlined in Box 2.

### References

Limitations Although 85 per cent of the trainees contributed to the focus groups, their views may not be representative of all participants in the programme. Some participants may have disliked being recorded during the focus groups, and may have given different responses had this not taken place. All participants could ensure that their responses were excluded from the analysis.

In addition, the programme, which had been devised as a peer support specialist programme in the United States and had not been adapted for local trust use, may have seemed misplaced in the cultural context of healthcare services in the UK, although one participant suggested that the US had valuable lessons to share.

Conclusion
The authors' study has identified several important steps in the process of integrating the peer support worker role into mental health services. These are:

Development, with the help of potential peer support workers, of a clear workforce strategy to underpin the training process.

Ensuring that local service issues are central to peer support worker training programmes.

Addressing and overcoming the resistance of staff to integrating peer support workers.

Overall, trainees reported that the programme had enabled them to apply recovery principles to other people, including those experiencing distress. They also said that the trust was insufficiently committed to the development and integration of peer support worker roles in the workforce, possibly because guidance and support from the Department of Health is inadequate.

Since the evaluation, a peer support specialist network supported by the trust has met to regularly. Vocational training has been made available to them, and some participants have taken up paid and voluntary roles as peer support worker roles are being pilot by the trust and local partners. A second training programme was devised in 2009 and a follow-up evaluation of the experiences of peer support workers in substantive posts is being undertaken.

Find out more
More information about the peer support worker training programmes offered by Recovery Innovations is available at www.recoveryinnovations.org

Sussex Peer Approach training graduates can be contacted at sussexspa3@yahoo.co.uk

For information about other aspects of this article, contact Clio Berry at c.berry@sussex.ac.uk

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