Editorial

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Where is peer support going?

Peer support is not new. For as long as people have used mental health services, people diagnosed with mental health challenges have provided support to each other and peer led groups and services have become widespread in many parts of the world (see, e.g. Chamberlin, 1978; O'Hagan, 2014). Today, numerous local peer support initiatives exist, many peer support and peer led groups have developed within voluntary sector organisations. For example, Bipolar UK[1] and the Hearing Voices Network[2] have long seen peer support as a core part of their business and a core part of Mind's 2012–2016 strategy is to ensure that "Everyone in England and Wales with mental health problems can access peer support by 2016" (Mind, 2013, p. 1). More recently, Mind's Peer Support in the Community programme 2018–2021 aims to establish ten Community Peer Support Hub Networks, with each Hub supporting 60 local peer support leaders and groups. In addition, a range of on-line peer support opportunities have developed[3].

As the value of peer support has been increasingly recognised, so more formal peer roles have been created in mental health services across the western world (Repper *et al.*, 2013) and the need to increase the availability of peer support has been widely recognised and included in policy documents (see, e.g. Mental Health Task Force, 2016). It has been argued that peer support workers employed in mainstream mental health services are "not really peer", and that within the hierarchies, rules and legal framework of such services real, reciprocal relationships are not possible: "real" peer support needs to be independent. However, the peer led research conducted by Onken *et al.* (2002), found that people greatly valued peer support in their journey of recovery. In relation to peer support, people said they found diverse models of peer support helpful, including peer support workers employed within traditional mental health services.

Peer research indicates that introducing peer support workers into clinical teams can have a positive influence on the culture of the team with staff becoming more optimistic about the recovery potential of all those using the service. Peer support has also been shown to improve the outcomes of people receiving it, enhancing their sense of hope and empowerment, reducing length of stay in hospital and increasing their engagement in community activities (see Repper and Carter, 2011; Repper *et al.*, 2013). On top of this, being a peer support worker can improve the recovery of peers themselves. Indeed, Slade *et al.* (2017) claim that there is more evidence underpinning peer support than any other mental health profession.

Not surprisingly increasing numbers of organisations are employing peer support workers within their workforce. Peers are now working across mental health services including not only adult community teams and inpatient wards, but also children and adolescent, forensic and dementia services. They are working in primary care, in community navigation roles and their numbers are growing in physical health services for example in palliative care services, as breast feeding support workers and with people who have complex and long term conditions.

In addition, there are an increasing number of people working as nurses, psychiatrists, psychologists, occupational therapists and social workers who have their own lived experience of mental health challenges. Increasingly such people are feeling able to use their personal experience of mental health challenges, alongside their professional expertise, in their work in mental health services. However, while people employed in other professional roles may use their lived experience to enhance their professional skills they are not peer support workers. A professional who also has lived experience of mental health challenges is still a professional: traditional power, hierarchy and claims to special knowledge remain and impede the mutuality

and shared journey of peer support. In contrast, for peer support workers, the primary source of reference is their personal lived experience.

Although the employment of peer support workers in mental health services is a largely positive development, as their numbers increase many questions and challenges are emerging.

Whilst the definition of peer support, and the core principles on which it is based, are largely agreed (see, e.g. Repper *et al.*, 2013) as yet there is no shared agreement about the role that peer workers should play in services. This debate focusses on whether peer support workers should have a specifically defined role and tasks or whether they can engage in a range of roles or tasks as long as the nature of support that they provide is led by their own experience. For example, there are debates about whether peer support workers can perform the tasks typically conducted by healthcare assistants.

We would argue that peer support is less about what peers do than about the way they do it, however even this is not consistent or clear. Training for peer support workers varies in length, content, aims, in who provides it and in how it is run. There is no nationally agreed standard to guide trainers and no benchmarks by which to assess quality. Further questions arising from this concern the practical competencies required to offer peer support. Few training courses assess the competency of peer support workers and once again, there is no agreement about what these competencies should include.

At a fundamental level, there are questions about what constitutes peer support in specialist settings. For example, if peer support is about shared experiences do peer support workers employed in forensic services need to have experience of forensic services or can they be employed on the basis of their shared experience of mental health problems, or their shared cultural background? Do peer support workers in acute inpatient wards need to have spent time in an acute inpatient ward themselves?

Other issues that urgently require consideration include the ongoing support and supervision provided for peer support workers. This is critical if peers are to retain their distinct identify and approach rather than become imbued with routine practices and traditional approaches that influence them in their day to day work. But does it need to be provided by a peer? If so, how do we grow and develop a peer workforce with these skills? Currently there are few courses available specifically to train peer workers in leadership, development and supervisory roles.

There is also the question of career pathways for peer support workers. Whilst the banding of peer support workers within NHS services begins at two-third and there are a few senior posts banded at four, there are unlikely to be posts available at a higher level unless peer support workers move beyond offering practical and emotional support at an individual or group level. To move into managerial or training posts, peer support workers will need to change the focus of their work and this raises questions about whether they will remain primarily peer workers or become managers/trainers with lived experience. Is it realistic or desirable to develop a progressive career in peer support, in parallel with the professional careers of other professionals, or should they be enabled and supported to plan a career in which their peer skills can be transferred into other roles, maybe training as managers, trainers, or nurses, psychologists, etc.?

At a more practical level, questions about what peers should and should not do in their day to day work are fiercely contested. Should peer support workers be involved in practices such as restraint, administration of medication, lone working in the community? If they choose to take up these roles how can they be supported to work in recovery focussed ways and to bring their experience to bear on the routine practices of other team members – change the ways in which such things are done and, in the case of restraint, maybe obviate the need for it at all?

What has become apparent in all of the research undertaken is that the organisational context in which peer support workers are employed is critical in determining their success. Yet, once again, there is no agreement about how to support organisations to prepare for peer support workers.

It is possible to provide answers to these questions; answers that are based on research and evidence from best practice. Indeed several organisations in England alone are developing charters, organisational support to employ peer support workers, peer to peer forums and many different definitions and value sets have been developed. Both Sussex and Wessex are in the

process of developing locality wide frameworks to guide the recruitment, training, employment and ongoing support of peer support workers across voluntary sector and statutory health and social care services, physical and mental health, primary and secondary services. Furthermore, international research and development programmes offer tool kits, checklists and guidelines, but these generally focus on peer support in a specific context.

As with any new development, time is needed to experiment, pilot, evaluate, learn, etc. However, it appears that we have reached a point where sufficient evidence and experience has been accumulated, and the time is right to use this to develop national standards. What appears to be needed is a central forum to discuss, debate and coproduce nationally agreed guidance for the increasing numbers of organisations employing peer support workers.

At the same time, we must also recognise that employing peer support workers in mainstream services is not the only, or arguably the most important, type of peer support. As Onken *et al.* (2002) demonstrated, people value a diverse range of different types of peer support in their recovery journeys. We must continue to support informal mutual support and community based groups and initiatives and explore how these inter-relate to ensure that people have access to what they need, when they need it in a manner that meets their wishes and preferences.

Notes

1. www.bipolaruk.org/
2. www.hearing-voices.org/
3. www.elefriends.org.uk/

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