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Peer Support in Adult Mental Health Services: A Metasynthesis of Qualitative Findings

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Objectives: Peer support involves people in recovery from psychiatric disability offering support to others in the same situation. It is based on the belief that people who have endured and overcome a psychiatric disability can offer useful support, encouragement, and hope to their peers. Although several quantitative reviews on the effectiveness of peer support have been conducted, qualitative studies were excluded. This study aimed to synthesize findings from these studies. ***Method:*** A qualitative metasynthesis was conducted, involving examination, critical comparison, and synthesis of 27 published studies. The experiences of peer support workers, their nonpeer colleagues, and the recipients of peer support services were investigated. ***Results:*** Peer support workers experiences included nonpeer staff discrimination and prejudice, low pay and hours, and difficulty managing the transition from "patient" to peer support worker. Positive experiences included collegial relationships with nonpeer staff, and other peers; and increased wellness secondary to working. Recipients of peer support services experienced increased social networks and wellness. ***Conclusions and Implications for Practice:*** The findings highlight training, supervision, pay, nonpeer staff/peer staff relationships, as important factors for statutory mental health peer support programs.

Keywords: peer support, mental health, qualitative research, recovery

Peer support draws on direct and shared experience as a resource for mutual benefit. Peer Support workers are people who have survived a psychiatric disability, who offer useful support, encouragement, and hope to others in similar situations (Davidson, Chinman, Sells & Rowe, 2006). There are various types of peer support, with examples emerging internationally.

Solomon (2004) categorizes peer support into self-help groups, peer run services, peer partnerships, and peer employees. This research focuses on peer partnerships and peer employees. In peer partnerships, peer and nonpeer staff, such as mental health workers, share management responsibility (Solomon, 2004; Adame & Leiner, 2008). Peer employees are individuals hired into designated peer positions. Examples are peer advocate, peer specialist, peer counselor, consumer case manager, and peer support worker (Solomon, 2004). The distinction between peer partnerships and peer employees is narrow, and many programs span these categories. Some mental health centers hire up to three peer employees (Forchuk, Reynolds, Sharkey, Martin & Jensen, 2007), whereas others hire several (Rivera, Sullivan & Valenti, 2007; O'Donnell et al., 1999). The point at which management responsibility becomes shared and therefore a partnership is unclear. For this research, the term peer support referred to both peer partnerships and peer employees.

Evidence for peer support has been reviewed, concluding that peer support workers produce outcomes comparable with their nonpeer colleagues and in some cases are more effective (Simpson & House, 2002; Solomon, 2004; Davidson et al., 2006). Other studies have confirmed that peer staff and nonpeer staff produce similar outcomes (Rivera et al., 2007; Sells, Black, Davidson & Rowe, 2008; Schmidt, Gill, Pratt & Solomon, 2008; Resnick & Rosenheck, 2008). Reports have suggested peer support programs exist in Canada, the United States, New Zealand, Australia, and the United Kingdom (Forchuk et al., 2007; Rivera et al., 2007; Lawrence, 2004; O'Donnell et al., 1999; Perkins, Buckfield & Choy, 1997). This has been driven in part by policies, which, to varying degrees, mandate peer support (DOH, 2009; Kirby, 2006; Surgeon General's Report, 1999; New Zealand Ministry of Health, 2005; AHMC, 2009). Yet there is wide variation across regions. In the United States, peer support workers bill Medicaid (GCPSP, 2010; Sabin, 2003) and peer operated services were recently recognized as best practices (Substance Abuse and Mental Health Services Administration, 2011). In the United Kingdom, a Recovery College has been set up, which trains peer support workers (Wilson, 2010). In Ontario, Canada, community mental health care teams are mandated to hire peer support workers (White, Whelan, Barnes & Baskerville, 2003).

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However, compared with the evidence base for supported employment programs and assertive community outreach programs, peer support is far behind (Davidson, Drake, Schmutte, Dinzeo & Andres-Hyman, 2009). Salzer's (2002) review concludes that peer support services require more systematic research to be viewed as evidenced-based. Davidson et al. (2009) and Rivera et al. (2007) call for the development of training curricula and fidelity measures. More evidence is needed to foster the development of peer support programs into mainstream health service delivery. The findings from qualitative studies on peer support have not been synthesized to underpin development, and so the aim of this research was to fill this gap. The research objectives were to uncover the active ingredients of peer support by systematically investigating data drawn from the experiences of peer support workers, their nonpeer colleagues, and the recipients of peer support services.

Method

A qualitative metasynthesis aims to examine, critically compare, and synthesize a collection of published qualitative studies on a common topic (Walsh & Downe, 2005). Metasynthesis is similar to the more commonly known meta-analysis, the difference being that metasynthesis is for qualitative papers, whereas meta analysis is for randomized control trials. Its use has emerged because of the growing number of qualitative research papers (Lloyd Jones, 2004) and a growing interest in the merits of their synthesis (Booth, 2001; Walsh & Downe, 2005; Pope & Mays, 2009, Centre for Reviews and Dissemination, 2009). Qualitative metasynthesis can provide practitioners with evidence based on a critical summary, generalizing qualitative findings. This can overcome issues of small sample sizes and nonrepresentative samples (Whalley-Hammell, 2007; Sandelowski & Barroso, 2005; Sandelowski, Lambe & Barroso, 2004).

Search Strategy

This search strategy is reported in STARLIGHT format (Booth, 2006) for transparency and replication. All relevant papers in English published between 1990 and 2010 were sought, including only qualitative and mixed methods papers with qualitative sections. 2890 papers were identified from the databases CINAHL [EBSCO], PsycINFO [EBSCO], PsychARTICLES [EBSCO], AMED, Allied and Contemporary Medicine [OVID], MEDLINE [OVID], BNI, British Nursing Index [OVID], SCOPUS. The search terms used were based on the Simpson, Barkham, Gilbody & House Cochrane Collaboration Protocol (2003) on peer support in conjunction with terms to identify qualitative research (Sandelowski & Barroso, 2006). Two further studies were obtained: one from expert consultation, and the other through hand searching. Filtering using the inclusion criteria resulted in 17 eligible studies. By following up the reference lists from these studies, 10 more were identified, resulting in 27 papers.

The inclusion criteria targeted studies that investigated experiences of peer support, from the perspectives of recipients, peer support workers, and professional colleagues. Statutory mental health settings and settings that share leadership with statutory mental health settings were included. Charity organizations and peer-run organizations were excluded. Peer support was defined as providing direct services to people in recovery from mental health problems including substance misuse. Studies concerned with other health issues were excluded. Also excluded were studies of consultative roles with no direct contact with people in recovery, self-help groups, and peer-run organizations.

Results of Paper Appraisal

Each study was appraised using the CASP appraisal tool followed by a posterior analysis of noise to examine the extent each study's findings featured in the overall findings in accordance with the Dixon-Woods et al. (2006) two-pronged approach. The Carlston, Rapp, and McDiarmid (2001) paper poorly differentiated between study findings and imported data. The Dixon, Krauss, Lehman (1994) and Fisk, Rowe, Brooks and Gildersleeve (2006) papers were case reports. All received low CASP scores but did not over-contribute to any findings and so were included.

Findings

A metasummary was conducted using a technique developed by Sandelowski and Barroso (2006). This involves (1) extracting findings, (2) editing findings for accessibility to readership, (3) grouping findings in common topical domains called abstracted findings, (4) naming each abstracted finding, and (5) calculating frequency effect size (number of papers containing an abstracted finding/total number of papers).

Three hundred seventy-one findings were extracted and consolidated into 24 abstracted findings. In this section and the discussion, papers of the review are referenced by number. See Table 1 for number assignment and Table 2 for abstracted findings and frequency effect sizes.

Peer Support Worker Experiences

The highest frequency finding about peer support worker experience (44% of papers reviewed) was concerned with low pay and few hours. However, positive experiences included benefits for wellness, social networks, and opportunities to move onto other things. Peer support workers reported increased confidence (1, 13, 16, 22), increased self-esteem (2, 5, 13), and increased social networks through fellowship with other peer support workers (1, 12, 13, 20). Peer support workers saw the peer support worker role as a stepping-stone back into employment (8,16) and a chance to reintegrate into the community by interacting with others, including nonpeer staff, on an equal footing (22).

Challenging experiences included negative and/or rejecting nonpeer staff attitudes and being treated as a "patient" rather than a colleague by nonpeer staff. Peer support workers spoke of nonpeer staff paternalism (4, 8). Examples of "black humor" by nonpeer staff about people in recovery was witnessed by a researcher during ethnographic research (17) and expressed by peer support workers in a case report (13). Peer support workers spoke of not being invited to outside work events (9), and not being invited to certain work activities (13). Incidents of nonpeer staff treating peer support workers as "patients" rather than

Table 1
Key Features of Studies Included in Metasynthesis

Study #	Study	Location	Study participants: Peer support workers	Study participants: Nonpeer staff	Study participants: People in recovery	Stated method
1	Armstrong et al. (1995)	Canada	16			Interviews
2	Besio et al. (1993)	USA	30			Survey (open-ended questions) Focus groups
3	Carlston et al. (2001)	USA	6	6		2 Focus groups
4	Chinman et al. (2008)	USA	59	34		4 Focus groups
5	Colson et al. (2009)	USA	13	8		Ethnography: observations, interviews, focus groups
6	Davidson et al. (2001)	USA			21	2 Interviews per person in recovery
7	Dixon et al. (1994)	USA		3		Case study
8	Doherty et al. (2004)	UK	2	8		Interviews
9	Fisk et al. (2000)	USA	2	1		Case study
10	Gates & Akabus (2007)	USA	15	93		Interviews focus groups
11	Grant (2010)	Canada	14	16		Ethnography
12	Mancini (2005) Mancini & Lawson (2009)	USA USA	15			Interviews
13	Manning & Suire (1996)	USA	16			First person stories
14	Meehan et al. (2002)	Australia	10			Mixed methods Focus groups
15	Moll et al. (2009)	Canada	6	6		Interviews
16	Mowbray et al. (1996)	USA	16			Mixed methods Activity log analysis and focus groups
17	Paulson et al. (1999)	USA	4	4		Mixed methods, Activity log analysis and ethnography
18	Pudlinski (1998) Pudlinski (2001)	USA USA	3			Participant observation, examination of training manuals and interviews
19	Richard et al. (2009)	Canada	5			Interviews
20	Salyers et al. (2009)	USA		16	14	Mixed methods Interviews
21	Silver (2004)	USA	12			Interviews Focus groups
22	Straughan & Bucjenham (2006)	UK		19	19	Mixed methods Interviews and participant observation
23	Truman et al. (2002)	UK		18	34	Interviews Focus groups
24	Yuen et al. (2003)	Australia	3			Interviews
25	Mowbray et al. (1998)	USA	11			Interviews
Total			279	232	88	

Note. All peer-support workers were paid except for studies 1, 6, and 23, where peer support workers were volunteers.

colleagues included labeling a work issue, such as calling in sick, as a symptom of psychiatric disability (4, 10, 13). Another challenging experience was managing the transition from a "patient" to a peer support worker, and knowing where to draw the line between friend and service provider. For example, at the "warm lines" service where peer support workers staff call lines, peer support workers are asked to perform three roles: friend, uninvolved listener, and lay expert, which leads to role confusion (18).

Nonpeer Staff Experiences

Nonpeer staff developed increased empathy and understanding toward people in recovery as a result of working with peer support workers (2, 8, 9). Nonpeer staff also gained from peer support workers a belief in recovery (19). Some feared that the "cheap labor" provided by peer support staff may lead to less nonpeer staff job positions (4, 10, 14, 23).

People in Recovery Experiences

The highest frequency finding in this category (44% of papers reviewed) was people in recovery viewed peer support workers as role models (2, 4, 5, 7, 8, 10, 15, 16, 20, 21, 23). People in recovery experienced increased hope, increased motivation, and an increased social network as a result of working with peer support workers (4, 6, 10, 20, 22). People in recovery built rapport with peer support workers more easily then with their nonpeer staff (2,7, 8, 17), as a result of peer support workers having less professional distance (2) and peer support workers being "street smart" (7). "Street smarts" included knowledge about where a person would likely go after absconding from hospital, where a person's money may go, and the effect of environment on drug use (7).

Some papers reported that peer support workers are not role models for people in recovery (4, 8, 9, 13). Reasons included a belief that without formal training (4) and that because of their

Table 2
Frequency Effect Sizes (FES) of Abstracted Findings

Findings (n = 25)	FES (%)	Papers
Peer support worker experiences		
Low pay and few hours	44	4,7,9,10,13,15,16,25,19,20,21
Feelings of inclusion and exclusion in the work place	36	4,7,8,9,11,12,15,16, 19,
Helps own recovery	32	1,2,5,13,16,21,22,24
Nonpeer staff negative attitudes (prejudice)	32	2,4,8,10,11,12,13,17
Difficulty negotiating boundary between friend and service provider	32	5,7,9,10,15,16,18,23
Being treated like a "patient" by non-peer staff	28	4,7,10,12,13,19,21
Difficulty changing from a person in recovery to a peer support worker	28	2,4,7,9,10, 12,15
Increased social network	24	1,12,13,16,21,24
Nonpeer staff rejecting and avoidant behaviors (discrimination)	16	9,11,13,16
Peer support work is a "stepping stone" to other things	16	1,8, 23, 25
Frustration when people in recovery miss appointments, display difficult behavior	16	1,14,16,25
Nonpeer staff experiences		
Learning from peer support workers	36	2,4,5,7,8,9,10,11,20
Worry nonpeer jobs will be replaced by peer support worker jobs	16	4,10,14,23
People in recovery experiences		
Peer support workers are role models	44	2,4,5,7,8,10,15,16,20,21,23
Peer support workers are easy to build rapport with	40	1,2,4,5,6,7,8,14,17,20
Increased wellness (hope & motivation, more friends, and better illness management skills)	20	4,6,10,20,22
Peer support workers are not role models	12	4,8,9
Statutory mental health organisations experiences		
Peer support workers helps de stigmatize mental illness	28	2,5,6,7,16,22,23
Peer support workers take more sick time than non-peer staff	20	2,7,8,17,25
Tension on the role of professionalism for peer support workers	20	5,7,13,16,20
How/ when to who and what should peer support workers disclose?	16	5,9,10,15
Confidentiality of people in recovery records policy poses issues	8	2,10
Recommendations		
Training and supervision are important for the success of the peer support role	44	2,3,4,7,8,9,13,15,16,19,21
A clear job description is a strategy to alleviate role confusion	24	3,4,7,10,13,15

Note. Frequency Effect Size (FES) = number of papers containing a finding/total number of papers.

diagnosis of a psychiatric disability (8) peer support workers would be ineffective helpers.

Statutory Mental Health Organization Experiences

A benefit of the peer support worker role for organizations was decreased stigma to mental health problems. The peer support worker role set a positive example to other sectors in the community (2, 16). The role enabled people with a psychiatric disability to find a place in the community beyond being a "patient" (6, 21).

A challenge for organizations was managing the tension over the role of professionalism for peer support workers (5, 7, 13, 16, 20). Specifically, training was questioned as leading to professionalization and interference of the advantage of being a peer (7). Confidentiality, disclosure and increased sick time of peer support workers compared to nonpeer workers were also issues for organizations.

Recommendations

Training and supervision was the highest frequency recommendation (44% of papers reviewed). Supervision from other peer support workers as opposed to nonpeer staff was reported valuable (8, 15). A clear peer support worker job description to avoid role confusion and anxiety was recommended (3, 7, 10, 13). Vagueness of job role was also described as an advantage by allowing job creativity (7, 15).

Discussion

The findings add to the current evidence by identifying qualities of the experience of peer support. The findings highlight challenges for peer support workers and raise interesting and important questions about the way forward for peer support worker programming. Peer support workers were role models, established rapport with people in recovery, decreased stigma, increased wellness (in themselves and the people they serve), and taught nonpeer staff about recovery. Each of these characteristics could contribute to the effectiveness of peer support.

The highest frequency findings were as follows: peer support workers experience low pay and few hours; recipients of peer support services experience peer support workers as role models; and increased training and supervision is important for the success of the peer support role (all 44% FES). Training, however, may interfere with the advantages of being a peer (Dixon et al., 1994). Increased pay may lead to co-option of the peer role by minimizing a peers' ability to speak out against the system and offer their unique peer perspective (Crossley, 2004). The prominence of these contradictory findings could be attributable to a broader issue about the nature of professional practice.

Peer Support Workers and Professionalism

Parsons (1954) defined a professional as "a technical expert by virtue of mastery." More recently, Fish (1995) described

professionalism as comprising a technical rational component (competency based, and protocol driven) and an artistic component (reflexive and values from lived experience). Fish (1995) cautions the forcing of professional practice into only a technical rational framework. Others agree. The limits of procedural, technical, and professional knowledge and collective professional roles have been widely discussed (Creek, 1997; Mackey, 2006; Sinclaire, 2007). Workplace definitions of professionalism have the potential to create environments that bolster or hamper the peer role. For example, a workplace that identifies with professional artistry would more likely create training and protocols that value and enable peer staff to use lived experience in therapeutic interactions. A workplace that identifies more with a technical rational definition of a professionalism may instead value maintaining strict boundaries on how and when peer support workers share their lived experience. For peer support workers, the implications of these varying definitions of professionalism are significant.

Interestingly, the FACIT (Fidelity Assessment Common Ingredients Tool), designed for use at consumer operated services, includes an item labeled "artistic expression" in the peer support section of the assessment (Substance Abuse and Mental Health Services Administration, 2011). Although not intended for use for the types of peer support reviewed in this article, peer employees and peer partnership, perhaps this tool could be adapted for such use in the future as a means to facilitate and appreciate the artistic component of professionalism for peer employees.

Peer Support Workers: Pay, Training, and Supervision

Low hours were equated with less opportunity for peer support workers to interact with nonpeer staff, which negatively affected team integration (10, 15, 16, 19). Low pay was associated with low job security and a devaluing of the role (7, 10, 13). Whether higher pay would add value to the role is not clear from the results. A workplaces' definition of professionalism is relevant here, too. In settings valuing a traditional, technical, rational definition of professionalism, increased pay may make peer support workers may feel compelled to conform to existing structure, limiting scope to speak out about their lived experiences. External supervision from other peers (7, 8) and opportunities for further on the job training (4, 8, 16, 19, 21) is called for. The risk of co-option of the peer role applies here, too. Happell and Ropper (2007) propose affirmative action strategies, including access to associations, journals, and conferences specific to peer support workers. An affirmative action context provides a mechanism to protect the unique peer perspective and avoid co-option, because affirmative action strategies have an inherent political agenda to redress past inequality (Sassi, Carrier & Weinberg, 2004).

Limitations

Of the studies reviewed for this metasynthesis, only four investigated the experiences of people receiving peer support services. Qualitative investigation of the recipients of peer support is an area for future research. A possible limitation of the frequency effect size calculation is that equal weight is given to each study regardless of how many participants a study has. This gives case studies the same weight as studies with 50 participants. However, to be consistent with the principles of qualitative research and the recognized limitations to generalizability, the quality of the findings is also important. Quality is not just associated with numbers of participants but with what the study adds to the knowledge of the topic.

Conclusion

Peer support workers were found to be role models, to easily build rapport with people in recovery, to destigmatize mental illness, and to teach nonpeer staff about recovery. At the same time, peer support workers were found to experience discrimination and prejudice from their nonpeer colleagues and to struggle with the transition from a "patient" to service provider. These conflicting findings highlight an underlying tension over how professionalism is defined within health care settings hiring peer support workers and on the value placed on formalizing the use of lived experience of people with a psychiatric disability as a therapeutic modality. Settings with peer support programs and those setting up such programs need to consider how professionalism is defined in their work place and how the lived experience voice fits into their definition. Doing so will assist peer support workers in their job. These findings illuminate the complexities of peer support worker/nonpeer staff relationships and highlight the utility of qualitative inquiry as a necessary adjunct to empirical inquiry both to build the evidence base and to inform service design.

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