Chapter 7

The role of peer providers: buddy, mediator, coach and co-worker

“The only source of knowledge is experience.”

- Albert Einstein -
Abstract

Aim
This article aims to provide insight into the role of peer providers working in mental health care teams, by investigating effects and bottlenecks.

Background
Over the past twenty years peer providers have become of increasing interest in mental health care. In the current literature, the focus is on the role of peer providers in the recovery of patients. Little is known about other roles of peer providers in mental health care.

Design
This study follows a responsive design.

Method
This study was done in a mental health care institution in the eastern part of the Netherlands. In this institution, peer providers were involved in a project aimed to reduce seclusion. Data were collected during the years 2009 and 2010 through document analysis, group interviews with stakeholders, and a dialogue meeting. Data collection and analysis were set up in an iterative way. Data analysis occurred concurrently with data collection.

Results
Peer providers can play a role on three different levels: patient level, interaction level and team level. Care workers and peer providers are also faced with several bottlenecks like the lack of a clear job description, vulnerability of peer providers and peer providers’ need mutual cooperation and support.

Conclusions
This study shows that the introduction of peer providers in the context of reduction of seclusion gives rise to new roles. Next to the traditional role of buddy, the roles of mediator, coach and co-worker can be seen. The combination of roles may create ambiguities and tensions. To deal with these tensions it is important to create an open learning process in which stakeholders become aware of each other’s issues and underlying values. This requires a joint reflection and dialogue between peer providers and professional care workers with attention for vulnerability, strength and mutual dependencies.

Introduction
Over the past twenty years peer providers have become of increasing interest in mental health care (Davidson, Bellamy, Guy & Miller, 2012). Peer providers are persons with a mental health condition who are employed as a counsellor, educator or companion to meet the needs of daily living of patients, and as advocates to empower people with psychiatric disorders (Gates & Akabas, 2007). The current interest in peer-providers reflects the increasing importance of experiential knowledge and the growing influence of the recovery movement. The recovery movement proposes a paradigm shift in mental health care, with recovery taking a central place in care processes and outcomes. Anthony (1993) defined recovery as: “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”. Autonomy of patients and self-determination are important principles of recovery (Solomon, 2004). Peer providers are envisioned to play an important role in promoting such principles. In this context peer support has been characterized as a form of help which is founded on key principles of respect, shared responsibility and mutual agreement of what is helpful, thereby enhancing recovery (Mead & MacNeil, 2006). Initially, the provision of services by peers primarily took the form of peer-led and peer-run mental health services, providing a recovery-based alternative to traditional mental health services (Repper & Carter, 2011). Nowadays, peer providers are increasingly employed in traditional mental health services. First experiences with peer-providers have led to the identification of a range of benefits and bottlenecks regarding their involvement in mental health services (Davidson et al., 2012; Gates & Akabas, 2007; Repper & Carter, 2011). Current evidence indicates that services provided by peers can have a beneficial effect in terms of fewer and shorter hospitalizations, improved social functioning, improved employment outcomes and gains in quality of life. In addition, involvement of peer-providers can enhance the effectiveness of treatment by reducing feelings of loneliness and rejection. Also the peer-provider may benefit from his helper role, as this supports their self-esteem and social role (Gates & Akabas, 2007; Repper & Carter, 2011). However, a number of challenges and barriers have been reported too, including: role conflict and confusion, lack of clarity around confidentiality, poorly defined jobs, a lack of opportunities for social support (Chinman et al., 2008; Gates & Akabas, 2007; Repper & Carter, 2011). Some of these barriers have been suggested to be specific for peer provision in traditional mental health services. In particular the issue of role conflict and confusion has received considerable attention, as peer providers have difficulties setting boundaries between being a buddy on the one hand and a service provider on the other hand (Gates & Akabas, 2007; Plooy, 2007; Repper & Carter, 2011).
In peer-led and peer-run mental health services, peer providers play mainly a role in the recovery of patients (Repper & Carter, 2011; Solomon, 2004). Little is known about the roles of peer providers in the context of professional health care services. Findings of this study provide insight into the roles of peer providers working in traditional mental health care teams, by investigating effects and bottlenecks.

The study was set up as a case study, providing an evaluation of the introduction of peer providers in the context of a project aimed to reduce seclusion. The study had a formative and a summative goal. On the one hand, the process was monitored, and adjustments were made during the process providing insight into success factors regarding implementation (formative evaluation). On the other hand, the qualitative effects of the participation of peer providers at the wards were described (summative evaluation).

Methodology

Setting

This study was done in a mental health care institution in the eastern part of the Netherlands. In 2006 the institution started with a project to reduce coercion and restraint. Seclusion is frequently used in mental health care to manage severe, behaviourally disturbed patients and is defined as locking up a patient alone in a specially designed closed room, with or without consent (Janssen, Van de Sande & Noorthoorn, 2011). The last decade, seclusion has become increasingly controversial in the Netherlands (Hoekstra, Lendemeijer & Jansen, 2004).

Because the use of peer providers had proved to be an important and successful strategy in reducing coercion in other countries (Murphy & Bennington-Davis, 2005), the project management decided to involve peer providers in the project. Peer providers participated in patient-staff meetings and were involved in education programs for staff. Later, some peer providers started working at a ward. Peer providers were mostly working at closed wards, since these wards generally have the highest number of seclusion rooms. The research was done at these wards.

Design

This qualitative study is based on a responsive design (Abma, 2005; Abma & Widdershoven, 2005; Cuba & Lincoln, 1989). Central to responsive evaluation is the exchange of experiences and perspectives between stakeholders through dialogue (Abma, Molewijk & Widdershoven, 2009). The aim is mutual understanding and practice improvement. In responsive evaluation, the researcher is embedded within practice and follow a dialogical and interactive approach (Abma, Molewijk & Widdershoven, 2009). The study was completed over a period of one year and took place in two stages:

- **Initial stage (March 2009 – July 2009)**
  The aim of the initial stage was to map the issues, the recent situation and expectations of working as a peer provider or working with peer providers. Data were collected on four wards. All wards were working with a peer provider or had the intention to work with a peer provider within a few weeks. Data were collected through interviews and a focus group.

- **Final stage (August 2009 – February 2010)**
  The aim of the final stage was to map the results of working with peer providers and to create mutual learning between two wards. One ward had experience in working with peer providers and one ward had no experience in this regard. Data were collected through interviews, focus groups and a dialogue meeting.

Data collection

In the first phase of the study, eight open interviews were conducted with peer providers (2), nurses (2), psychiatrists (2) and managers (2). Topics were the expectations of working with peer providers and their contribution to the reduction of coercion and restraint. When a ward was already working with a peer provider, first experiences with this were addressed in the interviews. The interviews lasted about 1.5 hour, were tape recorded and fully transcribed. All interviews were performed by the first author. Next to the interviews a focus group with six peer providers was organized. The aim of the focus groups was to gain a deeper insight in the successes and problems in working as a peer provider. The focus group lasted about 2 hours and was also tape recorded and fully transcribed.

The final stage took place on two wards. On the ward with experience with a peer provider 5 interviews were conducted; included were: one peer provider, two nurses, one psychiatrist and one manager. The interviews were semi-structured and a topic list was used. The topics were based on the data of the first phase. The interviews lasted about 1.5 hour, were tape recorded and fully transcribed. Moreover, three homogeneous focus groups were organized with peer providers. The aim of the focus groups was to gain a deeper insight in the implementation of peer providers at a ward. Furthermore, peer providers could exchange experiences and learn from each other. Finally, a dialogue meeting took place with all stakeholders. The aim of this meeting was to get insight...
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in the successes, effects and bottlenecks and how to deal with the bottlenecks when it comes to the participation of peer providers at the wards. In this way the care workers at the ward with no experience with peer providers could learn from the other ward. The focus groups and the dialogue meeting lasted about two hours, were tape recorded and fully transcribed.

Table 1 Overview data collection

<table>
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<tr>
<th>Stage</th>
<th>Aim</th>
<th>Data collection</th>
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| Initial stage | Map the issues, the recent situation and expectations of working as a peer provider or working with peer providers | • Interviews with:  
- Peer providers (n=2)  
- Nurses (n=2)  
- Psychiatrists (n=2)  
- Managers (n=2)  
- Focus group with peer providers |
| Final stage | Map the results of working with peer providers and to create mutual learning between two wards. | • Interviews with:  
- Peer provider (n=1)  
- Nurses (n=2)  
- Psychiatrist (n=1)  
- Manager (n=1)  
- Three focus groups with peer providers  
- Dialogue meeting |

Data analysis
The data collection and analysis process was iterative; data were analysed during the data collection and findings from initial steps steered the subsequent steps. The data analysis was open and inductive. The issues were not known in advance but were derived from the data. The data from the interviews and focus groups were labelled and categorized in clusters.

Quality procedures
To ensure the rigour and credibility of our study, principles of triangulation were applied, using several methods of data collection. Also, we followed the procedure of purposive sampling to enhance sample coverage. Moreover, the reports of the interviews and focus groups were subjected to a member check with the respondents to validate the analysis (Meadows and Morse, 2001). Finally, the analysis and coding process was discussed repeatedly in the author team (multiple coding) (Barbour, 2001).

Results
First, the contribution of peer providers will be described at three different levels: (1) patient level, (2) interaction level and (3) team level. Next, difficulties and bottlenecks in the implementation of peer providers at a ward are addressed.

Contribution of peer providers

1. Patient level
Peer providers have contact with and provide support to patients. Peer providers as well as care workers are convinced that the contact between a peer provider and a patient is helpful because of the establishment of an equal relationship. This results in more room to discuss uncertainties. A peer provider said:

“Regularly, patients come to me to discuss doubts and uncertainties. For example: How can I tell my family what has happened?”

A nurse recognized this:

“At the ward I see that patients feel comfortable to get in contact with the peer provider. Patients go more often to our peer provider than to one of the nurses.”

A peer provider can also give hope to the patient (there is still life after an admission in psychiatry). In contrast to care workers, peer providers can refer to their own experience or the experience of other patients.

A peer provider explained:

“While walking with a patient, I told about my dog, and she started crying. She told about her children and her dog and that she had no feeling for them. I told her that I had gone through a similar period. I also lost my feelings. But I also told that the feeling will recur. For a few hours she had the feeling that everything would be all right, she had some hope again.”

A psychiatrist also heard from a patient that the peer provider gave him hope. The psychiatrist said:

“In a conversation with a patient the patient told me that he had talked with our peer provider. He said: you can tell me that everything will be fine again, but when a peer provider says this, I really believe it!”
Care workers experienced that peer providers can play an important part in the recovery and empowerment of patients. Peer providers are, more than the care workers, present in the group, and the patients can ask question and help. Peer providers are easily accessible for patients. A peer provider described his contribution to the process of recovery and empowerment as follows:

“At the moment the patient tells his story, I will tell also my story if that is useful. I will talk about my story with the patient and at that moment the patient will order his story again. The vision on his problems will change and he will develop a new request for care and treatment. This is the beginning of recovery and empowerment.”

2. Interaction level
Peer providers contribute by helping to create a more equal relationship between care workers and patients. Often, care workers operate from a medical model, implying formal and distanced care. As a result, there is little recognition for the suffering of the patient. Given his or her own experience in psychiatry, a peer provider can recognize suffering and is therefore closer to the patient. Peer providers reduced the distance between the patient and the nurse. The peer provider then acts as a bridge, creating mutual understanding and respect. Both peer providers and care workers are convinced that peer providers can be important in closing the gap between patients and nurses. The peer providers emphasized that it is not the intention to “pull one of them to one side of the bridge”.

A peer provider said:

“I look critically to what the care worker is doing but also to what the patient is doing. I am not only ‘pro patient’ and I blow not only with the wind of the patient. But with the aim to do the right thing for the patient, I try to find a balance between the nurse and the patient, so they meet each other halfway the bridge.”

The peer provider can also help solving conflicts between care workers and patients. A nurse told the following story:

“A while ago, I had a conflict with a patient. According to the patient I was pedantic and patronizing. He did not want to talk to me and he was angry. I asked the peer provider for help. I said: ‘I’m completely stuck with this patient and this goes wrong! Can you help me?’ The three of us had a conversation. The patient told why he was so angry and I explained why I said what I had said. The peer provider ensured that we listened to each other and was a sort of mediator. After the conversation the patient and I were on speaking terms.”

Peer providers mentioned they can solve conflicts because they are independent. Although they are employee of the institution, they are not associated by patients with the nursing team, nor with treatment. Solving the conflict can prevent escalations and thereby the risk of seclusion.

3. Ward level
Care workers as well as peer providers indicate that a peer provider can have an important role in improving the quality of care. This is achieved by giving feedback to the care workers on the care they provide.

A nurse said that he appreciated the feedback of the peer provider. Especially with regard to the communication with patients the feedback is of great value. He stated:

“We have become blind to so many things. Often, the peer provider says to me why are you doing this? What do you want to achieve? I see your actions result in this and that.”

Some care workers ask for feedback or tips especially when there is a risk of seclusion. A nurse gave an example:

“If a patient is not doing well and is aggressive for example, and we are inclined to use coercion, we discuss this with the peer provider. Questions I ask are: What can we do best? How do you expect the patient will react? Can we still mean something in this situation?”

Next to giving feedback, and acting as a coach, peer providers can directly contribute to the care process, for instance by interventions which help creating a good atmosphere. A peer provider said:

“I am much more present at the group. Outside the conversations with patients I always make sure that the environment on the ward is pleasant. So, after dinner I put the flowers back on table. Often, nurses do not think about that.”

The peer providers contributed also to the development of comfort rooms at the ward. A comfort room is a nicely furnished room with relaxing light and sound, sometimes together with aromatherapy, and is meant to provide stress reduction. The room can be used by patients when feeling anxious, agitated or angry. The peer providers helped interpreting concepts like comfort, patient friendliness and good care. The perspective of the peer providers contributed to the design of these rooms.

Both by giving feedback and by playing a role in the care process, peer providers help care workers to become aware of the meaning of good care for patients. This is important, since care should meet the wishes and needs of patients. When care fits in with the
perspective of the patients, this results in less conflicts and leads to a reduction of the risk of seclusion.

**Implementation of the peer provider system**

The introduction of peer providers at the ward is not easy. A bottleneck is the lack of a clear job description. A further issue is the fear for vulnerability of peer providers. Finally, peer providers need mutual cooperation and support.

1. **Job description**

At the start of the project, the role of the peer provider was not clear. There was no job description and both care workers and peer providers reported many uncertainties. Care workers did not know what they could ask the peer providers and the peer providers did not know what they could do at the ward besides a conversation with the patient. A peer provider said:

   “Nothing is clear. Also colleagues don’t know what I can do, which role I have. I have to decide that by myself and in contact with my colleagues.”

Some care workers were reluctant to involve peer providers in processes at the ward, while others assumed that a peer provider might be addressed for all kinds of activities on the ward. A peer provider said:

   “In the beginning I got so much freedom and questions that I had to indicate my limits. Otherwise I was going to do things I did not want, even secluding patients.”

The peer providers doubted whether they should in any way be involved in secluding patients. Most of the peer providers did not want to be present when a patient was secluded because the contact with the patient would be under pressure.

The above mentioned uncertainties resulted in frustrations, resistance and powerlessness in both care workers and peer providers. A care worker said:

   “We have to work with a peer provider but I don’t know what he can do, what I can ask and what his role is. This is not a good start and results in frustration.”

The position of the peer providers frequently raised discussion. One of these issues concerned access to the patient record. Some care workers said that a peer provider should be regarded as a professional, so reading and writing reports is part of the job. Others said this was not allowed because of confidentiality and privacy. A similar issue concerned the presence of the peer provider at a team meeting, giving rise to similar arguments in favour and against their presence.

2. **Vulnerability of peer providers**

Various care workers had concerns about the vulnerability of peer providers. A psychiatrist said:

   “I am concerned about the peer providers at our ward. Sometimes there is violence or other incidents. That could be heavy for a peer provider.”

According to other care workers, vulnerability is not a good reason for refusing a peer provider to enter the ward. For everybody working at a closed ward can be confronting. It is up to the peer provider to cope with aggression. Care workers can also support in this. One of the peer providers emphasized that he is no different than the care workers at the ward:

   “I am just an employee. I run into problems and limits but that’s the same for other employees. In that case, there is no difference.”

This peer provider also mentioned that he has learned to deal with his illness. He said he knows his limitations and pitfalls and he can use this knowledge in his function as a peer provider. He recognizes there is always a chance of regress but to avoid this he has made a signal plan and has given this to the care workers at the ward.

   “I am just an employee. I run into problems and limits but that’s the same for other employees. In that case, there is no difference.”

3. **Cooperation and mutual support between peer providers**

Respondents mentioned that peer providers need guidance and support. This should include both group supervision and individual supervision on the ward. Moreover, peer providers should have the possibility to meet each other, and exchange experiences. Ideally, there should be two peer providers at one ward, ensuring continuity and mutual support. A psychiatrist said:

   “If we take the function of peer provider seriously, there should also be a peer provider present in the evening shifts, and not only in the day shifts.”

Various care workers doubted whether the presence of two peer providers on one ward would be feasible. They were afraid of having to choose between an additional peer provider and an additional nurse. Moreover they had doubts about the availability of enough good peer providers. A care worker said:

   “Good peer providers who want to work at a ward are not up for grabs!”
Discussion

In the project under study, both peer providers and care workers experienced positive effects of working with peer providers at a ward. Previous qualitative studies of mental health peer providers mainly focused on the benefits and barriers of peer providers for individual patients (Armstrong, Korba & Emard, 1995; Gates and Akbas, 2007; Solomon 2004; Moran, Russinova, Gidugu & Gagne, 2013). This study indeed reports on benefits and barriers at the patient level, but additionally describes in detail how peer providers can contribute to improving patient-care worker interactions and quality of care at the ward level.

On the individual level, the peer providers focus on the recovery of the patient. They listen to the story of the patient and because of the independent position and the equal relationship there is more room for uncertainties. Moreover, peer providers can be a role model and give hope to the patient. On this level, the role of the peer provider is that of a buddy. On the interaction level, the peer provider not only focuses on the patient but also on the care workers and, in particular, on the interaction between the patient and the care worker. Patient and care worker often speak different languages and have different views. Peer providers try to close the gap and foster mutual understanding, using their experience as a (former) patient. On this level the peer provider acts as a mediator. On the ward level the peer provider focuses on the performance of care workers and the quality of care. The peer provider gives feedback to the care workers, and can also improve the quality of care by taking action. On this level, the role of the peer provider is that of a coach and co-worker.

In the current literature, the role of peer providers is mostly described as that of a buddy (Moll et al., 2009; Solomon, 2004). Some authors, both in the Netherlands and elsewhere, claim that this is the only suitable role for a peer provider (Plooy, 2007; Solomon, 2004). The following quote clearly reflects this position: ‘consumer provided services need to remain true to themselves and not to take on characteristics of traditional mental health care services’ (Solomon, 2004, p.8). According to Plooy (2007), the role of mediator entails the risk that peer providers are being used as the extended arm of the care workers. In addition, Mead and others (2001) argue that peer providers can be a counterbalance against prevailing attitudes about mental illness, providing alternative views to those held by care workers in traditional mental health care settings. This implies that peer providers should have knowledge of treatment and support methods other than the regular methods of care workers, thereby introducing ideas from the patient movement and principles of recovery.

In our project, peer providers did not restrict their role to that of a buddy. In the context of reduction of seclusion, more appeared to be needed. Prevention of seclusion required a change in attitude of care workers and an improvement in contact and relationship between care workers and patients (Voskes et al., 2013). Peer providers helped bringing this about by taking the role of mediator and coach. They fostered understanding between the patient and the professional care provider, acting as a mediator. Furthermore, they enhanced the quality of care by giving feedback and playing a more active role on the ward (co-worker).

Adopting the role of mediator, coach and co-worker can provide an opportunity to enhance recovery-thinking among professionals and to embed recovery-oriented care in traditional mental health care systems. However, this might require trade-offs and dialogue, as power has to be shared among peer providers and care workers. Peer providers should prepare themselves for such negotiations by determining their own agenda and setting priorities. Furthermore, an equal power balance is needed to ensure that peer providers voices are heard and that they can become true mediators, coaches and co-workers. More research is needed with respect to factors influencing power in partnerships between peer providers and professional care workers.

In projects such as ours, peer providers increasingly have to cooperate with professional care workers. This may give rise to ambiguities and tensions. For care workers and peer providers, the tasks and responsibilities of peer providers may be unclear. Moreover care workers may think that peer provider are too vulnerable for these different roles. A clear job description and training and education of peer providers may be helpful in this respect (Chinman et al., 2008; Gates & Akbas, 2007; Moll et al., 2009). Yet, attention should also be paid to the training and support of professional care workers about their role and responsibilities in cooperating with peer providers. Given the multiple roles of peer providers, tensions cannot be fully avoided. As tensions and role-conflict are likely to become more apparent in situations where autonomy and self-determination of patients is reduced or threatened, such as seclusion, additional efforts will be needed in order to stimulate constructive cooperation between peer providers and professional care workers. It is therefore important to foster a climate in which mutual responsibilities can be openly discussed and new ways of cooperation can be developed in processes of joint learning.

Limitations of the study

In this study peer providers and care workers were involved. Patients and their relatives were not involved. There are no data of how patients or their relatives experience the presence of a peer provider on the ward. Only the care workers and the peer providers reported what patients told them about their experiences.
Conclusions

Peer providers can play an important role in traditional health services. This study shows that the introduction of peer providers in the context of a project which aims to reduce seclusion implies new roles. Next to the traditional role of buddy, they can act as mediator and as coach and co-worker. Peer providers as well as care workers experience an improvement of the contact with patients. Peer providers can easily make contact with patient but they also play an important role in the improvement of contact between patients and care workers. This may lead to less tensions, escalations and conflicts and can thus lead to the prevention of seclusion. Moreover peer providers may foster quality of care, by giving feedback to care workers on the communication with patients or other things that are taken for granted (blind spots). Peer providers can tell how to deal with a patient in crisis from their own experience and point of view. Next to acting as a coach, peer providers can act as a care worker. They can directly contribute to the care process and improve the quality of care. The combination of roles may create ambiguities and tensions. To deal with these tensions it is important to create an open learning process in which stakeholders become aware of each other’s issues and underlying values. This requires a joint reflection and dialogue between peer providers and professional care workers with attention for vulnerability, strength and mutual dependencies.

References


