Peer support workers: an untapped resource in primary mental health care

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ABSTRACT

The treatment of moderate to severe mental illness in a primary health care setting is an area under development and can be contentious. The capacity, capability, resourcing and willingness of staff and organisations all feature in the discussions among specialist services and primary health care providers about the opportunities and barriers associated with primary mental health care. This paper presents the peer support worker as an untapped resource that has the potential to support the patient, primary health care staff, and general practitioner in the care of people who fall outside the current understanding of 'mild' mental health problems, but who would nonetheless benefit from receiving their care in a primary health care setting.

KEYWORDS: General practice; mental health; mental health services, community; primary health care

A current service gap

The treatment of mental illness in primary health care in New Zealand (NZ) has generally been limited to those with mild or moderate mental health problems, with 'limited and variable' responses across the sector.[1] However, primary health care is also an important site to consider for the recovery journey and treatment of long-term moderate to severe mental illness, through the improved integration of primary and specialist services, and targeted support for increased self-care.[2]

Mental health issues are a part of the core business of primary health care.[3] One NZ study found that approximately 36% of primary care patients had a DSM-IV diagnosable disorder, such as depression, anxiety, or a substance abuse disorder in the previous 12 months,[4] while a study from Belgium found that a threshold/subthreshold psychiatric disorder was detected in 42.5% of all adult primary care patients.[5] Furthermore, 50–70% of diagnosed mental health conditions are managed within the primary care setting.[6] Current approaches to delivering primary mental health care in NZ include e-therapy, 'talking' therapies, sharing electronic notes, telephone advice to general practitioners (GPs) by mental health specialists, increased integration of specialist care into primary health care models, and the development of roles for mental health nurses in the primary care setting.[6–8] Although primary care for people with long-term moderate to severe mental health problems is an area of priority for government and is an emerging priority at individual primary health organisations (PHOs) across the country, there is little or no peer-reviewed evidence in this area.

Problems with the practical application of mental health care in NZ primary care settings have been previously identified and discussed in the literature. Notable examples include the ongoing underutilisation of primary care services by Māori and disadvantaged New Zealanders, postulated in the MaGPIe study to be a result of NZ's patient co-payment system for access to general practice and other primary care services,[4] and the prioritisation of more tangible physical care over mental health issues, as a consequence of time and resource constraints for the primary care practitioner.[9]

The New Zealand Ministry of Health previously recognised that primary mental health care needed a different approach that incorporated longer consultations, additional follow-up contact, and the involvement of multidisciplinary teams.[10]

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However, the co-payment primary care model is perceived as a barrier to this approach for both GPs and patients.[11] GPs claim government funding according to their enrolled population, with discretionary patient co-payments, whereas no co-payments exists for service users under district health board specialist care. This has created a situation where the continuation of specialist mental health service care is incentivised for both parties.[10] O'Brien et al.[12] found that while there was an identified need for mental health initiatives in primary care, lack of upfront funding discouraged the prioritisation of these initiatives.

The capacity, capability and willingness of primary care clinicians to include mental health care in their clinical practice has also been identified as a problem in the provision of primary mental health care.[13,14] Reasons for this range from overwork and poor organisational support, little formal training, lack of experience and clinician burnout, as well as the stigma and discrimination that is often associated with mental health problems.[13,15–17] It has also been asserted that secondary mental health teams are reluctant to discharge service users to GP care.[18] These reasons, combined with resource constraints, restrict the ability of clinicians in primary care to offer mental health care to service users who have long-term moderate to severe mental illness.

Bridging the gap with peer support workers

We contend that peer support is an important recovery-focused initiative that has the potential to support the management of mental illness within primary health care in NZ. The recovery approach to mental health care identifies social inclusion, self-determination and hope as essential to the development of personal resiliency and the improved ability for self-management of many aspects of mental health.[2,19] Attending to these factors has been shown to improve engagement with service providers and treatment plans, along with reducing the incidence of unattended appointments and unexpected extended consultation times.[20]

Defined by the Mental Health Commission's Blueprint II[2] as 'services that enable wellbeing, delivered by people who themselves have experienced mental health or addiction issues, and that are based on principles of respect, shared responsibility and mutual agreement/choice', peer support services generally espouse the value of taking responsibility for one's own recovery and making meaningful life choices.[21] Existing models of peer support include support groups and drop-in centres, service user–led clinical services, and the employment of service users as providers of clinical care.[22] Peer support is also used in chronic disease management, in which it has been shown to improve outcomes in health behaviours, health status, and decreases in hospitalisation across a wide range of illnesses.[23]

Studies into the effectiveness of peer support in mental health care show improved Global Assessment of Functioning scores, community integration, quality of life, general empowerment, and a reduction in distressing symptoms and days of hospitalisation

Studies into the effectiveness of peer support in mental health care show improved Global Assessment of Functioning scores, community integration, quality of life, general empowerment,[21,24] and a reduction in distressing symptoms and days of hospitalisation.[25] Research has also demonstrated recovery benefits for the peer support providers themselves.[26] In addition, one longitudinal study from Ontario, Canada showed system-level changes in practice and policy, and a broadened perspective of mental health service users from a recovery perspective.[27]

According to Scott et al.,[28] peer support workers occupy a 'hybrid position in which they identify with the experience of mental disorder while sitting outside it as providers of services' (p.188). This unique position is thought to provide an opportunity to address risk and encourage recovery through empathy, reciprocity and collaboration, as peer support workers can better relate to and

validate service users through their shared experience.[29] Peer support workers are naturally well placed to navigate primary care services by aiding in the transition from specialist care to community living, while preventing and reducing relapses and rehospitalisation.[29,30]

Peer support participants in the study undertaken by Scott et al.[28] reported that the main barrier to the practice of peer support is securing funding that is both adequate and continuing. The participants in their study felt that peer support had a 'tentative place' (p.9) in the NZ mental health sector.[28] This was the view, even though a number of peer support services are reportedly collaborating with clinicians, including through agreements with some district health boards (DHBs) allowing entry into hospitals to aid service user transition into both discharge and post-discharge care. In order to mitigate barriers to primary mental health care (e.g. funding issues), the Mental Health Commission's Blueprint II is calling for greater flexibility in the way funding is arranged to 'easily integrate services across primary, community and specialist care, and implement a stepped care model' (p.34).[2]

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Some of the GP and nurse participants in the O'Brien et al. study[12] self-identified that they lacked the skills and knowledge required to deal with long-term mental health service users. Areas of need included screening, assessment, brief interventions and specific training in sexual abuse and domestic violence. The need for follow-up training was identified in order to integrate new skills into daily practice. Peer support has the potential to fill this perceived learning and experiential gap, by identifying situations where service users may be receiving inappropriate or no care, or when they may incur unnecessary costs. Peer support workers in collaboration with PHOs may help clinicians better recognise (and therefore treat) mental and non-mental health issues of service users.

Given the tentative nature of peer support, peer support workers are ideally located in an NGO setting where funding and clinical accountability can be managed from a non-partisan perspective. Funding mechanisms for this already exist in the community support and packages of care models. The NGO sector is also well-placed to provide support, ongoing training, and career development for peer support workers.

Current evidence suggests peer support workers may help improve clinician responsiveness to long-term service users,[31] while contributing their unique experience and empathic abilities to create empowerment, acceptance and improved self-management through service user collaboration.[29] We argue that the recovery approach utilised through peer support has considerable potential in the NZ primary care context.

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COMPETING INTERESTS
None declared.