Service users: Undervalued and underused?

Alex Hossack *and* **Gemma Wall** *ask whether we're still ignoring vital allies in our practice.*

As psychologists, many of us go through years of training and supervision in order to help others through their problems. But if you were an alcoholic, or suffering with depression, wouldn't you want to talk to someone who had actually hit those depths themselves and bounced back? This article explores how the 'paraprofessional' service user can stand by our side to promote good mental health, and asks why we aren't tapping this rich resource more.

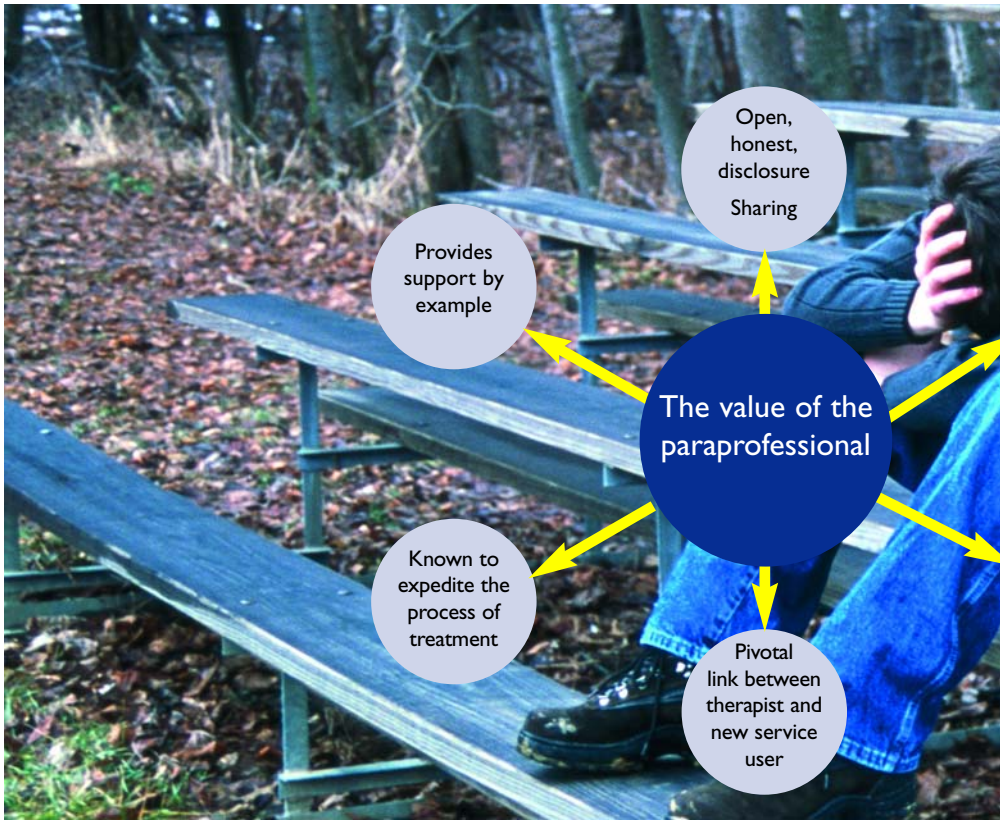
As vital as psychologists?

Voluntary support groups have been documented for many years, with Goodman and Jacobson (1994) reporting between 7.5 and 15 million people attending US support groups addressing almost every known mental health issue. Clinical psychologists in both the UK and the US have reported that the presence of a service user as a 'helper' promotes motivation, client inclusion and empowerment, and enhances the therapeutic relationship in the treatment of depression, alcohol and drug addiction, psychosis, and with sex offender treatment. Their role is growing, and government guidelines in the UK in the National Service Framework for Mental Health specify service-user involvement in mental health services. This issue is also relevant to occupational and educational psychologists: both have service users who can complement their own role.

One way of integrating service users into the treatment of mental health has been achieved by giving the role status, with the person becoming a 'paraprofessional' co-facilitator (Hossack, 1999). The service-user role is now supplemented through formal supervision and training (Hossack & Robinson, 2005); but what really makes these people a unique resource is their background: insight developed through the accumulation of knowledge and experience over many years of contact with services. The result is a growing population of service users who have come to understand and manage themselves in the mental health system (Borrill, 2000). The box opposite gives some examples of their roles in practice.

However, despite the evidence that this role has something unique to offer, involvement remains patchy, and it is not unusual to find service users involved at an elementary level, such as representation on a job interview panel. The lack of appreciation of this role limits inclusion and smacks of tokenism, a particularly contentious issue in the area of service-user involvement (Newnes, 2001). As a result, this potential resource pool remains untapped, undervalued and underused (Rose, 2001; Webb *et al*., 2000) in a health service that is understaffed and overworked.

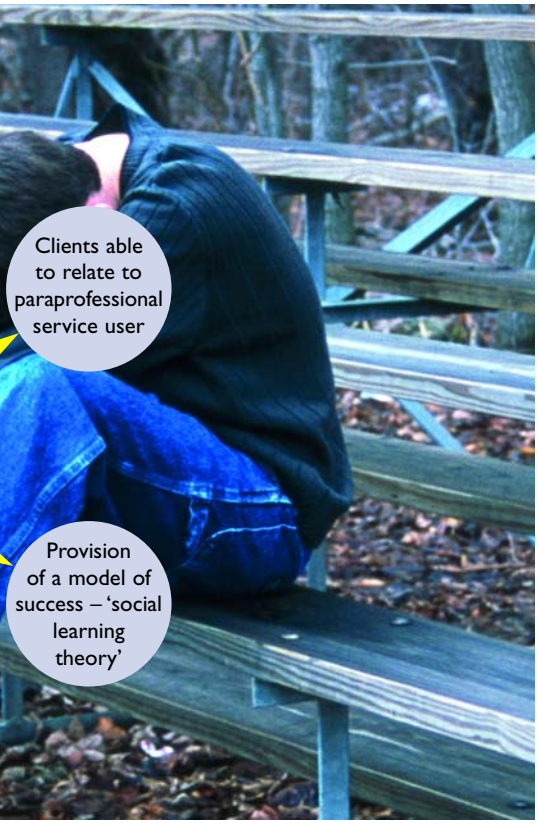
The lack of appreciation of this resource may in part be due to the confusion over the term *service user*, with people often categorised under other titles such as *support worker* or *volunteer*. It was Gartner (1971) who first identified the paraprofessional role as having its origin in three areas, beginning with the 'old' type of 'paraprofessional' such as the hospital worker or the psychiatric aide. Second, the educated middle-class individual, often



women, employed in a voluntary capacity. Third, and currently a more commonly used definition in the treatment of mental health, is the indigenous paraprofessional, the individual who would now fit the definition of service user recruited from target populations – the former alcoholic, drug addict or sex offender.

The effectiveness of the paraprofessional in mental health intervention has long been demonstrated (Karlsruther, 1976; Schortinghuis & Frohman 1974). Although many service users lack formal training, studies have concluded that the paraprofessional service user and the professional are equally effective in therapeutic terms, with some even questioning the necessity of high-cost training (Atkins & Christensen, 2001). Christensen and Jacobson's (1994) review concluded that it would be more beneficial to focus on the circumstance where the paraprofessional was preferable to the professional.

Although the literature clearly identifies the benefits of this role, it is still generally assumed that effective therapeutic intervention can only occur from years of supervised practice and academic study. But perhaps the research suggests that it's time for all mental health disciplines to reflect upon their own remit in terms of the benefit of this underused resource.



How does it work?

Support for the paraprofessional role was provided by Gartner (1979) who concluded that 'the single most common denominator is…the role of the person who has already lived the experience is crucial to helping others' (p.119). This was highlighted in a later study by Abdul-Quader (1992), who described the successful employment of ex–drug users in New York City as ex–service users/paraprofessionals. He concluded that important recruitment factors that assisted the drug user to relate to the paraprofessional were a similar past history of drug use, knowing the environment, an ability to communicate in the same language and style of speech, and an ability to build a trusting relationship. The paraprofessional worker was also able to provide a model of success for the drug user attending for help.

This idea of modelling is of course an established psychological principle in explaining learned behaviour. Lee (1986) concluded that modelling was most successful when the models themselves received consequences (rewards) that were reinforcing to them. And of course, people can help themselves by helping others: recovering alcoholics can maintain abstinence by assisting other alcoholics. If paraprofessionals are perceived as having a high prestige they are more likely to be revered (Wilson & O'Leary, 1980), with consequent effects on status, self-esteem and quality of life. This could clearly further fuel their prestige, making them still more effective paraprofessionals.

The new role has been observed in sex offenders to improve confidence, self-esteem and, possibly for the first time, approval of their honest and open presentation (Hossack & Robinson, 2005), in essence actualising what Ward and Brown (2003) felt necessary for successful treatment – the development of 'good lives'. Having achieved this, the now prestigious service user cum paraprofessional role is cherished and the fear of losing it is stated to be a factor in reducing relapse.

The importance of training remains

Although life experience is clearly important, that does not mean there isn't a role for the professionals in helping the paraprofessional to add to their skills.

THE PARAPROFESSIONAL IN PRACTICE

The service user cum paraprofessional role in therapeutic situations can take many forms: support worker, advocate, co-facilitator or adviser, mentor, or just as a 'model of positive change'. Consider the following examples:

- Sadalva (1982) discusses the recovered alcoholic acting in the role of a paraprofessional working with alcoholics and self-help groups such as Alcoholics Anonymous (AA). In the UK, AA service users who have been alcohol-free for over one year staff the helpline, respond to e-mails and accompany clients to their first meeting.
- The Hearing Voices Network in the UK (*www.hearing-voices.org*) provides an alternative to the medical model approach. Set up by professionals who also have the experience of hearing voices, support is offered in the form of understanding the meaning of the voices, destigmatising the experience and raising awareness of it as valid.
- The Paraprofessional Healthcare Institute in the US (*www.paraprofessional.org*) uses certified addiction counsellors who diagnose addiction and identify appropriate treatment. A key component of the programme is the use of paraprofessional peer counsellors who are themselves recovering addicts who have been drug- and alcohol-free for at least two years. Through outreach in the community, they engage, motivate and physically bring clients to treatment and provide support during the programme.
- Smith *et al.* (1974) completed a survey of 50 American state correctional agencies, the District of Columbia Department of Corrections and the Federal Bureau of Prisons and discovered that 38 agencies employed 280 ex-offenders. The largest single employment category was maintenance and service, the second was counselling (21.3 per cent). The most frequently stated strength of the offender/counsellor was their familiarity and rapport with inmates and the criminal justice system and their resultant ability to communicate more effectively with inmates than their non-offender counterparts.
- Here at the Mersey Forensic Psychology Service treated offenders/service users engage in the role of paraprofessionals co-facilitating group treatment programmes. They bridge the divide between the offender and therapist in the early stages of contact, commonly an anxiety-provoking time (Hossack, 1999, Hossack & Robinson, 2005). Acting as a non-collusive advocate, they support clients new to treatment, and on request are available for initial interviews, to co-facilitate group therapies and to speak to the media about the benefits of treatment. Since its inception in 1993 the outcomes have been positive, and the role itself deemed effective in terms of social learning theory providing a 'model' of success.

Weisz *et al*. (1987) concluded that the most important factors related to the paraprofessional as a practitioner were selection, training and supervision in methods developed by professionals. The conclusions drawn from the study strongly indicate that the unsupervised paraprofessional, without strategic direction and performance management, is unlikely to achieve the same effective outcomes. The breadth of professional training develops an academic frame and a theoretical background that enhances the ability to strategically develop, monitor and objectively provide direction, supervision and individual performance management, thus enabling the skill base of the paraprofessional. This principle applies to all paraprofessional settings.

In the Mersey Forensic Psychology Service in Liverpool, the paraprofessional follows this pathway:

- Enters treatment.
- Monitored for consistent and sensitive interactions with peers.
- Insight/self-awareness noted; considered as a service-user paraprofessional.
- Formal training given in-house, plus Level 1 counselling.
- Interventions supervised.

Additional training for the paraprofessional can raise awareness of professional issues as well as self-awareness, which may be limited in those recruited from an indigenous population. Self-awareness informs attitudes and behaviours and can help the person spot when they are interacting inappropriately, for example through overactive advocacy. With this in mind, supervised practice protects both the paraprofessional service user and the new service user.

Although professional monitoring through supervision may be a resource issue, the unique benefits of this role continue to be demonstrated in our day-to-day experience. Over the last 10 years, programmes at Mersey Forensic Psychology Service have demonstrated a maximisation of this resource on a very meaningful level in group and individual work, family interventions, interviews and representation to the media regarding their role. Thus, a unique aspect of service delivery in practice is established whilst the possibility of tokenism (which would patronise the service they have to offer) is eliminated.

Cost-effective and unique

The cost of medical and mental health care is always a topic for professional debate, and the issues of training vs. competence are germane in the field of mental health. However there is a substantial amount of growing evidence to indicate that the paraprofessional/service-user role is a cost-effective and productive addition to a range of mental health treatments. These findings challenge the assumption that substantial training and experience are prerequisites to successful treatment. The evidence now supports the proposal that the indigenous paraprofessional, adequately monitored, can provide a unique therapeutic dynamic, separate from that of the qualified clinician, that enhances and expedites the therapeutic process.

The conclusion to be drawn from this discussion is that in certain therapeutic endeavours, neither the paraprofessional nor the professional fares better, but it is the individual competencies and eventual effectiveness that can benefit the client. While the service user develops confidence and self-approval from their paraprofessional role, the professional is provided with a low-cost, effective co-facilitator who brings a unique therapeutic dynamic to treatment.

Future research could review in which areas of service provision paraprofessional intervention tends to be more frequent and successful. Aitkens and Christensen (2001, p.129) debate these issues and conclude: '…the question of therapeutic training is not just a practical issue. It also cast light on crucial theoretical questions about the mechanisms of change in therapy.' We believe that the answer lies in social learning theory; that is, the process of modelling, whereby motivation and hope are provided by the presence of the successfully treated and insightful service user in the role of a paraprofessional practitioner.

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