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**Knowledge and expertise in care practices:
The role of the peer worker in mental health teams**

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Experiential Knowledge and the Peer Worker Role: New Ways of Enacting Mental Health Care

ABSTRACT

Our research contributes an understanding of how different forms of knowledge and expertise are important in caring for people experiencing mental illness. We build on the theoretical developments regarding the multiple ontologies of knowing about illness, and how one can know illness as an object or a subject. We examine how knowledge of mental health problems, learned by being subject to illness rather than through objective study, is enacted in mental health care. Our case study examines how Peer Support Workers (PSW), individuals who have lived experience of mental health problems, contribute knowledge and expertise to mental health care by working within multidisciplinary healthcare teams. We interviewed 91 PSW and other stakeholders to peer support. We find the knowledge and expertise in practices of caring for people with mental health problems do not draw on a singular reality of mental illness, but rather multiple ontologies of knowing about mental and physical health. We suggest that this subjective knowing and expertise - experiential knowledge - is temporally embedded into lived experiences, in contrast to objective, decontextualized ways of knowing. Our findings suggest that experiential knowledge supports care practices around managing risk, ways of coping and the reshaping of relationships. (198 words)

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Experiential Knowledge and the Peer Worker Role: New Ways of Enacting Mental Health Care

Knowledge is central to modern healthcare delivery (Freidson 1972; Timmermans and Berg 2003; Oborn and Dawson 2010). The standard for medical knowledge and expertise has been defined in relation to professionally based knowledge, and the medical profession holds strong jurisdictional control over the content of knowledge as well as the definition of what counts as fact and expertise (Freidson 1972, 2001; McDonald 1995; Mol 2002). Foucault (1972) traces the modern organisation of medical knowledge through the 'medical gaze' in late 18th century medical clinics. He argues that through the careful study of patients' (live or dead) bodies, including their tissues, symptoms and behaviours, medical knowledge regarding patients' illnesses has developed and expanded. This simultaneously led to the medical separation of the patient's body and the patient as a person (Foucault 1973; Sullivan 1986). As highlighted by Mol and Law (2004) this form of medical knowledge is an objective, public and scientific way of knowing the body from the outside, as an object; the knower and the known are separate entities. This understanding of medical expertise underpins modern healthcare delivery, is epitomised through the gold standard of evidence based medicine and controlled clinical trials (Timmermans and Berg 2003), and is rarely questioned by professionals, wider state health regulators or the public at large (e.g. NICE 2016 website).

However, knowledge can also be developed as a subject. Thus one can learn about dyspnoea, depression or diabetes by living through, or with, the condition. Mol and Law (2004) argue that this ontology of knowing as a subject leads to a private and personal way of knowing about the body or illness from the inside. They point out that the critical task is not to arbitrate which way of knowing is better, but to point out the multiple realities by which knowledge about the body (and mind) might be posed. We build on these insights from Mol

(2002) and colleagues (Mol and Law 2004) regarding the multiple ontologies of knowing about illness; one can know illness as an object or a subject. Further we show that subjective knowing can arise from a different language and socialisation process that underpins meaning. In so doing, we also account for the important social processes that shape (mental) illness experiences, such as social isolation, fear and alienation. We examine how different forms of knowledge and expertise are important in developing the varied roles entailed in multidisciplinary teams caring for people with mental health problems. To do so, we build on Collins and Evan's (2007) understanding of specialist tacit knowledge to show how subjective forms of expertise differ from objective expertise and contribute novel insight into the varied nature of expertise. We also contribute insights into the organisational challenges of developing roles based on subjective expertise when integrating these multiple forms of knowing and expertise into multidisciplinary healthcare teams.

Literature Review

Concepts of expertise and competence in making knowledge claims have traditionally been defined through professional institutions (Abbott 1988; Freidson 1972). As such, knowledge is associated with strong theoretical underpinning and extensive periods of study and learning in professionally controlled environments (Friedson 1972; Abbott 1981), and provides an underpinning for the roles that organisational members take on in a wider healthcare team (Gittell and Douglass 2012).

As outlined by Collins and Evans (2007), expertise is also underpinned by specialist tacit knowledge. Tacit knowledge is socially derived, and learnt in a way that cannot be explicated (Tsoukas 2003; Polanyi 1967). Being expert and knowing 'what you are talking about' implies successful embedding within the relevant social group so that members interact with each other and gain 'interactional expertise' (Collins and Evans 2007). Expertise is also acknowledged to be associated with practical activity, such as practicing to be a midwife or

operating on patients as a surgeon (Lave and Wenger 1991; Hutchins 1995; Sennett 2008). These forms of knowing and gaining expertise arise from learning about, and engaging with an object of study whilst being temporally and physically immersed in the specialist culture of the practice in question (Lave and Wenger 1991, Emirbayer and Mische 1998). Thus healthcare professionals working in Emergency Departments in the UK have been shown to use both their experiential, tacit knowledge (about 'types' of cases) and technical knowledge (biometrics) when making rapid decisions during resuscitation procedures (Brumell et al 2016), while clinicians making care decisions in a neuro-rehabilitation team in the UK were shown to complement the codified knowledge offered by routine use of standardised clinical measurement tools with their intuitive, experience-based (tacit) knowledge of patients (Greenhalgh et al 2008).

It is also argued that tacit knowledge (about health and healthcare) is derived from aspects of selfhood beyond those derived from experience of clinical practice (Kontos & Naglie 2009). An increasingly important, yet competing, discourse in healthcare delivery is knowledge and perspective of the person as a patient or consumer of care (Mockford et al 2012; Staley 2009; Komporozos-Athanasiou et al 2011; Gauvin et al 2010). This form of knowing emanates from experiences of illness or of using healthcare services (Mazandurani et al 2013). As suggested by Mol and Law (2004 pp3) 'in being a living body we experience pain, hunger or agony as well as satisfaction, ecstasy or pleasure. And while the object-body is exposed and publicly displayed, the subject-body is private and beyond, or before, language.' For example, Mol and Law (2004) analyse how diabetic individuals can learn to manage the delicate balancing of blood glucose and insulin levels by learning to feel when a 'hypo' is coming on. As they suggest, in the daily lives of people with diabetes, 'hypoglycaemia is something they know about, [though] the point of their dealings with it is not to gather knowledge but to intervene' in their own illness management.

Thus, a recent shift in thinking about valid and relevant knowledge in medical services is to give more credence and acknowledgement that non-traditional forms of knowledge can be productively used. For example, in drawing on lived experience, a form of subjective knowing can be brought to bear on patient management. The current emphasis (e.g. in the UK) on patient feedback and patient centred care (Staley 2009) seeks to incorporate the perspectives of such subjective knowledge more formally into health service delivery and into the treatment processes. This has led to considerable effort to encourage self-care and management of one's own chronic disease (Corrigan 2006; Gillard et al 2013), though these forms of knowledge often work in tension with more formal objective knowledge of one's illness as held by trained professionals (Martin 2008; Davies et al 2014). For example, online patient forums have been shown to be sites of exchange of tacit knowledge about how to navigate the healthcare system, rather than a sharing of 'facts' about health and illness (Foster 2016), while the challenges faced by patients and practitioners in identifying goals as part of chronic illness self-management programmes has been attributed, in part, to tensions between tacit (lay) and professional knowledge (Williams et al 2011).

However, subjective knowledge about illness might also be used in treating or supporting the care of others; instead of remaining primarily as private knowledge, it might become a contributory expertise (Collins and Evans 2007) in that this subjective knowledge can enable new understanding about mental health problems, adding to current expertise. Quinlan (2009) describes a process whereby, through articulation in the public sphere, tacit knowledge becomes mobilised as 'new' knowledge in the context of clinical decision-making in multi-disciplinary healthcare teams. In developing what has been termed a 'periodic table of expertise' Collins and Evans (2007) highlight that having tacit knowledge in a particular subject area (such as mental illness) enables individuals to interact with others having similar expertise and possibly contribute new ideas to the evolving knowledge base. This however is

a fundamental challenge to current notions of (formal) expertise in healthcare, as well as raising the question of how this private knowledge might be made more publically available.

In this paper, we examine how Peer Support Workers (PSW) – consumer-providers; individuals who have lived experience of mental illness – contribute their expertise to mental health care by formally working within multidisciplinary healthcare teams, or by contributing to wider care and support. The research question we ask is ‘what forms of knowledge and expertise do PSW develop and how do they contribute to the care of people experiencing mental illness?’ We show how, in the treatment of people with mental health problems, self-awareness (as opposed to awareness through observation, or the Foucauldian ‘*gaze*’) need not be silenced, but can be used as a resource, and extended where this is possible into wider (and public) care practices.

We distinguish PSW from psychiatrists, nurses and psychologists, who know about mental illness as an object, and where knowledge related to self-interpretation or self-awareness is eliminated from the treatment and care practices in a formal sense. In a different manner, PSW, with lived experience of mental health problems, know about it as a subject. By drawing on knowledge derived from experiencing mental health problems and the processes of receiving psychiatric treatment, PSW develop knowledge and expertise that is integrated with self-awareness, rather than being formal and objectified; that is, experiential knowledge. For example, their knowledge of depression (or hearing voices etc.) is gained from living with mental illness; from knowing how mental health problems impact on key relationships, how others perceive you, the opportunities you have etc.. ‘Doing’ depression, including emotions of fear, anxiety, hopelessness, leads to a different knowledge, and in our case, brings a new form of expertise that can be made available to the healthcare team and the people they care for.

Methods

Case Context

The provision of peer support as a component of mental health care, including the employment of PSW by mental health service organisations, is increasingly common internationally (Gillard et al 2013). The evidence base for the impact of mental health services employing PSW is growing. Reducing admission to inpatient psychiatric care is the most frequently reported outcome – with some claims made for associated reduction in service cost – largely evaluated through observational (Lawn et al 2008), comparison group (Min et al 2007) and cross sectional (Landers & Zhou 2001) study design. More recently trials of peer support have indicated improvements in patient activation (Chinaman et al 2015) and empowerment (Mahlke et al 2017) compared to treatment as usual (mental health service delivery teams without PSW). Qualitatively, hope and strength of social networks have been indicated as important outcomes for people in receipt of support from PSW (Ochocka et al 2006).

PSW in this study refers to people employed to intentionally make use of their personal experiences of mental health problems in the delivery of care. The study took place in ten contrasting cases comprising Mental Health National Health Service (NHS) Trusts (governmental mental health service providers), voluntary sector (not-for-profit) service providers and partnerships between the NHS and voluntary sector providers. PSW were employed in a variety of roles, paid and unpaid, in psychiatric inpatient settings, community mental health services and Black and Minority Ethnic (BME) specific services. In all cases PSW based their knowledge, skill and practice on the lived experiences that they had acquired to therapeutically support or care for others. Cases included services where the employment of PSW was well established and cases where PSW roles had only recently been introduced. As indicated above, some of our cases took place away from formal health services. People receiving support from PSW were in no sense ‘patients’; indeed the

appropriateness of the term ‘patient’ in the context of mental health services is much debated (Christmas & Sweeney 2016). We use the expression ‘supported person(s)’ below to designate individuals receiving support from PSW, both in our study and more generally.

Data collection

Structured and semi structured interviews were conducted with 91 people involved in services employing PSW, recruited purposively in approximately equal proportion from the following stakeholder groups: supported persons (18); PSW (22); (non-peer) co-workers (17); line managers (14); strategic managers and commissioners (responsible for paying for the services; 20). Interviews were digitally recorded and transcribed verbatim.

The research was undertaken by a multidisciplinary research team, which included qualitative health services and management researchers, medically trained professionals, PSW and managers of peer-led services, and service user researchers (i.e. researchers using their experiential knowledge of living with mental distress alongside their research expertise). The whole team coproduced the interview schedules, informed by the emerging literature on peer support in mental health services, and interviews were undertaken by the service user researchers.

Data analysis

Data were initially analysed by service user researchers using a complementary thematic and framework approach to produce a set of analytical categories. This was an iterative process in which the wider research team was involved in shaping the framework as new data were collected and analysed. NVivo qualitative software was used to compare data between organisational contexts, service delivery settings and stakeholder groups (Authors, 2014). Theoretical memos were then developed around the conceptual themes of knowledge and expertise, sensitised and informed by the literature (Golden-Biddle and Locke 2008). These

theoretical memos were developed in two directions. First, narratives and themes were developed around the specific ways that subjective knowledge could contribute to the care of people experiencing mental health problems and how this form of knowledge differed from established, formal medical knowledge. Second, narratives and themes were developed around the challenges of integrating subjective knowledge in the health organisation.

Ethical approval for the study, including the recruitment and informed consent process, was given by the London – London Bridge National Research Ethics Service Committee, reference 11/LO/0703.

Results

We explore three ways that knowledge learned from lived experience enacts unique practices of caring in mental health services, as outlined in Table 1 below, articulating the role that peer workers play in: establishing trust and rapport with the supported person; understanding and interpreting the supported person’s mental distress; bringing insight into the processes of treatment and care.

Table 1. Findings related to how PSW develop and undertake care practices

Care Practices	Forms of Knowledge
Establishing trust and rapport with the supported person	<ul style="list-style-type: none"> • Shared experiential knowledge as a point of connection between peer worker and supported person • Enabling the supported person to be open with their experiential knowledge
Understanding the supported person’s mental distress	<ul style="list-style-type: none"> • Peer worker understandings of mental health as differential knowledge (complementing healthcare professionals’ knowledge) • Embodiment of experiential knowledge in the peer worker role • Validation of the supported person’s experiential knowledge
Bringing insight into the processes of treatment and care	<ul style="list-style-type: none"> • Peer worker’s experiential knowledge of using services • Liminal knowledge bridging the space between supported person and healthcare professionals

Establishing trust and rapport with the supported person

A recognition that peer workers bring knowledge of mental health grounded in their own experiences (of mental ill health) was identified as both a point of connection and a source of trust in the peer worker for people receiving peer support.

... the most important thing is the awareness about yourself and the insight you have ... I know probably they have some mental health knowledge before, their own mental health issues I guess, and things. But I feel comfortable because I know they know about mental health. You know, they're not scared of anything or be upset by anything I say... (Supported person)

I also think people know that we understand their experience ... because we've had our own experiences of crisis. So people trust our empathy and trust that we get what they're talking about. (Manager of peer-led services)

That sense of connection – around an experiential knowledge of mental health – seemed to apply even where there were other differences between people.

I just think people's, like, relief. Like they seem relieved that someone can understand what they're going through, in a sense. I think it's just a lot of comfort. It brings a lot of comfort to them even though I'm so much younger than some of the older people on the ward. (peer worker)

As such peer workers were able to establish trust with the people they supported more easily than most formally trained staff involved in their care. Data suggest that peer workers' experiential knowledge gives them access to some kind of shared space, or 'domain' with the people they are supporting, while the understandings of mental health that healthcare staff might voice, grounded in their professionally acquired knowledge, might prevent them from entering that space.

... [people] say, 'I couldn't speak to my nurse because they just didn't really get it, they didn't really understand me.' ... And it was really useful because the [peer worker] was sat in the lounge and we just started chatting about, 'Did you see [TV show] last night?' And we ended up talking about, whatever, hearing voices or... but in a different way. (Supported person)

The benefits for the patients are that it's somebody that I think they have felt – this is from feedback – they've felt less threatened by because a nurse, you know, wearing a nurse badge and asking questions, sitting chatting, you know, they perhaps find it a bit probing. And sometimes, dependent on their illness, their diagnosis, they can feel

a bit suspicious of us. But peer support workers introduce themselves as just being that, a peer support worker. They're here just to support, give advice, they introduce themselves by using, um, oh, their skills like music or arts and crafts and they kind of enter the patient's domain... Enter the patient's domain, kind of – well, 'lightly' is not the word – but less threatening. (manager)

Being able or trusted to enter that shared space seemed to engender an openness with the peer worker that could have potential therapeutic value to the individual:

A couple of them seemed really surprised when I said about it and she was like, 'Really, you've had mental health problems?' And I was like, 'Yeah, and I'm currently on medication and stuff.' And she was like, 'Really?' And she was like, almost like surprised but kind of like in her face you could see she was quite relieved as well, that she could talk to someone, I guess, that was feeling something similar to what she was feeling. (peer worker)

Peer workers noted how that privileged access resulted in the people they supported being more open with them than they might be with healthcare professionals:

Some of the patients who don't know me they'll say, 'Are you the doctor?' And I say, 'No, I'm not the doctor.... I'm a [peer worker]' and, and they're 'Oh, are you?' And they want to talk because if I was a doctor they'd probably just clam up. (peer worker)

I was sitting with a [supported person] in one of my rooms and we were having a discussion and then her care coordinator walked in and she just completely shut down ... and then when the care coordinator left she had become kind of another different person ... She was very open with me, very comfortable ... I've kind of seen that now with a lot of my clients ... (peer worker)

One member of professional staff identified the therapeutic value being in shared understanding around positive aspects of recovery rather than negative experience.

I was talking to somebody who has bipolar that is a peer support worker who said they found that really, really beneficial to reach someone on an Acute Admissions Ward, [being able to say] "Actually, when I was really high I remember those similar feelings"... there is some boundary sharing which comes around recovery and not so much about, 'This is what happened to me.' (Staff)

Importantly, a manager felt that the peer worker enabled people to open up about issues of risk that they might not always share with clinical staff:

...staff can sometimes struggle particularly around engaging [people] in their own risk assessment and management. There's almost this kind of mystique that exists... something that only very experienced, qualified clinicians can do because it's some magic art... and then we wonder why we have the incidents that we have... So there's

almost something about peers kind of being able to challenge that and be able to have, perhaps, more open and transparent conversations with [people] around them owning their own risks... Because actually, probably if you've got to the point of being a peer support worker, probably somewhere down there you've had to navigate your way through some risks? (Senior Manager)

Understanding the supported person's mental distress

One of the key challenges in mental health care lies in measuring and assessing symptoms in an objective and reliable way (for example, through a blood test). A large proportion of medical knowledge about mental illness is derived from observing and assessing behaviour. However, interpreting the meaning and implications associated with someone's behaviour is far from straightforward. As suggested in the following quotes, healthcare staff and peer workers often interpreted the supported person's responses to treatment differently.

Because sometimes you need the experience to understand why it is – other people don't know – people who haven't been in treatment, don't have personality disorder, they always seem to interpret this stuff differently (PSW Manager)

They [peer worker] will deliver a group or a one-to-one session in a very different way than we do. So they will, you know, in a sense I've seen, one individual in action and she doesn't skirt round the issues. She goes straight in there [on a topic] which we would really tread carefully about. (Staff)

I think they understand more because they've been through it ... than, like the [psychiatric nurse] are professionals ... they're more distant ... they're doing it on a very professional level. Whereas a peer support worker can relate to what you're going through more because they've been through it ... I think it's important for people to understand what you're going through. And I think peer support are brilliant at that. (supported person)

Importantly, in terms of contributing to an individual's care, PSW's knowledge could thus at times indicate an area of pending challenge for the supported person, based on their experience of having 'been there' and reading the situation from an insider point of view.

I think a lot of it is just understanding because sometimes it's spotting the danger signs. Sometimes it's just being aware of what might be difficult. I mean, everyone has such different triggers, but there are certain topics that you can go, well, you

know, which someone who hasn't had that experience might not realise because it's not always the obvious ones. So sometimes it's a little bit pre-emptive. (Peer Worker)

This knowledge comes through having lived with the feelings associated with a mental illness.

...it's anticipating– so if you say, 'Right, okay, if having this condition X, most people are going to feel anxious about, you know, items one, two and three' then it's important, that to understand and really know what those items are, to have lived through those items yourself... So the peer workers come from a position of understanding what those things feel like ... it's not guess work, it's actually based on reality... (PSW manager)

In this sense, knowledge about mental health that is used to support an individual's therapeutic recovery goes beyond knowledge of objective information about illness to using an understanding grounded in experience – in the peer worker's reality – to interpret meaning and gain insight into the experiential challenge of mental illness. This embodiment of tacit health knowledge, noted in the literature above, was also understood by peer workers:

I am my work. Obviously I am my work in a way ... I don't know if that makes sense, do you know what I mean? It's like I am using myself and my experience and that is my work, it's part of my work and I'm lucky enough to be paid for it. (Manager of peer-led service)

As such, enacting the self was as important an expression of experiential knowledge as verbally imparting it:

... for me, it feels like it's about being human and I don't feel I need to be saying, 'I've had mental health problems, it was tough for a while.' (Peer Worker)

Having said that, one peer worker did not immediately recognise the validity of knowledge grounded in their own lived experience:

I'd had a bit of a journey myself in terms of not valuing my own journey, my own experiences ... I've had the difficulties over more than a ten-year period, but I didn't value that ... but, I suppose being selected for this [peer worker role], and then, you know, the training, helped me to acknowledge that. (Peer Worker)

Ultimately, the embodiment of experiential knowledge in the peer worker role had a therapeutic, role modelling effect for people receiving peer support.

... it's also about being a positive role model. So, 'I've been through the service. I'm here. I'm recovered. I'm a peer support worker. You're not going to be ill ... for the

rest of your life. It comes in peaks and troughs.' ...This is a small part of your life. It feels like, you know, you're at your lowest ebb at the moment but seeing somebody who's been through it can be positive. (Manager)

As such peer workers offered a 'living proof' that hope in the future was grounded in a lived reality, rather than being empty words offered by someone who did not share those experiences.

...I think it's to know that you can have life beyond this ... I think it's very inspiring and useful and perhaps critical ... thing to have contact with people who've sort of moved to the next step. (Supported person)

If you're depressed you don't see any other light. You don't see the other side. But if you meet somebody who tells you, 'Oh, I've been through depression, it gets easier. You just have to hang on through it.' And if you realise that person is telling you the truth and you can see that because they're saying things that you've felt then you can resonate with that and it does give you some hope. (Supported person)

Perhaps just as importantly, peer workers had lived experience of the wider associated stigmas and social challenges of mental illness, such as living on a psychiatric ward for extended periods of time or being unemployed. Knowing how to cope with stigma, understanding the alienating feelings related to stigma was an important aspect to knowing about mental illness grounded in lived experience.

We've all got our own different experiences of mental health problems and how we cope with our problems. How we come off the ward, how we get back into the community. We've all got a different way to how we cope to getting back into the community. But from you being on the ward for a whole year, for a whole year out of your life – ... I think it allows for people to be much more honest. Your cards are on the table. (peer worker)

All the stigmatisation and discrimination, the pain that that labels bring on to that one person, I could never understand that breadth of it. (staff)

There was also an understanding that people receiving peer support had their own experiential knowledge of their mental health validated through the way the peer worker embodies their own experiential knowledge.

[Supported persons] feel more understood, a great sense of validation, it's less directive, that there's a real value to feeling that the person you're talking to actually has a lived experience of what you're experiencing.....There's a greater sense of acceptance. (Staff)

From a care perspective, an important aspect of recovery is acknowledging the challenging feelings and mental states that are associated with mental illness. This goes beyond identifying and treating feelings as symptoms, but rather acknowledging their reality. This validation of experiential knowledge could be used by peer workers to encourage the people they were supporting to actively engage with their own feelings.

You sit with feelings and somebody else, like, acknowledges them, like, to me that's the most powerful thing, like being with a feeling and not trying to hide it. To me, that's where the problems start, if you squash them down or try and ignore them or try and get on with it, put on a brave face ... (peer worker)

Bringing insight into the processes of treatment and care

We noted in the literature review how healthcare professionals complement their formal, training-based knowledge with tacit knowledge of healthcare practice, acquired through lived experience of enacting care. Our data indicate how peer workers also bring a tacit, or experiential knowledge of mental healthcare practice to the teams they work in or alongside. However this tacit knowledge is not acquired through experience of delivering care but through receiving care and as such is distinct from the tacit knowledge brought by healthcare professionals.

I think it's just the lived experience aspect, like, especially when, like, you've had experience of mental health services, whether in hospital or in the community, just knowing what it feels like to take medication ... (peer worker)

... it was just great, suddenly there was this person that really understood me. I wanted to have a discussion about my medication in preparation for my discharge with someone that's honest, that might have experienced it from my point of view. (Supported person)

Conversely, peer workers who lacked experiential knowledge of using mental health services could be at a disadvantage in the role:

So I guess the knowledge [of receiving care] is quite important ... most of the cohort had all been part of the services but one lady particularly struggled because her admissions had been a lot of years ago, sort of the old-school services, so to speak, and since then her contact's only ever been with her psychiatrist. So when we started

talking about a lot of the language around the services she was totally out of the loop. So we had to do a lot of education through the training ... (manager)

Just taking on the label of having a diagnosis in itself comes with a challenging set of feelings, regardless of how the mental illness itself might affect the individual. A repeatedly important aspect of enabling someone to acknowledge where they are in their illness journey is to understand where they are at emotionally in relation to their diagnosis.

You know, the minute you're labelled as [personality disorder] you're seen as on a professional basis as untreatable, on a personal level people think that you're crazy or that you make things up or that you're not to be trusted. I mean, there's so much just having that [personality disorder] label. (PSW)

Thus the knowledge that a PSW brings to the supported person's care process goes beyond insight into the illness itself, but also knowledge about the stigma, misunderstanding and disempowerment associated with being treated for mental illness and being cared for in a formal organisational context.

In addition, becoming part of the formal care system often implies strict control over the person's behaviour. In the following quote, for example being 'sectioned', which means that the person is deemed to not be able to make their own choices and thus care is placed in the hands of the state or formal care system, implies the added challenge of dealing with the loss of personal autonomy and corollary emotions. Peer workers who have experienced being sectioned or administered mood altering medication against their will have unique insight into the emotions that the supported person is experiencing.

... to be Sectioned, to, you know, sit in a meeting with a panel who are all deciding how you're going to be treated, effectively. You know, just understanding some of the emotional levels that you go through as you journey through the mental health system. (peer worker)

Thus the professional healthcare worker would have knowledge regarding when a 'Section' might be most appropriate in managing risk; yet they have much less subjective knowledge of the actual challenge to one's personal autonomy when forced into care.

As such staff, and particularly managers, spoke about the role peer workers play, using that distinctive knowledge base, bridging between the person receiving care and the healthcare professionals on the team:

... the peer support worker sits right between professional and the service user ... because of their lived experience and because where they sit within the team they see things from a different perspective... And sometimes you get conflict from, say ... how [the peer worker] sees the professional's dialogue with the service user ... and [the peer worker will] pick up on things that you wouldn't generally, as a professional, pick up on. (manager)

This bridging role was valued by clinical teams, and attributed to the insight peer workers have gained through experiencing care:

I think it's because they have a different perspective of working in that environment, they are able to inform staff about any particular issues they may have found and also relay any information that service users have, or any experiences that they have, negative ones or positive, that are impacting because of the environment or because of how, you know, staff were interacting. And it's only when you've gone through that, in this environment, that you kind of understand what the issues are. (manager)

In some cases the peer worker's approach could be a challenge to the predominant approach to formal care, one which is diagnosis focused and based on more objective forms of mental illness knowledge.

[Our PSW led service] came out of a deep dissatisfaction with [existing] services. That's why we exist. Because what is on offer is a medical approach to mental distress, a diagnostic approach, a medication-based approach, which people have found really unsatisfactory. And so our service was explicitly set up to provide something that was an alternative. (Manager of peer-led service)

Discussion

Our paper draws on conceptualizations for re-thinking expertise (Collins and Evans 2007) and subjective knowing, and develops an understanding of how experiential knowledge and expertise of mental illness, learned as a subject through lived experience, shapes the emerging role of PSW in providing care to people with mental health problems. We make three contributions to the literature.

First, we argue that subjective knowing about mental illness through lived experience is a unique form of expertise, one that is qualitatively different from, and can work in concert with, the knowledge held by formally trained mental health professionals. Collins and Evans (2007:27) highlight that tacit knowledge is developed through acquiring a social understanding as one is 'socialised into relevant group practices'. One key difference in subjective and objective forms of mental illness expertise stems from the very different socialisation processes and locations of practice in acquiring the tacit knowledge. While medical experts learn their knowledge through the social conventions of medicine and the medical 'gaze' of observing the mentally ill, subjective expertise is socialised through personally experiencing the illness, including relatives' reactions to the illness, hospital treatment processes and ones' own self-evaluation of the illness experience.

Since subjective knowledge is learned through living with the illness and engaging in a social sphere where others in society (eg family, work colleagues, hospitals) are reacting to the illness, the language of socialisation by which knowledge is gained concerning mental illness is entirely different. Scholars have pointed out that language is crucial for the development of expertise as it enables individuals to apprehend non propositional knowledge (Polanyi 1967; Tsoukas 2005). Collins and Evans (2007), in particular, point out that there are two forms of expert knowledge, one which they term 'interactional expertise' and another 'contributory expertise'. Whilst fully developed contributory experts are able to add new knowledge to the practice of experts, the slightly 'lower form' (in Collins and Evans terminology) of interactional expertise enables individuals to discuss and converse on a topic in a way that enables mutually understood, shared tacit knowledge, even if the interactional expert is not able to fully practice and build on the knowledge base. Thus in our context, informed interaction and knowledge sharing with other trained mental illness specialists (i.e. the wider healthcare team) is in large part dependent on linguistic skill (Collins and Evans 2007). Yet,

PSW (generally) lack *formal* expertise in the specialised medical language of mental health illness, having never been immersed in this professional context of practice. PSW' subjective expertise is learned through being immersed in the culture of experiencing mental distress, and socialised in the challenges of living with mental illness; of being treated in specific places, such as clinics and hospitals. As such, PSW' language and socialisation around the mental illness knowledge is closer to that experienced by the people they are supporting. As our findings highlight, PSW have strong interactive ability with the people they support, in part because of their common lived experiences, which allows them to both understand and interpret people's mental health problems and to be able to develop trust in the process. The corollary is also true; formally trained mental health experts without their own lived experience will always lack the social understanding of living with mental illness. Their knowledge will be limited in this dimension as will their ability to verbally engage people, for example, in establishing connections through shared knowledge.

Second, and relatedly, we suggest the ontology of subjective (experiential) knowing is necessarily temporally embedded in practice (Emirbayer and Mische 1998), and therefore differs from objective professional knowing which aims to be universalistic, decontextualised and atemporal (Abbott 1981). Subjective knowing, based on lived experience of illness, is thus embedded in time as well as space. People experiencing mental illness (and the PSW that support them) do not separate out their knowledge of mental illness from their living of life in different places, and how they felt and thought at different points in time. Subjective knowledge of mental illness comes with a particular history of a specific lived onset, present expression of risks and future potential for personal recovery. The contributory potential of this knowledge lies in it being embedded in living in time and space, highlighting the importance of its situated nature. On the other hand, objective knowledge aims to remove the disorder of context and life from what is considered the actual illness (Abbott 1981), leaving

the relevant psychiatric issues professionally defined and offering a universal perspective of the illness.

As highlighted by Emirbayer and Mische (1998) all action is temporally embedded, though individuals will vary in how they are orientated towards the past, present and/or future. We suggest that the PSW' subjective expressions of expertise are able to temporally align alongside the supported person in a unique way, for example giving them hope of recovery, allaying fears about drug side effects and suggest their current symptoms are in some way normal in the trajectory of illness. This sense of alignment embodies the PSW-supported person relationship with therapeutic potential in two important ways. First, there is the sense of connection (that lies at the heart of all therapeutic relationships) between PSW and supported person, made real in the experiential knowledge of having 'been there' (or somewhere similar) at some point in time. Second, there is the act of 'being alongside', perhaps physically, in person, but certainly in some knowing, discursive space, as the PSW re-enacts or re-imagines their own lived journey of mental illness and recovery as they support the individual (Authors 2015). As such the emergent nature of living with illness is not erased, but instead is woven into the very fabric of knowing and therefore into the dynamics of relationships, activities of daily living, interacting with an often stigmatising wider world, and of their anticipation of the future for both PSW and supported person.

Further, we suggest that the particular temporal embeddedness of the PSW's tacit knowing (Emirbayer and Mische 1998) enables unique coordinating mechanisms in managing risk in their caring practices (Jarzabkowski, Le, Feldman 2012). For example, our analysis shows that the experiential and temporal dynamic of knowing is consequential in enabling PSW to offer therapeutic support in anticipating pending risk (Holley, Gibson, Gillard 2015). PSW orientate themselves differently to potential risk associated with uncertain futures, often using the projective element of (future) time as part of the therapeutic process, for example,

encouraging supported persons to confront and manage the consequences of their behavioural risks rather than eliminating consequences by removing risk.

The focus of this knowing is not about the illness per se, but about how to go on living with it and how to work through the new relational challenges it presents at different points in time.

We suggest that it is thus more difficult to standardise and commodify (and thus performance manage) subjective expertise when compared to objective knowing, as the knowledge is wholly socialised (Ribeiro and Collins 2007).

Third, our findings contribute new insight into why it has been difficult to incorporate workers such as PSW, whose expertise is based on subjective knowledge, into the wider healthcare teams (cf. Berry, Hayward, Chandler 2011; Gates, Akabas 2007; Gillard et al 2013). Workers' knowledge shapes the roles they take on in organisations, for example setting boundaries around their tasks (Lamont and Molynar 2002). The uniqueness of PSW' subjective knowledge in an organisational context where formal, objective knowledge is dominant, has implications for how their roles evolve and become enacted in practice.

Subjectively derived expertise blurs the boundary between insiders and outsiders, in terms of the formal identities of being a patient or being a member of staff. Thus subjective forms of knowledge challenge the social relations between 'carer' and 'those cared for', relations which have become formalised in health organisations. In our study, PSW often struggled with their own challenges of ongoing recovery, and other healthcare providers on the wider team were aware of the PSW' vulnerability in this regard. Yet for expert professionals these role boundaries are clearly defined through the process of formal training and professional codification of knowledge (Abbott 1988) and insight was limited into how to best to support PSW in a way that valued, rather than constrained their use of experiential knowledge.

Further, knowledge that is shared between organisational members enables coordination between different roles (Bechky 2003) and facilitates collaboration (Carlile 2002) in

healthcare teams (Faraj and Xiao 2006, Oborn and Dawson 2010). Gittell and Douglass (2012) have shown how shared knowledge, along with shared goals and mutual respect, enables organisational members with different roles to successfully coordinate and align their work to the situation (such as caring for a patient) and to one another. Elsewhere our findings have indicated how PSW are able to act as a ‘bridge’ between service user and mental health professional, the linguistic and experiential connection between PSW and service user working to convey both trust and insight to the clinical team (Authors 2013). However, despite this potential, given the different tacit dimensions and temporal orientations associated with PSW’ experiential knowledge, the ability to share that knowledge with other members of the healthcare team remains challenging in formal healthcare settings (Authors 2015).

Conclusions

Our research contributes new understanding of how the emerging role of peer support workers draw on and uses different forms of knowledge and expertise in caring for people with mental health problems. We find that this knowledge and expertise need not draw on a singular reality of mental illness, but rather can engage multiple ontologies of knowing (Mol 2002) about the body and mental illness. Our study highlights that peer support workers can contribute caring practices through their unique interactional expertise and subjective knowledge in quite distinctive yet complementary ways. Specifically, tacit knowing developed through lived experience – experiential knowledge – is acquired through different socialization processes and locations of practice. It does not depend on the same tacit knowledge or socialization through discursive practices of formally trained specialists. Further, our findings suggest that this experiential knowledge is necessarily temporally embedded, and uniquely oriented towards the past, present, and future, and that this can inform care practices in, for example, managing risk, ways of coping and the reshaping of

care relationships. Future work could usefully examine challenges of integrating the PSW role into healthcare teams by examining how the distinctiveness of experiential knowledge and peer expertise can be retained while enabling the sharing of knowledge and expertise across the team. New understanding is needed of how the subjective, interactional knowledge brought by PSWs – given that this knowledge is not socialised across the team in the same way as objective, professional knowledge – can best contribute to the shared knowledge base, and therefore therapeutic potential of the team as a whole.

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