New ways of working in mental health services:
a qualitative, comparative case study assessing and
informing the emergence of new peer worker roles in
mental health services in England

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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This report

Abstract

New ways of working in mental health services: a qualitative, comparative case study assessing and informing the emergence of new peer worker roles in mental health services in England

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Background: A variety of peer worker roles are being introduced into the mental health workforce in England, in a range of organisational contexts and service delivery settings. The evidence base demonstrating the effectiveness of peer worker-based interventions is inconclusive and largely from outside England. An emerging qualitative literature points to a range of benefits, as well as challenges to introducing the peer worker role.

Aims: In this study we aimed to test the international evidence base, and what is known generally about role adoption in public services, in a range of mental health services in England. We also aimed to develop organisational learning supporting the introduction of peer worker roles, identifying learning that was generic across mental health services and that which was specific to organisational contexts or service delivery settings.

Team: The research was undertaken by a team that comprised researchers from a range of academic and clinical disciplines, service user researchers, a peer worker, and managers and service providers in the NHS and voluntary sector. Service user researchers undertook the majority of the data collection and analysis. We adopted a coproduction approach to research, integrating the range of perspectives in the team to shape the research process and interpret our findings.

Study design: The study employed a qualitative, comparative case study design. We developed a framework, based on existing evidence and the experiential insight of the team, which conceptualised the challenges and facilitators of introducing peer worker roles into mental health services. The framework was used to inform data collection and to enable comparisons between different organisational contexts, service delivery settings and the perspectives of different stakeholders.

Settings: The study took place in 10 contrasting cases comprising mental health NHS trusts, voluntary sector service providers and partnerships between the NHS and voluntary sector or social care providers. Peer workers 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.

Participants: Participants were 89 people involved in services employing peer workers, recruited purposively in approximately equal proportion from the following stakeholder groups: service users; peer workers; (non-peer) coworkers; line managers; strategic managers; and commissioners.

Data collection: All participants completed an interview that comprised structured and open-ended questions. Structured questions addressed a number of domains identified in the existing evidence as barriers to, or facilitators of, peer worker role adoption. Open-ended questions elicited detailed data about participants' views and experiences of peer worker roles.

Data analysis: Structured data were analysed using basic statistics to explore patterns in implementation across cases. Detailed data were analysed using a framework approach to produce a set of analytical categories. Patterns emerging in the structured analysis informed an in-depth interrogation of the detailed data set, using NVivo 9 qualitative software (QSR International Pty Ltd, Victoria, Australia) to compare data between organisational contexts, service delivery settings and stakeholder groups. Preliminary findings were refined through discussion with a range of stakeholders at feedback workshops.

Findings: Many of the facilitators of peer worker role adoption identified in the existing evidence base were also evident in mental health services in England, although there were issues around pay, leadership, shared understanding of the role, training and management where good practice was uneven. A number of examples of good practice were evident in the voluntary sector, where peer worker roles had been established for longer and organisations were more flexible. In the NHS there were a range of challenges around introducing peer worker roles into existing structures and cultures of practice. Peer workers were able to engage people with services by building relationships based on shared lived experience – the language they used was particularly important in BME-specific services – but barriers to engagement could be created where roles were overformalised.

Conclusions: Key barriers to, and facilitators of, peer worker role adoption were identified, including valuing the differential knowledge and practice that peer workers brought to the role (especially around maintaining personally, rather than professionally defined boundaries); maintaining peer identity in a role of work; changing organisational structures to support peer workers to remain well in their work; and challenging organisational cultures to empower peer workers to use their lived experience. Recommendations for future research include developing a theoretical framework articulating the change mechanisms underpinning 'what peer workers do', piloting and formally evaluating the effectiveness and cost-effectiveness of peer worker interventions, and mixed-method research to better understand the impact of working as a peer worker.

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List of abbreviations

ASN	Arts and Social Network	PSW	peer support worker
BME	black and minority ethnic	R&D	research and development
CCG	Clinical Commissioning Group	RIAZ	Recovery Innovations of Arizona
CMHT	community mental health team	SGUL	St George's, University of London
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust	SHFT	Southern Health NHS Foundation Trust
CPN	community psychiatric nurse	SPFT	Sussex Partnership NHS Foundation Trust
EMU	Enfield Mental Health Users Group		
KMI	knowledge mobilisation initiative	SWLSTG	South West London and St George's Mental Health NHS Trust
LSLCS	Leeds Survivor Led Crisis Service		
PEER	Peer Expertise in Education and Research	WRAP	Wellness Recovery Action Planning

Plain English summary

Peer workers are increasingly being employed in mental health services in England. Peer workers are people with personal experiences of mental health problems, employed to use those experiences to help other people. There is some research about the benefits of peer workers but most of it is from outside England. The aim of this research is to find out if that international evidence is useful in helping to develop new peer worker roles in England.

We interviewed 89 peer workers, coworkers, managers and service users about their views and experiences of the peer worker role. We interviewed people in 10 different mental health services, in NHS mental health trusts and voluntary sector organisations. Some peer workers were working on psychiatric wards, some in community services and others in projects for black and minority ethnic communities.

We found a lot of good practice in the projects we studied, although there was room for improvement around pay, training and management for peer workers. Some things were done better in the voluntary sector, where peer workers had been introduced a few years earlier. Making new roles fit with existing structures was a challenge in the NHS. The most important issues were around valuing and supporting peer workers to use their personal experiences of mental health problems. Organisations needed to be flexible and allow traditional ways of doing things to change if peer workers were to do their jobs well and stay well themselves.

Scientific summary

Background

A variety of new peer worker roles are being introduced into the mental health workforce in England, in the NHS, voluntary sector and organisational partnerships, and in a range of service delivery settings. Peer workers are seen to support a number of policy agendas including self-care, mental health recovery and improving the skills mix in the mental health workforce. The evidence base demonstrating the effectiveness of peer worker-based interventions is inconclusive and largely from outside the UK. An emerging qualitative literature points to a range of benefits for peer workers and the service users they support. This literature also begins to identify some of the organisational challenges to introducing the peer worker role, while a more generic organisational literature is indicative of a range of barriers to, and facilitators of, role adoption in public services. We used this evidence base, along with the experiential insight of members of the research team and our service user reference group, to develop a conceptual framework in a number of key domains, identifying a comprehensive set of organisational conditions supporting the adoption of new peer worker roles.

The research team consisted of health service, organisational and service user researchers, and peer workers, managers and clinicians from the NHS and voluntary sector. We employed a 'coproduction' approach to research, with key decisions about how we did the research distributed across the team, and much of the data collection and analysis undertaken by service user researchers.

Aims

This study aimed:

1. to test the existing evidence base indicating facilitators of, and barriers to, adoption of peer worker roles in a range of mental health service settings in England, in the statutory and voluntary sectors
2. to provide mental health service organisations with guidance on the development and introduction of peer workers in the delivery of mental health services.

Study design

The study employed a qualitative, comparative case study design. We used a 'pattern-matching' approach to case study analysis. The conceptual framework referred to above constituted a 'pattern' of organisational conditions supporting peer worker role adoption. The study was designed to identify where the proposed pattern was replicated across cases (i.e. applied across mental health services), and where variation in the observed pattern could be explained by alternative sets of conditions in specific contexts (e.g. in the voluntary sector or in the NHS).

Settings

The study took place in 10 contrasting cases comprising mental health NHS trusts, voluntary sector service providers, and partnerships between the NHS and voluntary sector or social care providers. Peer workers 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. Cases included services where the

employment of peer workers was well established and cases where peer worker roles had only recently been introduced.

Participants

Participants were 89 people involved in services employing peer workers, recruited purposively in approximately equal proportion from the following stakeholder groups: service users; peer workers; (non-peer) coworkers; line managers; strategic managers; and commissioners.

Data collection

All participants completed an interview that comprised structured and open-ended questions. The structured part of the interview comprised 40 items in six domains roughly corresponding to our conceptual framework. Two questions were asked of each item: (A) *is this happening here?* and (B) *how important is this to you?*. Open-ended questions elicited detailed data about participants' views and experiences of peer worker roles, again corresponding to the domains of the conceptual framework.

Data analysis

Interviews were digitally recorded and transcribed verbatim. Structured data were analysed using basic statistics to explore patterns in implementation across cases. Question A responses to each item were reported as proportions (percentages) of responses in each category (i.e. *yes*, *partly*, *no*, *don't know*, *not relevant*); question B responses were reported as mean scores for each item on a scale of importance from 1 (*not at all important*) to 4 (*extremely important*). To identify any variation in response, we compared responses between groups of participants as follows:

1. employer: NHS cases; voluntary sector cases
2. organisational context: NHS-only cases; voluntary sector-only cases; partnership cases
3. service setting: two inpatient cases; two community cases; two BME-specific cases
4. stakeholder group: peer workers; service users; non-peer staff; line managers; strategic managers; commissioners.

In-depth data were analysed 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. The whole data set was coded to those categories using NVivo 9 qualitative analysis software (QSR International Pty Ltd, Victoria, Australia). As we undertook that analysis we began to group categories into broader, explanatory themes that elucidated the barriers to, and facilitators of, peer worker role adoption. We presented and discussed those emerging themes in two feedback workshops with study participants and other stakeholders, in order to explore the wider validity of our themes and to refine our analysis.

We systematically synthesised our structured and in-depth data. Where patterns emerged in the structured analysis – that is, where there were similarities across all cases, or alternative patterns characterised groups of cases or stakeholders – this informed an interrogation of the in-depth data. We used NVivo qualitative software to retrieve and compare data from relevant categories between organisational contexts, service delivery settings and stakeholder groups.

Findings

Many of the facilitators of peer worker role adoption identified in the existing evidence base were also evident in mental health services in England; on the whole, recruitment practices were good, role-specific training was widely in place for peer workers, peer workers were largely well supported by teams and their line managers, and there was good strategic support for introducing peer worker roles within organisations. However, parity of pay with others doing similar work and opportunities for promotion were not widely in place; leadership for peer worker roles did not often come from within the communities where peer workers worked; shared understanding of the role was uneven; and training for other members of teams working alongside peer workers was patchy.

A number of examples of good practice were evident in the voluntary sector, where peer worker roles had been established for longer and organisations were more flexible; roles were more distinctive and practice boundaries were better managed. In the NHS, there was a range of challenges around introducing peer worker roles into existing structures; shared understandings of the role were not always in place, and access to appropriate supervision and support for peer workers could be limited by a lack of awareness of the role among managers and teams. Peer workers were able to best demonstrate their distinctive practice in partnership contexts, but it could be challenging to work in two different organisational cultures.

The peer worker role was at its most distinctive in inpatient settings, but that distinctiveness could easily be eroded where there were competing demands on staff time. There were differences of opinion on whether or not peer workers should receive NHS training to manage violence on inpatient wards. The use of language was particularly important in BME-specific services, although overformalisation of the peer worker role was a challenge to building peer relationships in BME settings.

Conclusions

Key barriers to, and facilitators of, peer worker role adoption were identified. We conclude that it is crucial that the differential knowledge that peer workers bring to their work – and their ability to engage service users with mental health services by building different relationships – must be understood, acknowledged and valued for the role to be meaningfully adopted. Peer workers need to be supported and enabled to use their peer identity in their work, and to be in control of how they share their lived experience. This means supporting peer workers to maintain personally, rather than professionally, defined boundaries even where that challenges conventional ways of working. Role-specific, rather than just task-related support and management should be given that acknowledges, but does not overmedicalise, the challenges that can result from working from a lived experience perspective.

We identified a number of ways in which organisational structures need to change to support the adoption of peer worker roles: employing a critical mass of peer workers within services and teams, building sufficient flexibility into the way teams work and having supportive management through all levels of the organisation. Rigid approaches to structure, policies and procedures – forcing the role to adapt to fit organisational norms – and allowing the peer worker to become a repository of low-value tasks will dilute peer worker roles. As well as challenging conventionally boundaried practice, where peer workers are enabled to speak out, they can address habitual stigmatisation and change the conversations teams have about mental health and the people they support. Organisational cultures need to change to support the adoption of new peer worker roles; at the same time, peer workers are potentially powerful agents of change where the organisation enables rather than resists that change.

Recommendations for future research

Building on this research project, the following research would support and lead to high quality, formal evaluation of peer worker-based interventions in a range of organisational contexts and service delivery settings:

1. 'pre-clinical' theoretical work to develop a coherent theoretical framework, describing how the mechanisms of 'what peer workers do' are linked to identifiable service- and individual-level outcomes
2. developmental work to model and then pilot peer worker-based interventions – in a range of organisational and service delivery contexts – to ensure that interventions are feasible, acceptable and can be delivered with sufficient fidelity to enable formal evaluation
3. development and testing of fidelity measures to support formal evaluation of peer worker interventions
4. experimental or quasi-experimental studies, appropriately designed to best evaluate complex, peer worker-based interventions
5. testing of the organisational conditions for implementing new peer worker roles developed in this study – through role development and piloting – in a range of other service delivery settings (e.g. forensic mental health services)
6. mixed-methods studies to better understand the longer-term impacts for peer workers of working in a peer worker role (including health, well-being and employment outcomes)
7. developing better understanding of the commissioning, organisational, service, team and individual benefits and challenges of partnership working, where organisations with very different cultures of practice work together to provide a complex intervention
8. evaluating the organisational learning tools in development as part of this research project.

Funding

Chapter 1 Introduction

A definition of terms

A number of terms exist to describe peer worker roles, including peer support worker (PSW), peer support specialist and, in the USA, consumer-provider. We use the more generic term *peer worker* throughout this report because it does not specify or limit the range of roles under consideration. At the same time, by including the word *worker* we are making it clear that we are interested in a role of work, be that formal or informal, rather than peer support that is mutually given and received, intentionally or incidentally, between people sharing a similar need.

It was necessary to further define, from the outset, what we meant by 'the peer worker role' so that the scope of the study would be clear. However, this was a working definition only – we had no intention of imposing meaning on the roles we encountered – and, as we anticipated, we found this definition to be stretched and challenged by the data and by the individuals we spoke to. In designing and undertaking this project we proceeded on the basis that:

> *A peer worker is employed to make explicit use of their personal experiences of mental health problems for the benefit of another person currently experiencing mental health problems or using mental health services.*

When we carried out our interviews, participants also used a range of alternative terms for the peer worker role, and sometimes these differences in language were important and meaningful. Similarly, participants used different words when talking about people using the services we studied: patient, visitor, member and survivor, as well as service user. We discuss the use of language in some depth in the report. Some of that language was specific to particular cases. To preserve the anonymity of our participants, when we quote directly from interview transcripts we replace that case-specific language with the terms peer worker and service user, except where we are analysing the significance of the use of language in particular contexts.

Background

Claims have been made for the introduction of peer workers, alongside or as new members of existing multidisciplinary teams, to address issues of both service quality and cost for health service providers. Peer support generally, and peer worker roles more specifically, have been identified as facilitators of both generic health policy such as self-care[1] and personalisation,[2] and mental health agendas such as recovery.[3] Department of Health workforce policy advocates recruitment to new peer roles as part of the New Ways of Working, Creating Capable Teams Approach,[4] with peer workers seen as helping mental health service teams to enhance their capabilities and skill mix. A recent UK mental health strategy[5] articulates a vision of recovery-focused, service user-directed mental health care, but also demands measureable outcomes.

Involving patients more closely in directing care has been shown to contribute to lower demands on health services over the longer term.[6] UK assessments have shown that cost efficiencies might be made by adjusting the skill mix of frontline staff, thereby increasing productivity.[2] New UK health strategy[7] heralded an era of general practitioner (GP)-led, patient-focused commissioning that would increase both quality and choice, and drive down costs. In 2010, the total annual cost of providing health and social care for mental health services was estimated at £21B.[8] With new Clinical Commissioning Groups (CCGs) having come online in April 2013, mental health NHS trusts are faced with the same requirements to reduce cost as the rest of the NHS.

The introduction of new peer worker roles appears to respond to this range of quality and cost agendas. The evidence base for the impact of mental health services employing peer workers is growing, but originates mostly from North America, Australia and New Zealand. Reducing admission to inpatient psychiatric care is the most reported outcome – with some claims made for associated reduction in service cost – but is largely evaluated through observational,[9] comparison group[10] and cross-sectional[11] study design, rather than randomised controlled trial. A before-and-after study[12] and a cross sectional survey,[13] both from the USA, found significant improvement in measures of individual empowerment associated with receiving peer-based support. Hope and the strength of social networks have also been indicated as important outcomes for service users in receipt of support from peer workers.[14,15] A recent Cochrane Review[16] of 11 trials of interventions involving peer workers in adult statutory mental health services found only limited evidence of a reduction in use of emergency services, some change in productivity (peer workers spent more face-to-face time with service users than did professional staff) but no good-quality evidence relating to cost.

A recent literature review[17] details a relative wealth of qualitative research based on lived experience that attests to the benefits of peer worker initiatives in mental health services, both for peer workers themselves and for the service users they support. Benefits included enhanced personal sense of empowerment, developing better social support and furthering personal recovery.[18] This qualitative literature, attesting as it does to some of the organisational challenges to introducing peer worker roles (e.g. Mead and MacNeil[19]), will be explored in more detail as we develop a conceptual framework underpinning this study (see *Conceptual framework*, below).

It has been noted that professionals, particularly in health care, are subject to pressure to conform to and support reform.[20] Against this backdrop of closely aligned policy agendas and assumptions about potential cost savings, and despite the relatively inconclusive nature of the evidence base (most of it from outside the UK), a range of approaches to employing and deploying peer workers has emerged in mental health services in England. An implementation programme to support the UK mental health strategy[5] has been established in England, with a specific remit to develop and demonstrate new peer worker roles (www.centreformentalhealth.org.uk/recovery/supporting_recovery.aspx).

Rationale

The policy case for the further development of the peer worker role in mental health services in England is therefore compelling. There is some evidence identifying potential benefits of peer workers in mental health service provision[9–15,17,18] (see *Background*, above). However, the evidence base explicitly associating peer workers with measurable quality and cost outcomes currently remains limited. The introduction of a new role into an existing team, or to complement an existing care pathway, constitutes a complex intervention, for which systematic feasibility and piloting work in both development and evaluation are generally considered necessary.[21]

In short, current evidence – and especially evidence from the UK – is neither of consistently high quality, nor sufficiently cohesive to develop clear guidelines for the introduction of peer worker roles. This lack, in part, might explain the plethora of in vivo experiments in role design and implementation currently taking place nationally. In completed research undertaken by the research team[22] exploring support for self-care provided by mental health services, peer worker roles were evolving as a component of all case studies. This research indicated a number of key uncertainties that need clarification in order to ensure that the development, implementation and evaluation of interventions involving peer workers are informed by a strong evidence base.[23] In addition, there is an established organisational research literature[24,25] that identifies a range of organisation conditions that need to be in place for successful role adoption to occur (see *Conceptual framework*, below).

As such, there is a strong rationale for a study that will systematically examine current initiatives to introduce peer worker roles in mental health services in England against a framework of what is already known internationally about the organisational challenges to role adoption. Such a study would identify where that international learning can be meaningfully applied in this country, and where there are challenges and opportunities specific to the health and social care system in England. This insight would inform the further development of peer worker roles nationally, on an applied level increasing the likelihood that new roles will be successfully adopted into existing services and teams, while also supporting the manualisation of peer worker interventions for robust, formal evaluation.

Our scoping of new initiatives nationally indicates that peer worker roles are being developed in a range of different service delivery settings (e.g. inpatient and community mental health service settings), and take on a wide variety of organisational forms; some peer workers are employed by the NHS and some by voluntary sector agencies. In the context of new commissioning arrangements, NHS mental health services are increasingly likely to be 'contracted out' to third sector providers, be they profit making or not-for-profit, while some voluntary sector organisations operate completely independently from the NHS, or in partnership with social services departments.

Thus, this study should not assume that there is a single model of peer worker role that can be defined and replicated across settings and organisational contexts. It will be necessary to adopt a comparative study design that captures and interrogates the range of organisational variation that might impact on the role adoption process. The study should identify facilitators of, and barriers to, peer worker role adoption that are generalisable across mental health services in England, and those that are specific to particular settings or organisational contexts.

Aims

In response to the strong rationale for a study to support the further development and future formal evaluation of peer worker roles in mental health services, the aims of the project were:

1. to test the existing evidence base indicating facilitators of, and barriers to, the adoption of peer worker roles in a range of mental health service settings in England, in the statutory and voluntary sectors
2. to provide mental health service organisations with guidance on the development and introduction of peer workers in the delivery of mental health services.

To achieve these aims, this study was grounded in a clear framework that sets out what was known about new peer worker roles in mental health services internationally and the processes of role adoption in public services generally. A conceptual framework (see *Conceptual framework*, below) based on that evidence was systematically tested in this study in a number of comparative cases.

Service user researchers and 'coproduction' in the research team

In developing this study, the team felt strongly that any investigation into the introduction of peer worker roles in mental health services – essentially the integration into an existing interdisciplinary environment of people working explicitly from a perspective of lived experience of mental health problems – should be reflected in the research team. This necessitated the inclusion of researchers working from lived experience of mental health problems as core members of the research team. We felt that not to do so would be both unethical[26] and would not be good science in a project that would particularly seek to elicit and understand the views of people who were using their lived experiences of mental illness to provide services.

The team has a long-standing commitment to active service user involvement in research, and to understanding the impact of that involvement on the research process.[27,28] This study was largely undertaken – in terms of fieldwork, data collection and analysis – by two researchers with personal lived experience of mental health problems (hereafter referred to as service user researchers).

Evidence for the impacts of service user involvement in research is building.[29] These include better shaping of the scope and aims of the project towards the real world;[30] improving the design of interview schedules[31] and enabling research to be conducted in ways which make participation easier. Using service user researchers to undertake site engagement and data collection aspects of research reduces the power differential between 'expert' researcher and study participant roles. It has been suggested that this increases the credibility of the project,[32] puts qualitative interview participants at ease and enables honest and candid explanations of issues discussed.[33] In this study, as service user researchers were employed on the basis of their lived experience of mental health problems, there was the added advantage of the researchers having rich understanding and experience of the issues which participants raised and discussed. This capacity to explore issues with insight and depth, through interview, analysis and synthesis of data, is evidenced in other studies[34] and has been shown to correct misinterpretation of data, identify missed themes, ensure focus on findings most relevant to service users, increase ownership and commitment of stakeholders to the project, and mean that findings are more likely to be seen as credible and actionable.[35,36]

In addition to the two service user researchers, a peer worker from one of our partner mental health NHS trusts and managers with lived experience of mental health problems from our voluntary sector partner played an integral role in study design and key research decision-making as the study proceeded. Study priorities and questions were informed through ongoing work with the Peer Expertise in Education and Research (PEER) service user reference group at St George's, University of London (SGUL), detailed in the *Conceptual framework* section below.

To ensure that priorities and concerns around the introduction of peer worker roles among wider service user and peer-led mental health services audiences were reflected in the research, we also invited a range of relevant people onto the research steering group. Two members of the PEER group were supported by the team to sit on the steering group, as were two representatives of independent peer-led mental health organisations identified by our voluntary sector partner. Alongside academics and representatives of other relevant organisations, half of our steering group was made up of people with lived experience of mental health problems.

Support for service user researchers and other service users involved in this study as reference group, research team and steering group members included clear role and job descriptions, formal recruitment processes, clear and fair payment policies for expenses and meeting attendance, pre-briefing and debriefing meetings, and peer support from others working from lived experience, taking access requirements for meeting participation and communication into account. In addition to management, regular supervision and debriefing from the project principal investigator during fieldwork, the service user researchers also had access to bimonthly, individual external mentoring from an experienced researcher with lived experience of mental health problems, as an additional independent support. Good practice for service user involvement in research was built on principles drawn from survivor research,[37] the Mental Health Research Network,[38] INVOLVE[39] and SGUL's own guide to the employment of service user researchers in mental health research.[23]

As well as university researchers from SGUL and business schools at Kingston University and the University of Warwick, the team also included clinicians and managers from three mental health NHS trusts, and managers from the mental health charity Together for Mental Wellbeing, i.e. 'end users' of the research. As such, the perspectives of service user members of the team – as we developed and undertook the research – were complemented by the perspectives of team members from a range of clinical and academic, and voluntary sector and NHS backgrounds. 'Coproduction' of research knowledge of this sort

has been shown to close the 'relevance gap' between research and practice[40] and improve the sustainability of innovative developments in service delivery.[41] Our previous research has shown that the impact of service user researchers on the production of knowledge about mental health services can only properly be understood if the input of *all* members of the research team into the research process – as academic, clinician, service user, manager, etc. – is taken into account.[28] Employing peer workers in mental health services can be described in terms of the coproduction of mental health care. This study is underpinned by a coproduction approach to the research process.

Conceptual framework

As well as the emerging literature on peer support roles presented above (see *Background*), organisational researchers on the team brought insight into a wider, generic organisational literature on issues around the adoption of new roles in public service organisations. This literature is indicative of a number of issues at individual, team and organisational levels that can impede or support the successful introduction of new roles,[25] and offers a framework within which to situate the more specific literature on the peer worker role in mental health services.

It was also important that the views of people who had lived experience of working in peer support roles, or of being supported by peer workers, shaped the conceptual underpinnings of the research. As we developed the study we met on a number of occasions with the PEER group, and through a series of workshops (a total of four groups took place) identified the group's priorities for the study.

The conceptual framework was therefore informed by three distinct bodies of knowledge, summarised below:

1. the existing evidence base on peer support generally, and the processes, challenges and impacts of introducing formal peer worker roles in mental health services
2. understandings of how new roles are successfully adopted, derived from a wider, empirically based organisational research literature on role adoption in public services
3. experiential insight into the introduction of peer worker roles, informed by insight from the research team and members of the PEER group at SGUL.

The existing evidence on peer worker roles in mental health services

A review of peer support roles in mental health,[17] as well as a new summary of the research recently undertaken by study authors,[42] summarises existing international evidence identifying a range of individual-, team- and organisational-level factors that might impact on the implementation of peer worker roles in mental health services:

i. *Shared understanding of the peer worker role* A number of studies have indicated that an absence of a clear job description can impact upon not only the peer worker's role within services (e.g. Stewart and colleagues[43]), but also their working relationship with other employees, including health workers, managers and supervisors (e.g. Kemp and Henderson[44]). For example, Creamer and colleagues[45] found that a shared understanding of what is expected of peer worker roles ensures appropriate referral to and from other professional sources of help.
ii. *Confidentiality* Some evidence suggests that peer workers may be concerned about information about their mental health history remaining confidential within the mental health team (e.g. Scott and colleagues[46]).
iii. *Job structure and career pathway* The importance of employment and the shift from consumer to provider, in order for peer workers to become valued and contributing citizens, was noted by Hutchinson and colleagues.[47] More specifically, engaging in peer training and taking courses encourages peer workers to go on to successfully pursue other educational and vocational goals.[48]

iv. *Supervision, training and support* Kemp and Henderson[44] argue that it is important for managers and other members of staff to consider peer workers as equal members of the team, and to create strategies which will reduce the risk of isolation. More specifically, managers can support peer workers in team meetings, provide peer workers with access to other organisational support and increase opportunities for peer workers to support one another.[44] Repper and Carter[17] conclude their review by highlighting the importance of dedicated training and support for the peer worker role.

v. *Valuing the peer worker role* Mowbray and colleagues[49] note that peer workers may experience feelings of being part of the team, but also of lower status in comparison with other members of the team. In order to adopt meaningful consumer participation, it is suggested that a power shift is required in the realm of practice.[43] Mead and colleagues[50] point out that formalising peer support, by applying the same performance criteria as for non-peer staff and offering payment, training and titles, may minimise these power differences. Stewart and colleagues[43] suggest that formalising the peer worker role should also run parallel with reorienting mental health workers' education. As such, it is also seen as important for both managers and team members to receive information about the role of a peer worker through the creation of a peer support manual or handbook.[44]

vi. *Relationships with service users* A number of studies demonstrate how peer workers offer a unique relationship to service users in comparison with other mental health professionals. For example, one qualitative study's findings indicated that clients who were provided with a peer worker as their case manager were more likely to feel they were being listened to, valued and understood.[45] This was further supported by Mead and colleagues,[19] who reported a shift in language whereby peer workers are more likely to talk about experiences instead of symptoms. There has, however, been some evidence that suggests there are boundary issues between peer workers and service users, where sharing personal information and intimate stories could be understood in terms of friendship rather than professional relationship.[49] Peer workers may also be concerned about being responsible for others' well-being where they feel that service users have become overly dependent on them.[51]

Previous research undertaken by the team on the evolution of new peer worker roles in mental health NHS trust services supporting mental health self-care[23] indicated an additional set of issues which might impact on peer worker role adoption:

i. Informal or semiformal recruitment processes could lead to a lack of shared expectation between peer workers and teams about what peer worker roles entailed.

ii. Provision of flexible working practices for peer workers, and a benevolent, protective approach to peer workers taken by the rest of the team, could reinforce hierarchy within the team and mitigate against the inclusion of peer workers as equal members of the team.

iii. Reinforcing existing clinical practice boundaries in the work done by peer workers could inhibit the emergence of distinctive work undertaken by peer workers.

iv. Where there was not good shared understanding of the exact nature of the work that peer workers were doing, peer workers might not feel supported by the training and supervision that managers worked hard to put in place for them.

v. There could be a lack of awareness among non-peer team members of the challenges faced by peer workers where preliminary work had not been done in the team to develop shared expectation of the role.

The organisational role adoption literature

There is specific literature on role development, derived from empirical studies in a range of organisational settings, private and public. Established theories of role change (including the introduction of new roles) indicate that strain on a role system can provide impetus for change and favourable conditions for rapid and widespread role transformation, followed by a reconfiguration of roles as the crisis subsides.[52] The current productivity and quality challenges facing the NHS, which would see payments to the NHS aligned with the quality of care that patients receive,[7] arguably present such a strain. The employment of peer workers provides an opportunity to review traditional skill mix in mental health provision, offering cost efficiencies while at the same time being seen to facilitate the recovery,[53] self-care[1] and personalisation[2]

agendas, and improving health and social care outcomes for those people accessing mental health services. A diffusion model of role change[24] describes change beginning with a small number of innovators, followed by early acceptors, an early adopting majority, a late adopting majority and a few remaining late arrivals completing the process. Turner[25] describes a tipping point at which a critical mass of adoption leads to the role change being institutionalised formally, and identifies a number of factors that either facilitate or inhibit that widespread implementation. Networking undertaken by members of the team indicated that development of peer support roles in mental health services nationally was probably currently somewhere around the innovation/early acceptors stage, at a critical point in terms of widespread implementation. Turner[25] suggests that implementation is more likely when the role system in question is interdependent with other systems (in our case, role systems in the mental health trust with those in primary care, social care and the third sector); when role incumbents feel closely tied to the system (peer workers with their employing organisation); and when role incumbents bring power to the system.

This last factor seems particularly important, with Turner[25] indicating that non-professional groups bring little power with their new role unless they exercise a monopoly of practice over a distinctive expertise. The sociology of professions literature (e.g. Abbott[54]) describes 'communities of practice' which define themselves and their work jurisdiction by their specific expertise. Recent research has shown how the boundaries of a community of practice are guarded in order to maintain jurisdictional control, legitimacy claims and professional identity,[55,56] with a number of studies documenting the power of clinicians to block innovative practice.[57,58] Role change – especially the introduction of new roles – brings about challenges over task and expertise boundaries, with Turner[25] suggesting that a range of factors such as client support, availability of differential knowledge, institutional support (including training) and a culture shift in the organisation all help to define the boundaries of a new role. Dierdorff and Morgeson[59] suggest that role expectation is a key factor in maintaining a role system, and that consensus about role requirements enables the meaningful combination of roles within teams. They found that consensus on role was highest where role responsibilities were associated with specific tasks, rather than broad organisational responsibilities that might be shared across roles. This literature suggests strongly that the meaningful establishment of a peer worker role within existing mental health teams is more likely where that role clearly enacts highly specific expertise and tasks, enabling a consensus of expectation across roles (existing and new) and avoiding jurisdictional challenge to (and resistance from) existing professional roles.

Recent studies exploring the introduction of new roles have indicated how prevailing work practices are changed incrementally as new roles becomes embedded.[60] Within UK mental health services, challenges in introducing new roles over the last decade have included a disparity of terms and conditions of employment across health-care, social care and third sectors, and a lack of clarity and awareness over roles (who is doing what and in which sector/organisation).[61] Other organisational change literature has shown how organisational learning is more easily sustained within, rather than across, communities of practice,[62] how power relations between communities of practice mediate organisational learning,[63] and that the implementation of new ways of working can 'stick' at the interfaces between professional groups.[64]

Experiential insight into peer worker roles in mental health
Members of the research team held three small group discussions with members of PEER in the development of the outline proposal for this bid, and a further, larger group discussion in the development of the full proposal. Members of PEER raised the following main points about the introduction of peer worker roles, from their perspectives as mental health NHS service users with experience of giving support as peers (including in formal peer worker roles) and receiving support from peers:

i. role that peer workers should play: act as 'guides' through mental health services, especially for new service users; interface between service users and professionals; prevent people falling through the net between services; 'seeing the whole person'; empathy+experience+training

ii. clarity needed about degree of professionalism of the role: peer workers should have a professional manner but should not be overprofessionalised/medicalised or benefits will be lost; what skills should peer workers have ('common sense' or professional)?

iii. service users are aware of 'suspicion' and 'resentment' among professional staff concerned that they are being replaced by peer workers

iv. need to identify the benefits and impacts of peer workers, for service users and more widely

v. concern that introduction of peer workers is happening too quickly/without proper planning because it is seen as a 'cheap option' by trusts

vi. importance of providing peer workers with sufficient support, from their managers, from the organisation (training and through supported employment programmes) and with their peers (support groups with other peer workers)

vii. concerns about the extent to which peer workers will be expected to disclose their mental health issues, both to service users and to professional colleagues, extending an 'us and them' (service user and professional) culture into the staff team.

The conceptual framework derived from this knowledge is summarised in *Figure 1*.

Job description/competencies

- Clear job description/person specification
- Distinctiveness of role (compared with existing team roles)
- Competencies associated with the role articulate a specific body of 'peer practice'
- Role made to fit existing (inappropriate) profile

Training

- Accredited training: sufficient, role specific, ongoing
- Degree-level/professional training
- Training for trainers and training for the rest of the team in working with peer workers
- Training provided by specialist (outside) agency

Strategic support

- Integration of peer workers into wider strategic initiatives within the organisation
- Cost/productivity as a strategic rationale
- Risk management policy/practice/training specifically addresses peer worker issues
- Strong cross-sector (health; social care; community) strategic alignment supporting introduction of peer workers (strategic interdependence)
- Organisation-wide strategic initiative
- Explicit strategic recognition of the specific, differential contribution of peer workers
- Clear organisation communication strategy about introduction of peer worker roles

Expectations of the role

- Consensus about expectations of the peer worker role among stakeholders
- Clear understanding of boundary issues in policy, training and practice
- Clarity about degree of disclosure expected of the peer worker role
- Shared expectations of the degree of professionalism/lay expertise enacted in the peer worker role
- Role in providing acute/crisis support

Human resource management

- Targeted recruitment and advertising
- Reasonable adjustments to HR policy (e.g. experience accepted in lieu of qualifications)
- Opportunities for promotion and career pathway
- Remuneration and reward evaluated by same criteria as other staff
- Clear HR policy on recruitment of peer workers/impacts on existing workforce
- Parity of terms and conditions across sectors

Support

- Formal supervision
- Informal mentoring (provided externally)
- Peer support with other peer workers
- Availability of benefits and welfare advice
- Clear access to support if the peer worker becomes unwell
- Support for team

Teamworking

- Clarity of division/sharing of tasks and responsibilities
- Clear risk management protocol
- Understanding of the role of the team in supporting peer workers
- Confidentiality about peer workers' clinical history within the team
- Integration of peer workers into the team

Leadership and management

- Sufficient management skills at line/team management level
- Leadership limited to one or two individuals
- Support for peer workers at all levels of management

FIGURE 1 Conceptual framework for investigating the development of peer worker roles in mental health services. HR, human resource.

Chapter 2 Methods

Study design

In this study we employed a qualitative, comparative case study design to test the existing evidence base describing the facilitators of, and barriers to, introducing peer worker roles in mental health services. We adapted a 'pattern-matching' approach to analysis[65] to test the evidence base in a number of cases in mental health services in England.

The conceptual framework underpinning the study, illustrated previously (see *Chapter 1*, *Conceptual framework*), describes a particular 'pattern' of peer worker role adoption, as indicated by existing evidence. That is, the framework proposes a set of organisational conditions under which peer worker roles might be introduced into mental health services. Yin[66] suggests that if the proposed pattern is replicated across multiple cases then the pattern provides a valid explanation for the phenomenon being investigated. However, if the pattern is not replicated in particular groups of cases, and that variation can be accounted for in terms of a predictable set of circumstances, then rival explanatory patterns can be iteratively developed. Comparative case study approaches in health services research[64] are commonly used to identify where conditions supporting innovative service development are generalisable across organisational contexts, or are context specific. In our study, we aim to establish whether organisational conditions supporting adoption of new peer worker roles apply across mental health service providers in England, or whether there are implementation variables that are context specific (e.g. that are specific to cases where peer workers are employed by mental health NHS trusts, or by voluntary sector organisations).

We collected structured, qualitative interview data from each case to test the extent to which the pattern of peer worker role adoption articulated in our conceptual framework was in evidence in each of our cases: our first research aim. Triangulation of perspective[67] between different stakeholders was used to explore tensions in the implementation process (e.g. the extent to which both peer workers and their managers thought that training provided was appropriate).

Structured qualitative data were complemented with in-depth interview data. This enabled us to interrogate and understand any patterns in peer worker role adoption as they applied in different organisational contexts. This provided a much deeper understanding of the facilitators of, and barriers to, introducing new peer worker roles: our secondary research aim. Feedback workshops were held with case study participants to check the validity of our findings as our analysis progressed.[68] Through this process we developed a new conceptual understanding of the issues that impact on the introduction of peer worker roles in the context of mental health services in England. We present and explore this understanding in *Chapter 4*.

We indicate below the specific contribution made by service user researchers to shaping and undertaking the research.

Research governance

This study collected data about the personal experiences of people using mental health services, and staff working in those services. In anticipation of these issues, we applied for NHS ethical approval for the study. Ethical approval also applied to non-NHS sites in the study.

Our application for ethical approval detailed our recruitment and informed consent process, a risk assessment process for each new interview location, and procedures – in the form of a written

protocol – to be followed should participants or researchers become distressed during an interview. Data management and anonymisation processes were also detailed in the application. Appropriate research training was given to researchers, including training using NVivo 9 qualitative analysis software (QSR International Pty Ltd, Victoria, Australia), and training for recruiting and obtaining informed consent from participants.

Scientific aspects of research governance were addressed through the NHS research and development (R&D) approval process, formally assessed by the R&D Committee at the lead NHS site and, through the site-specific approval process, at all other NHS sites. In addition, where any of our voluntary sector or partnership sites recruited service user or staff participants through the NHS, R&D approval was obtained from the local NHS R&D Committee.

The study was formally sponsored by the principal investigator's host university.

Settings

The study took place in a range of adult mental health service settings, in the NHS and in the voluntary sector. Ten cases were selected to cover the many different approaches to employing peer workers in mental health services in England. Services were being provided for adults with serious, long-term mental health problems and were not condition specific, with the exception of one service for people with lived experience of personality disorders. All services included some form of peer worker role as integral to the service provided.

Cases were selected purposefully to cover a range of variation in organisation and practice. Two primary criteria were used to select cases: organisational context and service delivery setting. Criteria were identified on the basis of the team's extensive knowledge of peer working nationally, and gave maximum coverage of the different approaches to the use of peer worker roles in mental health services in England.

The *organisational context* criteria comprised NHS, partnership and voluntary sector cases. New commissioning arrangements in England – in place in shadow form while this study was taking place – are likely to result in an increase in the commissioning of mental health services from outside the NHS, and so including voluntary sector and partnership cases was particularly relevant to study aims.

In NHS cases, peer workers were directly employed by the mental health NHS trust to work within or alongside existing NHS teams. In partnership cases, peer workers were employed by a partner agency to provide a service to NHS service users, either in a mental health trust setting or where NHS service users were referred to the partner agency. The partner agency employing the peer workers was either a voluntary sector organisation or a local authority social services department. In voluntary sector cases, organisations were either professionally led or peer led (i.e. wholly run by people with lived experiences of mental health problems).

As we undertook our scoping it was evident that many of the voluntary sector organisations we considered had good, informal working relationships with the local mental health NHS trust – people often used both voluntary sector and mental health trust services – but that these arrangements fell short of formal partnership. Some voluntary sector organisations were also partially or wholly commissioned by their local authority social services department. We included these organisations as voluntary sector cases where no formal partnership with the NHS was in place, either through commissioning arrangements or referral pathways.

The *settings* criteria comprised peer workers working in psychiatric wards, in the community (in a range of different types of services) and in black and minority ethnic (BME)-specific services (community based, providing a range of services to one or more community groups). We included BME-specific services as a

distinct criterion as we were aware that issues of peer support and mental health were understood differently in some cultural contexts.[69] Although we intended to explore issues of ethnicity and diversity in all our cases, including BME-specific cases would enable us to identify culturally distinctive issues around the peer worker role. In some cases, where there was a range of relevant work taking place, we included more than one service or setting in the case study.

The range of potential cases enabled us to apply other selection criteria. We included cases where peer workers were in paid and unpaid employment; those where peer worker roles were well established and others where roles had been recently introduced; and cases from a range of geographical and sociodemographic areas. Cases were also grouped geographically to ensure that data collection from a London base was feasible. The final set of 10 cases is shown in *Table 1*.

Case descriptions

Detailed descriptions of case study sites

We include detailed descriptions of each of our cases to place our findings and the analysis that follows in context. As part of the setting up and definition of each case study, the service user researchers met with site leads to conduct a one-to-one interview (in one peer-led organisation which worked on a community basis, this took the form of a group interview). Interviews covered the organisational context in which the peer worker roles had been developed, language and definitions of the roles, settings, staffing, training, recruitment, support and populations served. These interviews were invaluable in ensuring that the cases were well defined, and that the purposive sampling and recruitment strategy were fitted and implemented in each site taking account of roles, relationships and all ethical processes. Interviews were also important for understanding and ensuring that the language used in subsequent interviews was relevant and understandable to the participants. The descriptions below are based on these interviews with key informants at each site, and were sent to those people to be checked for accuracy before being included here.

Enfield Mental Health Users Group

Enfield Mental Health Users Group (EMU) is a service user-led organisation set up to provide group advocacy for people using mental health services in the London borough of Enfield. It was established in 1993 by a group of like-minded patients who formed a group at Chase Farm Hospital. They got support from the Community Health Council, which helped the patients to put together bids to apply for funding.

TABLE 1 Key case characteristics

Organisation	Setting	Location	Employment	History
NHS	Community	Urban/rural	Paid	New
NHS	Inpatient	Urban/rural	Paid	Established
NHS	Community	Inner city	Paid	New
Partnership (NHS/voluntary)	Inpatient/community	Suburban	Paid	Established
Partnership (NHS/social services)	Community	Urban/rural	Volunteer	Established
Partnership (NHS/voluntary)	Inpatient	Urban/rural	Paid	Established
Voluntary	Community (crisis)	Suburban	Volunteer/paid	Established
Voluntary	Community (arts)	Inner city	Volunteer/paid	New
Voluntary	BME (community)	Inner city	Paid	Established
Voluntary	BME (community)	Suburban	Volunteer	Established

As the organisation grew it employed a co-ordinator, and in 1998 was able to employ its first full-time user involvement worker. EMU runs monthly groups such as reading and bingo, and weekly activities such as badminton and Qui Jong, in different community settings, including church halls, day centres, and at the Lancaster Centre in Enfield. These groups aim to encourage self-support and empowerment, and help people recover confidence, self-esteem and hope. It runs advocacy groups on inpatient wards and a group for the over-65s at a day hospital. It also organises social events and day trips. At the time of the study, the organisation had about 80 members and three paid workers; the manager, an advocate and a user involvement worker. However, the threat of losing funding was a constant issue for this case study, and during the length of the research project the advocacy worker was made redundant in order to save money, and then reinstated as the funding contract was renewed.

Leeds Survivor Led Crisis Service

Leeds Survivor Led Crisis Service (LSLCS) was established in 1999 by a group of campaigning service users. It was set up to be an alternative to hospital and statutory services for people in acute mental health crisis. It runs three projects: Dial House, a house just outside Leeds city centre, which is open 18.00–02.00 Friday, Saturday, Sunday and Monday; Connect, a telephone helpline which is open every night of the year 18.00–22.30; and the group-work programme, which runs social and support groups for visitors. The whole organisation works from a person-centred therapeutic approach, which means that the support workers (peer workers) maintain a warm, empathetic, non-judgemental attitude and believe that the clients are the experts in their own lives and have the resources within themselves to find their own solutions. Dial House itself is a homely, welcoming and respectful space for visitors to come and spend time doing what they need to do, whether that is baking a cake, having a shower, chatting with other visitors or having one-to-one time with a support worker. Most Dial House visitors are at high risk of suicide and/or self-harm and are survivors of trauma, most commonly sexual abuse in childhood. The service is governed and managed by people with direct experience of mental health problems. It is an exciting, innovative service which attributes its success to being different to other local provision. At the heart of this is the survivor-led approach and the fact that the service is in the voluntary sector, so visitors and callers come to the organisation of their own volition. It has been recognised by winning numerous national awards, including the Charity Times 'Charity of the Year' award in 2009 and the Charities Evaluation Service Learning and Innovation Prize in March 2011. The organisation is also frequently in the media, having featured in the Guardian, the Independent and the Yorkshire Post, and on Radio 5 Live.

Emergence

Emergence is a service user-led organisation, established in 2009 with the vision of making a life-changing difference for everyone affected by personality disorder through support, advice and education. They campaign to change attitudes and challenge stigma associated with personality disorder; provide awareness training and consultancy services to organisations; undertake research; and provide direct services. This case study centred on the London-based Arts and Social Network (ASN), which was developed by people with lived experience of personality disorder as an opportunity for people who identify with the diagnosis and their carers and friends, as support if necessary, to enjoy monthly arts and cultural events. ASN enables service users to meet together in a safe and containing way and gives people who may be very isolated an opportunity to make new friends and enjoy the experience of going to a cultural event with a peer group who can appreciate the difficulties of having a personality disorder. The hope is that, through this, people may overcome anxieties and build confidence to do and see things they felt unable to do on their own. Emergence staff, the large majority of whom have lived experience of a personality disorder themselves, steward the events. The ASN group attends the event together and socialises afterwards in a café. Emergence has built working relationships with galleries and cultural venues including Tate Modern, the Together Gallery, the Wellcome Gallery, the Institute of Contemporary Arts (ICA) and the National Portrait Gallery. Events have included tours led by education curators, participatory creative workshops and a photo walk.

4Sight

4Sight is a service user network for black African and Caribbean people with mental health problems in Hackney, East London. It is committed to enriching the lives and promoting the well-being of its members through increased choice and control in their lives. Its focus is on providing one-to-one support, peer support and activities (including trips, events and a monthly Sunday lunch) and developing various initiatives for about 60–70 members. 4Sight started in 2005 as a focus group of 32 African and Caribbean men who came together to highlight their experiences of using mental health services. The themes raised in the focus group were made into four small drama skits (the name 4Sight comes from these plays) by professional actors, and these were shown to mental health staff teams in Hackney and Newham to raise the issues faced by African and Caribbean men using mental health services. 4Sight grew out of the organisation Mellow, which had been established for 12 years and at the time was funded by East London Foundation Trust. 4Sight continued to grow and focus on a variety of projects as the needs and wishes of the group developed and as different funding streams came and went, including a mentoring programme, training for front-line police and a project on access to talking therapies for black and ethnic minorities. When Mellow lost the Trust funding in 2010, 4Sight became based at Social Action for Health (a community development charity based in East London), which also became responsible for its management. 4Sight currently employs two part-time workers and runs a monthly Sunday lunch programme and regular social activities for its members.

Touchstone

Touchstone is a Leeds-based health and well-being charity, started in 1979, with a wide range of projects and partnerships in health and social care and community development. Opportunities for service users and volunteers to be involved in shaping and delivering services include peer advocacy, research, training, and health and well-being groups focused on needs and strengths within particular communities. This case study centred particularly on two of its projects within the area of community development in specific BME communities. The 'Talking our language' training, part of the Pacesetters programme (a Department of Health initiative to address the health inequalities that some groups experience in society), was developed in 2008 and delivered by community members (activists/facilitators/educators) to groups of people from within their own communities (Pakistani, Chinese and Irish), as a means of raising awareness of, and combating, stigma around mental health issues. The training followed periods of engagement within the communities (e.g. within a children's centre, pubs, social clubs and via a local housing association) and aimed to equip members to use their experience to pass on information and support others. Neither course facilitators nor participants are labelled as 'people with mental health problems' in these services, though they are explicitly using their own lived experience in this setting. The second focus of the case study was a weekly Chinese walking group with a focus on well-being, which is led and attended by people from within the Chinese community. This case study drew on expertise in working across language and culture, developing shared understandings of ideas, values and principles around mental health.

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) has a well-established PSW employment project with about 30 PSWs in post in a wide variety of mental health service settings. The drive for this innovative work came from members of the board of the Trust being inspired by the work of Gene Johnson, the director of Recovery Innovations of Arizona (RIAZ) in the USA. He has been committed to creating environments that empower people with mental health problems to recover, including providing individual and hospital-based peer support. Members of the Trust board made a trip to RIAZ in 2009 and were told that implementing peer workers would be the most immediate and effective thing they could do to build a recovery focus in the Trust. They appointed a project manager of the Peer Employment Programme in 2009, set up a steering group with clinical leads and people from human resources and occupational health involved from the start, and established their first peer worker training course in May 2010. In this setting, peer workers were recruited to the peer worker training and then, on successful completion of the course, could apply for jobs in a variety of mental health service settings across the Trust. For the purposes of this research, we focused on the peer worker role in two inpatient wards in a

mental health hospital on the outskirts of Cambridge city centre. Here, the peer workers were employed to be part of the multidisciplinary ward staff team.

South West London and St George's Mental Health NHS Trust

South West London and St George's Mental Health NHS Trust (SWLSTG) has a strong reputation for employing people with lived experience of mental health problems in existing roles across the Trust, via its user employment programme. Peer worker posts have been developed as an evolution from earlier, less formal opportunities for work in voluntary or consultancy roles. At the time of the research there were a number of different peer worker roles across the Trust, including six inpatient PSWs based on particular wards, to whom inpatients on those wards had access during their stay; an assistant recovery coach who works, as part of a community mental health team (CMHT), with their own caseload of people who also have separate care co-ordinators; and six peer trainers, working across the Trust's Recovery College sites in partnership with clinician trainers to coproduce day and longer-term courses, which combine elements of recovery and self-management approaches with peer support in an educational rather than therapeutic setting. This case study included the community- and Recovery College-based roles. Peer workers in SWLSTG have lived experience of mental health problems, and are formally recruited and trained to use this experience appropriately and intentionally in the care and support of current service users of the Trust, and in the case of trainers, also in the support of carers and staff. Within the Trust there are also developing partnership peer working projects focusing on specific areas, e.g. peer befriending offered by Canerows and Plaits (a service user-led organisation with a BME focus).

Pathways

Pathways is a day service in West Yorkshire which offers people with mental health problems a variety of meaningful activities in order to build up their confidence and self-esteem, enable them to learn new skills, and increase and develop their strengths and interests. The service supports people to volunteer, go back to work and study at college, and runs activity groups at local sports centres, libraries and community centres. The Pathways centre runs arts groups such as music, pottery, creative writing, digital photography, digital painting and computing. They have two peer worker roles: 'support workers' who are current service users and 'volunteers' who are sometimes, but not always, past service users. The support worker role has gradually evolved over the last 10 years. It grew out of the service wanting to both move people on and enable them to be better prepared for the world of work. It therefore has primarily a developmental function for the support workers themselves, and is seen as a way of increasing their responsibility and developing their skills in a supported way. Pathways is an integrated service between South West Yorkshire Partnership Foundation NHS Trust and Kirklees Council, and staff are employed by one or the other of these organisations. It is a very well established service where relationships have developed over many years, and there is a lot of personal knowledge of people, and attention and care in the service provided.

Southern Health NHS Foundation Trust

This case study focused on a pilot peer support project set up in November 2010 in East Hampshire. The original context for the project was that it was funded by Hampshire County Council and had a personalisation agenda. As time went on, it was increasingly taken over by Southern Health NHS Foundation Trust (SHFT) as the Trust became more involved in the government's Implementing Recovery through Organisational Change programme. Although the project remained funded by Hampshire County Council until its completion in June 2012, the Trust supported the pilot by employing the PSWs on bank contracts. A peer worker project development worker was in post from the end of 2010, and she developed the training package on to which people were then recruited. The training ran from March 2011 until May 2011, and the six successful PSWs started to see referrals in late June 2011. A joint referral process was used, involving both the service user and their care co-ordinator or another health-care professional. The PSWs usually met with their clients once a week, for a period of 6–8 weeks, when they reviewed the work. This case study was marked by change as the direction and the remit of the pilot altered its course midway through. By the end of the research study, the Trust was considering how, and in what form, to take peer working forward in this area.

CAPITAL

CAPITAL Project Trust is a charity run for and by people who use mental health services in West Sussex. They have about 150 members, who meet monthly in three localities and centrally once a quarter. They employ a number of paid staff at their office base and offer volunteering opportunities, training for service users on mental health issues, confidence and assertiveness skills, group advocacy and mutual peer support. They also work to develop mental health services, raise awareness of mental health issues and promote social inclusion. The case study centred on the CAPITAL Inpatient Peer Support Service, which employs PSWs to work on all adult acute wards across three sites in West Sussex, within Sussex Partnership NHS Foundation Trust (SPFT). CAPITAL was commissioned to develop the service as a result of a consultation on reducing inpatient beds, which highlighted the value of peer support and started in January 2011. At the time of the case study, it employed eight PSWs part-time and a bank of relief PSWs, enabling the service to be offered 52 weeks a year, 5 hours a week per ward. PSWs work alongside inpatients independently of, but in liaison with, the ward staff team. The service is a result of close partnership working between CAPITAL and SPFT staff in setting up the service. PSWs have a range of backgrounds, skills and experience to offer through a range of creative, well-being and information groups and open access informal peer support activities on the wards.

Key characteristics of peer worker roles at each case

In the key informant interviews we also established the key characteristics of the peer worker role at each site, detailed in *Tables 2a* and *2b*.

TABLE 2a Key role characteristics 1: organisational context

Case study site	Employer and partners	Population	Setting	Recruitment	Commissioning and funding
EMU	Service user-led voluntary sector organisation with NHS partnership	Adults with mental health problems	Advocacy groups on inpatient wards and activity and social groups in the community	Formal interview process	Funded by PCT, local authority and charitable donations
LSLCS	Survivor-led voluntary sector organisation	Adults with acute mental health problems who are in crisis. Many of the visitors are suicidal and/or self-harm	Dial House (receives people in crisis Friday–Monday nights), nightly Connect telephone service and weekly social and support groups	Formal interview process	Funded by NHS Leeds CCGs, Leeds City Council (Adult Social Care and Public Health), York Partnership Foundation Trust and charitable trust funding
Emergence	Service user-led voluntary sector organisation Community interest company	Adults who identify with the diagnosis of personality disorders, along with their carers/friends if needed for support	Monthly ASN events in cultural venues around central London	Semiformal recruitment process Formal interview process	Originally funded as a pilot by CSIP, now supported internally via Emergence's other workstreams
4Sight	Service user network hosted by voluntary sector organisation (Social Action for Health)	African and Caribbean adults with mental health problems	Social groups and activities in the community	Informal process for original 4Sight members, formal interview process for development workers from Social Action for Health	Social Action for Health

TABLE 2a Key role characteristics 1: organisational context (*continued*)

Case study site	Employer and partners	Population	Setting	Recruitment	Commissioning and funding
Touchstone	A health and well-being charity (company limited by guarantee) The Chinese walking group is affiliated to Walking for Health, a national network of health walk schemes	Adults from the Chinese (walking group and Pacesetters MH awareness training) and Irish (Pacesetters MH awareness training) communities with an interest in maintaining and promoting mental health awareness and well-being	One-off (2-day) MH awareness training courses delivered to the Chinese and Irish Communities in Leeds (these have been delivered in other communities) Ongoing weekly Walking for Health group for people from the Chinese community in Leeds	Informal process; trainers identified by Touchstone community development workers as people with an interest in mental health who were well connected within their own communities Walk leaders recruited from within the group	Original Pacesetters training programme commissioned by Leeds Partnership NHS Foundation Trust (2009); further work now funded internally through community development and service user involvement budgets. Chinese walking group has no external funding
CPFT	NHS trust	People with mental health problems on inpatient wards	Two inpatient wards in a hospital for people with mental health problems	Formal recruitment to the training. People who complete the training then apply for jobs through a formal interview for each specific job	Initial funding from strategic health authority SWIFT innovation funding, which covered the project manager post and development training
SHFT	NHS trust	Adults with mental health problems	One-to-one meetings are held in rooms in local mental health organisations, the local CMHT office and cafés in the community	PSWs were recruited formally to the PSW training	Hampshire County Council funded the pilot
CAPITAL	PSWs are employed by CAPITAL, a peer-led voluntary sector organisation, to work in SPFT	Adults (including older adults) with mental health problems who are inpatients of SPFT	Informal and formal one-to-one and group work in inpatient wards areas and therapy/resource rooms and around three hospital sites	Formal recruitment by CAPITAL either to PSW roles or to a bank of PSW relief staff	Commissioned and funded by NHS West Sussex in response to consultation about inpatient bed loss. Initial 6-month pilot at one site rolled out across all three hospital sites
SWLSTG	NHS trust	Adults with mental health problems seen by CMHT in which assistant recovery coach is based, or attend courses at the Recovery College	A CMHT base, people's own homes and local community, and in groups attending the Recovery College	Formal recruitment process for each post from pool of people who have completed accredited PSW training course	NHS trust health and social care funding. Commissioned by PCTs and local authorities across five London boroughs
Pathways	NHS trust and social care partnership	Adults with mental health problems who are in distress	A day service which runs a variety of activity groups in the main building, e.g. photography, and in the community, e.g. archery, walking	Support workers are identified through staff and their care plans. Volunteers have a more formal recruitment process	South West Yorkshire Partnership Foundation NHS Trust and Kirklees Council

CSIP, Care Services Improvement Partnership; MH, mental health; PCT, primary care trust; SWIFT, Strategic Workforce Investment Fund for Tomorrow.

TABLE 2b Key role characteristics 2: role, support and team

Case study sites	Name of role	Function	Training	Supervision and support	Team and coworkers
EMU	Service user liaison worker/advocacy worker	Provide peer support in monthly activity groups and advocacy on inpatient wards	Ad hoc training on a variety of issues, from health and safety to counselling skills	Regular supervision with line manager	Other peer workers within EMU, non-peer mental health professionals on wards
LSLCS	Crisis support worker, connect support worker and group work support workers	Provide support to visitors and callers in crisis. In Dial House visitors can book a 1-hour one-to-one session with a support worker during their stay	Support staff do a course in the person-centred approach. Ongoing monthly training on issues such as relaxation and attachment theory	Monthly reflective practice groups, regular team meetings, one-to-one supervision and a well-being budget of £145 per person per year	Other support workers within LSLCS
Emergence	ASN stewards	Welcome ASN members at or near the event venue. Role model participation interacting authentically with ASN members	All received mental health first aid training which has not been needed. Ongoing learning through reflection via post event debriefing	Informal peer support through postevent debriefs All stewards have support of line managers as part of wider Emergence roles	Three to four stewards (usually two now) attend each event, drawn from a pool of eight peer and non-peer stewards (less likely to have non-peer stewards); working towards members becoming stewards Event facilitator, organisers and curators at cultural venues/galleries
4Sight	Development workers/project workers/PSWs	Build relationships, provide support and sustain membership of 4Sight network	Informal training of emerging 'leaders' of 4Sight network to facilitate the group	Regular supervision and support from Mellow manager and from project co-ordinator for mental health projects at Social Action for Health	Other 4Sight project workers, and share an office with Social Action for Health workers
Touchstone	Community activists/ cofacilitators (Chinese); community health educators (Irish MH training); walk leaders (Chinese walking group)	Codevelop, promote, deliver and translate MH awareness training for their own community (training roles); plan and lead health walks and related activities	'Train the trainers' training from RECC, MH awareness training. Walk leader training (Walking for Health)	Community development workers provide support to trainers but no 'line management' or 'formal supervision'	Community development workers and team are there as backup during the training and are the first point of contact for walk leaders
CPFT	PSWs	Carry out group work, and one-to-ones with patients on the ward	4- to 5-week accredited training course (developed by RIAZ). Ongoing Trust training once in post	Supervision from ward manager and/or OTs; regular contact with peer employment team project lead. Monthly reflective support forums	Part of ward team including nursing staff, health-care assistants, OTs, administrative staff, consultants and managers

<div align="right">continued</div>

TABLE 2b Key role characteristics 2: role, support and team (*continued*)

Case study sites	Name of role	Function	Training	Supervision and support	Team and coworkers
SWLSTG	Assistant recovery coach (based in CMHT) and peer trainers based in Recovery College Trust also employs inpatient PSWs who were not included in this case study	Recovery coach works one to one on specific goals of people with mental health problems, e.g. transition from inpatient to community or towards discharge Peer trainers cowrite and codeliver training courses on recovery-related topics	Half-day 'What is a peer worker?' course, via which people are formally recruited to the 10- to 12-day PSW training accredited by Sheffield Hallam University and delivered by Nottinghamshire Healthcare NHS Trust. Peer trainers do the 'Train the trainers' course and developing a 'How to tell your story' course	Supervision by CMHT leader/manager or Recovery College manager Access to user employment programme support and support from head of recovery and social inclusion and mentors in the Trust	Part of CMHT (e.g. CPN, social worker, OT, psychologist, psychiatrist) Clinician trainers and other peer trainers at the Recovery College
Pathways	'Support workers' who are current Pathways service users and 'volunteers' who are not	Develop the responsibility and skills of the support worker, support service users in the activity groups and provide backup for staff	Support workers get tailor-made training. Volunteers encouraged to access ongoing council-run training	Staff provide ongoing support to support workers on an informal basis, as individual needs and issues arise	Other support workers and volunteers. Working alongside paid members of staff in activity groups
SHFT	PSWs	Focused one-to-one support for clients involving WRAP, Recovery Star tools and signposting	Specifically designed training course which ran 2 days a week for 6 weeks. Ongoing Trust training available	Monthly supervision with peer support development worker, and in between if more needed. Fortnightly team meetings	Manager and other PSWs. Care co-ordinators of clients who are referred
CAPITAL	PSWs	5 hours peer support per ward per week; (co)facilitating groups (well-being, creative, information access), formal and informal one-to-one support for inpatient peers	CAPITAL and SPFT inductions and ward induction Level 2 peer mentoring training (group facilitation, boundaries, safeguarding, etc.) delivered by local Mind/West Sussex County Council. Accredited by OCN. Ongoing CAPITAL and SPFT training	Fortnightly supervision with one of three CAPITAL locality managers. Separate line management Peer support from other PSWs and informal support from ward and therapy staff	Other PSWs based at their hospital site and across the service PSWs are independent of, but work alongside, ward staff team and check in with them regarding any risk issues each shift Some contact with therapy staff team

CPN, community psychiatric nurse; MH, mental health; OCN, Open College Network; OT, occupational therapist; RECC, Race Equality Culture Competency or Capability; WRAP, Wellness Recovery Action Planning.

Sampling strategy

Participants were the stakeholders to peer worker roles in each case study service under investigation. Previous research (see *Chapter 1*) has indicated that there were different perspectives on the challenges and potential benefits of the peer worker role among people employed as peer workers, the non-peer staff they work alongside, their managers and the people who receive support from peer workers. In addition, the introduction of new commissioning arrangements in the NHS in England suggested that we should explore strategic and commissioning perspectives on the introduction of peer worker roles.

Our sampling strategy was to select sufficient participants to capture variation in perspective across cases, in order to identify and understand emerging patterns in different settings and organisational contexts. A purposive approach is appropriate where variation, rather than representation, is being sought in the data. Two participants were therefore selected from each of the following stakeholder groups at each site: peer workers; service users; (non-peer) coworkers; line managers; and strategic managers and commissioners (i.e. up to 10 participants per case). Roles varied between sites; for example, in some voluntary sector and partnership cases, where the organisation was wholly or largely staffed by people with lived experience of mental health problems, we recruited as non-peer coworkers staff from the local mental health NHS trust who worked alongside the same service users. A strategic manager might be the director of a voluntary sector organisation, or the recovery and social inclusion lead in a mental health NHS trust. In some of our voluntary sector cases – especially in BME-specific settings – peer work was taking place in the context of a network of related projects, rather than a formal organisational structure. In those cases, we identified participants as individuals having a relevant stake in the peer worker role, rather than by their formal job title.

Recruitment process

Potential participants were selected through discussion between a member of the research team and an identified local case lead. This could be the manager of the case study service at the site, or a manager with responsibility for introducing or co-ordinating peer worker roles within the organisation. Once a list had been agreed, potential participants were sent information and invited to discuss the project with the researcher, give informed consent and undertake the interview. It is important to note that in some sites, especially in case studies in peer-led organisations and BME cases, discussions with site leads around identification of potential participants were not straightforward. This was often because the term 'peer worker' was not used in that organisation. In addition, where all or most members of the staff team had lived experience of mental health problems, it was not always clear which individuals occupied a peer worker role or who relevant non-peer colleagues might be. These discussions were relevant to understanding the approach to role development and employing peer workers at those sites and are reflected on in *Chapter 5, Strengths and limitations of the study*.

A total of 89 participants undertook the interview described above (between six and 10 per case), of whom 86 completed both parts of the interview (two service users from BME organisations completed Part 2 of the schedule only as they felt that the language of the structured Part 1 schedule did not reflect their experiences of receiving peer support, as did one staff member on an inpatient ward who was short of time). Key characteristics of the 89 participants who undertook the research interview are illustrated in *Table 3*.

TABLE 3 Key characteristics of the sample

Case	Role							Gender		Age (years)							Ethnicity										
	Case total	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner	Men	Women	18–25	26–35	36–45	46–55	56–65	Over 65	Not known	White British	White Irish	White European	Black African/black Caribbean	Indian	Bangladeshi	Chinese	Asian other	Mixed	Not known
NHS 1	9	2	1	2	1	2	1	4	5	0	2	3	1	3	0	0	9	0	0	0	0	0	0	0	0	0
NHS 2	10	2	1	2	2	2	1	0	10	0	1	6	1	2	0	0	9	0	0	1	0	0	0	0	0	0
NHS 3	7	2	2	1	1	1	0	4	3	1	0	4	1	1	0	0	4	0	0	0	1	1	0	0	1	0
Subtotal	*26*	*6*	*4*	*5*	*4*	*5*	*2*	*8*	*18*	*1*	*3*	*13*	*3*	*6*	*0*	*0*	*22*	*0*	*0*	*1*	*1*	*1*	*0*	*0*	*1*	*0*
Partnership 1	9	2	2	1	2	1	1	4	5	0	1	1	3	1	0	3	3	0	0	0	0	0	0	1	1	3
Partnership 2	10	2	2	2	1	2	1	6	4	0	0	4	2	3	1	0	9	1	0	0	0	0	0	0	0	0
Partnership 3	10	2	2	2	2	1	1	3	7	2	1	2	5	0	0	0	9	0	0	0	0	0	0	1	0	0
Subtotal	*29*	*6*	*6*	*5*	*5*	*4*	*3*	*13*	*16*	*2*	*2*	*7*	*10*	*4*	*1*	*3*	*21*	*1*	*0*	*0*	*0*	*0*	*0*	*2*	*1*	*3*
Voluntary 1	9	3	2	1	1	1	1	3	6	0	1	7	1	0	0	0	7	1	0	0	0	0	0	0	1	0
Voluntary 2	9	2	2	3	1	1	0	2	7	0	2	2	3	0	0	2	4	0	2	0	0	0	0	0	1	2
Voluntary 3 (BME)	6	2	2	0	1	1	0	4	2	0	1	3	2	0	0	0	0	0	0	5	0	0	0	0	1	0
Voluntary 4 (BME)	10	3	2	2	1	1	1	2	8	0	0	3	3	3	1	0	3	2	0	1	0	0	4	0	0	0
Subtotal	*34*	*10*	*8*	*6*	*4*	*4*	*2*	*11*	*23*	*0*	*4*	*15*	*9*	*3*	*1*	*2*	*14*	*3*	*2*	*6*	*0*	*0*	*4*	*0*	*3*	*2*
Total	**89**	**22**	**18**	**16**	**13**	**13**	**7**	**32**	**57**	**3**	**9**	**35**	**22**	**13**	**2**	**5**	**57**	**4**	**2**	**7**	**1**	**2**	**4**	**2**	**5**	**5**

Developing the interview schedule

This study used an interview schedule with structured questions in the first part that would allow systematic comparisons across cases, and open-ended questions in the second part to collect rich qualitative data that would enable us to develop applied research outputs.

Part 1: structured questions

The development of the structured interview schedule was an iterative process undertaken in several phases of design, review and revision. An initial set of items to be covered was derived from the existing knowledge base as outlined in the conceptual framework (including the research team's previous research). Questions were revised following discussion by both the wider research team and the steering group to check language and coverage of relevant items. For example, an organisational researcher in the research team suggested that a question about access to trade union representation should be included. A steering group member representing an organisation specialising in BME user-led perspectives in mental health research suggested that the language and concepts used might not be relevant to BME participants, and that without explicit questions diversity issues might be overlooked. A separate Part 1 section and Part 2 question on diversity were therefore added.

Items were organised into five domains that reflected the areas of the conceptual framework (some domains combined two areas of the framework) with an additional peer workers and diversity domain. Two questions referring to each item were designed to establish participants' views on what was happening in practice at each case, and the value that different stakeholders might attribute to each item:

(a) Is this happening here? (Yes, partly, no, don't know, not relevant.)
(b) How important is this to you? (Extremely important, quite important, not very important, not at all important, don't know, not relevant.)

In addition, participants were asked to identify three items that they thought were the most important issues in the introduction of new peer worker roles and to explain why they had chosen these. The schedule was tested in a small number of pilot interviews in the first case, and further refinements to item wording and layout were made to aid understanding and completion of the interview. The final version of the structured component of the interview is included as *Appendix 1*.

Part 2: open-ended questions

From our previous experience of using structured interview schedules, we were aware that some participants articulated the reason for their response as they completed the interview, and that this process can produce good qualitative data. We included a second part of the interview with open-ended questions to ensure that we elicited qualitative data from across the conceptual framework in all interviews. We produced, piloted and refined sets of open-ended questions that were relevant to each stakeholder group (e.g. peer workers, service users, managers). Research team and steering group members reviewed the interview schedules, focusing on the schedules designed for people working from their particular perspective; for example, clinicians and managers reviewed the staff and manager questionnaires. In addition, concluding open questions were added eliciting participants' views on what would constitute 'successful' introduction of peer worker roles and the 'essence' of the peer worker role. Schedules can be found in *Appendix 6*.

Conducting the interviews

The large majority of interviews were conducted by the two service user researchers. Participants were made aware that the researchers were working from the perspective of lived experience of mental health problems themselves. We reflect on the impact of this in the discussion (see *Chapter 5*, *Coproduction and research*).

In general, interviews followed the format of the schedule, with participants first completing the structured Part 1 before answering Part 2 open-ended questions. Interviewers gave the participants the option to 'think aloud' as they were completing the Part 1 questionnaire to ensure that their answers were understood in context by the research team. In this way, many participants explored the meaning of items in Part 1 and verbalised the reasoning behind their answers. The whole interview was digitally recorded to capture and systematically analyse this reasoning.

Researchers were flexible in the questions they asked from Part 2 of the schedule, and focused on asking Part 2 questions in domains highlighted as important in completing Part 1 but not yet explored in depth. In three interviews, participants did not complete Part 1 of the schedule because of time restrictions or because researcher and participant agreed that they would not be able to relate the schedule meaningfully to their experiences of the peer worker role. In those instances the whole of Part 2 was completed in depth. In a few other instances, participants gave such full explanations of their responses to the structured Part 1 interview that the Part 2 schedule was used only to elicit concluding comments.

In pilot interviews it was apparent that the language used or concepts explored in Part 1 were not relevant to all participants' experiences of the peer worker role. Researchers were at all times mindful of the work that they had undertaken in setting up the case studies to ensure that the interview schedule was appropriately contextualised. We decided that each interview would commence with a short discussion clarifying the participant's understanding of the peer worker role in the context of that case study. This allowed participants' definitions and language use around peer worker roles and settings to be used to contextualise Part 1 items and follow-up questions asked in Part 2 of the schedule. This was especially important in settings where the term 'peer worker' was not used, i.e. in BME cases, one of the peer-led voluntary sector cases and one of the partnership cases. Where English was not the participant's first language, the need for translation was explored, and in its absence items were put across in simpler terms. This opening to the interview was also productive of further data about the peer worker role in each case.

Researchers also made it clear to participants that they were not expected to know about every issue and that we were interested in how participants understood, experienced and described the peer worker in *their* organisation. Researchers stressed that the interview was not 'evaluating' peer work against a standard (i.e. the interview schedule was not a checklist of good practice 'scoring' the introduction of the peer worker roles). Participants were informed that they could and should use the 'don't know' and 'not relevant' answers on the Part 1 schedule where they were not sure, or felt that items did not apply to them or the setting they were familiar with.

The analysis process

A composite approach was taken to data analysis, reflecting the different types of data collected and the need to address project aims (see *Chapter 1*, *Aims*). The first aim was to test the existing evidence base for the introduction of peer worker roles in a range of mental health service settings. We analysed our structured Part 1 data using simple, descriptive statistical comparisons, enabling us to look for different patterns of role adoption in different (organisational) contexts. These patterns were then illustrated using qualitative interview data to elucidate meaning and give context to emerging patterns. This analysis is presented in *Chapter 3*.

The second aim was to develop learning for mental health service organisations on introducing peer worker roles. We analysed our in-depth qualitative data using a complementary thematic and framework analysis approach.[70] These processes are described in detail below. This more in-depth analysis of the data, and the organisational learning that arises from it, is presented and discussed in *Chapter 4*.

Analysing structured qualitative data

Responses to (a) questions about each item – *Is this happening here?* – were analysed as simple percentages of total number of respondents in each category. Responses to (b) questions – *How important is this to you?* – were analysed as a mean score on a scale of 1–4. Frequencies of selection of 'top 3' items were quantified. To identify any variation in response we compared responses between groups of participants as follows:

1. employer: NHS cases; voluntary sector cases
2. organisational context: NHS cases only; voluntary sector cases only; partnership cases
3. service setting: two inpatient cases; two community cases; two BME-specific cases
4. stakeholder group: peer workers; service users; non-peer staff; line managers; strategic managers; commissioners.

Examples of this output are given below (see *Synthesising structured and in-depth qualitative data*). The full analysis can be found in *Appendix 4*.

We were also interested in comparing role adoption patterns in peer-led and non-peer-led services (whether these were in the NHS or voluntary sector). Some of our voluntary sector organisations – the organisations that hosted the BME cases – were not peer led. However, the project work we investigated in those cases was peer led in a meaningful sense, and so a comparison of non-peer and peer-led cases would not be different from a comparison of NHS and voluntary sector cases. This limitation in the research is discussed in *Chapter 5*, *Strengths and limitations of the study*.

Analysing in-depth qualitative data

In-depth qualitative interview data were analysed using a complementary thematic and framework analysis approach[70] to produce an analytical framework that organised data into categories. Analysis proceeded in a number of iterative cycles as follows:

1. preliminary analysis of sections from a subsample of interview transcripts – chosen to ensure coverage of the whole schedule from a range of stakeholder perspectives – undertaken by the two service user researchers using standard coding tools of inductive, qualitative enquiry[71]
2. development of a provisional analytical framework by the core research team (service user researchers and first author) comprising a number of categories, each with a label and brief description of category content
3. presentation of the provisional framework (category labels, description of category content and example quotations) for discussion by the wider research term, in order that the multiple perspectives of the team informed development of the analytical framework
4. revision of the framework by the core research team, amending category labels and content, collapsing or subdividing categories and creating new categories on the basis of the wider team discussion.

This whole cycle was completed in full twice, the first time based on a preliminary analysis of interview transcripts from cases where peer workers were employed in the voluntary sector, and the second cycle incorporating data from cases where peer workers were employed in the NHS. A third, partial cycle was completed by the core research team only, incorporating data from BME cases. With each cycle, categories were refined and new categories added to accommodate data that did not fit the existing framework.

Stage 5 of the process involved uploading all interview transcripts into an NVivo qualitative analysis software database, creating a set of *nodes* that corresponded to our analytical categories, and coding the entire data set to the analytical framework. Descriptors of category content were further refined as necessary as we coded data. The process is illustrated in *Figure 2*.
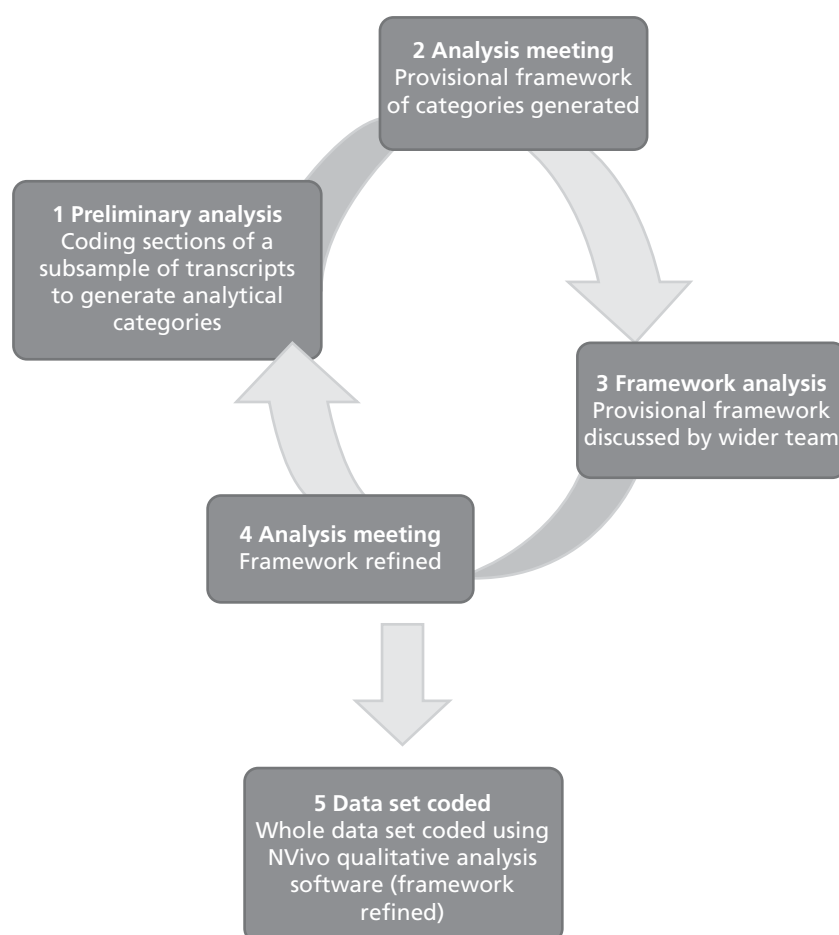
FIGURE 2 Developing the analytical framework.

The analytical framework

The analysis process described above produced a final analytical framework that comprised 65 categories. The framework evolved through the iterations of the analysis cycle; the first version of the framework comprised 34 categories that each fitted into one of the six domains of the Part 1 interview schedule, plus an additional domain that contained a number of categories capturing participants' answers to interview questions about their views on the 'success and essence' of peer worker roles (see *Appendix 2*).

As we analysed data from a wider range of interviews, shared our analysis with the whole research team and began to code the full data set, new categories were added reflecting the insight brought by the wider team. Some of those categories fitted into a single domain from the Part 1 interview schedule, while others cut across domains. We also added new 'inductive' categories that did not correspond to any particular domain. We added colours to the framework to identify some of those relationships across domains. As such, the framework became less rigid. These coloured links began to inform the emerging themes discussed in *Chapter 4*. The final framework is illustrated in *Figure 3*. A table detailing the title and content of each theme can be found in *Appendix 3*. We used this table when we were working with the NVivo software to help us code the transcripts to the analytical framework.

Synthesising structured and in-depth qualitative data

The primary aim of this study was to test the existing, provisional evidence base indicating facilitators of, and barriers to, the successful introduction of peer worker roles in a range of mental health services in England. The structured data from Part 1 of the interview was indicative of patterns emerging in the way peer worker roles were introduced, structured and supported in different settings and organisational
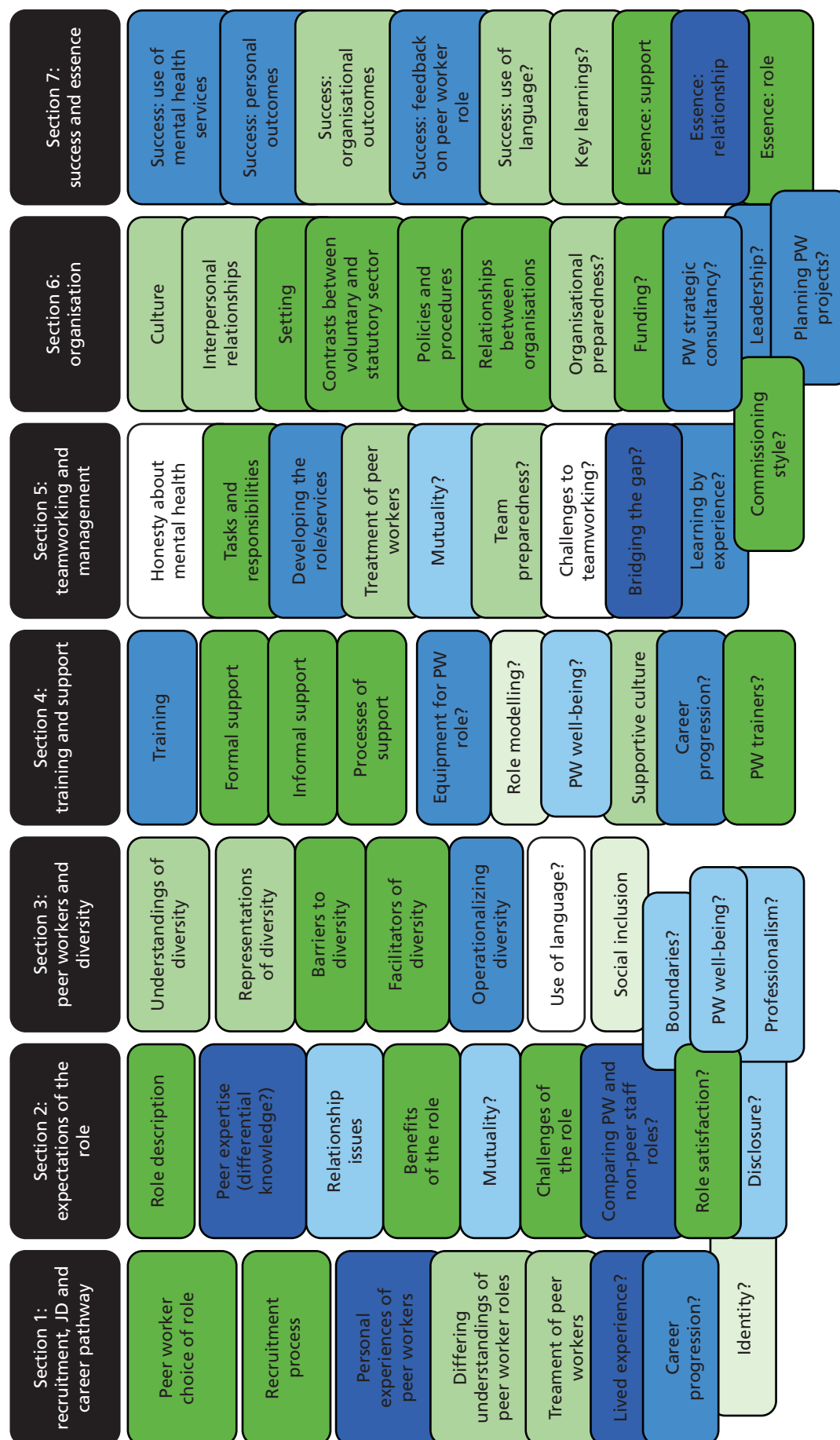
FIGURE 3 Final analytical framework. JD, job description; PW, peer worker.

contexts, and how important different stakeholders thought those issues were. Tables detailing output from this analysis are given in *Appendix 4*.

It is important to note that this analysis of Part 1 data is an element of the qualitative, pattern-matching approach, and not a statistical analysis. This study uses a purposive, rather than a cross-sectional or random, approach to sampling and so it would be inappropriate to interpret that analysis as representative or statistically meaningful (e.g. to infer that peer workers were proportionally more likely to be recruited formally in one setting than another, or to explore the significance between different stakeholder groups' importance ratings).

Instead, our intention was to use evidence of patterns emerging in the structured data to direct our qualitative enquiry, and mine our qualitative database for in-depth data that illustrated those patterns. As such, we were interested where the proposed pattern of introducing peer worker roles implicit in our conceptual framework was replicated in the structured data across our cases.[66] We were also interested where the pattern was not observable in our data, and especially where alternative patterns were indicated in the data (e.g. in our NHS-only cases, or our voluntary sector-only cases).

We undertook this synthesis in a number of stages (see analysis protocol in *Appendix 5*):

1. Based on the analysis of structured data, we identified individual items from the Part 1 schedule, or groups of items within a particular domain, which either confirmed our proposed pattern or were suggestive of alternative patterns.
2. We identified the categories from our analytical framework that were relevant to the particular item we were considering.
3. We identified the organisational contexts, service settings or stakeholder groups we wanted to compare to explore emerging patterns.
4. We used the *matrix query* function in NVivo to generate reports that organised data from those categories by comparison groups we were interested in.
5. Where the pattern suggested by the structured data was also evident in the qualitative data (this approach has been referred to as 'triangulation by method'[67]), one researcher drafted a descriptive analytical narrative around exemplar quotes from relevant interview transcripts.
6. The analysis was then checked and revised by another member of the team; for example, alternative quotes were used where these better illustrated a comparison.

The following outlines an example of this process.

Both the emerging literature on peer worker roles and the generic organisational literature on new role adoption suggest that shared understanding of the new role is an important facilitator of role adoption. Question 2.1 on our structured schedule addressed this issue.

Analysis of structured data for this question (*Tables 4* and *5*; see also *Figure 4* and *Table 6*) revealed that the issue was considered to be important across cases and stakeholder groups.

However, our data suggested that this shared understanding was less likely to be in place in cases where peer workers were employed in the NHS (compared with cases where the voluntary sector was the employer) (*Figure 4*).

We also looked at 'top 3' issue choices and found that *shared understanding* seemed more likely to be selected by peer workers and their line managers than other stakeholders (*Table 6*).

This analysis of our structured data confirmed that the issue of shared understanding was important across mental health services in England – reflecting the pattern we were testing – but suggested that shared

TABLE 4 Expectations of the role: comparison by employer

| | Employer | |
Question	Voluntary	Statutory
2.1 There is a shared understanding of the role of peer workers in the organisation	3.5	3.9
2.2 The peer worker role is clearly different to other roles in the organisation	3.0	3.4
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.5	3.8
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	2.9	3.1
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.8	3.7
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.3	3.4
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.0	3.4
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.6	3.4

TABLE 5 Expectations of the role: comparison by stakeholder group

| | Stakeholder group | | | | | |
Question	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
2.1 There is a shared understanding of the role of peer workers in the organisation	3.5	3.3	3.9	3.8	3.8	4.0
2.2 The peer worker role is clearly different to other roles in the organisation	3.0	3.2	3.2	3.2	3.2	3.9
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.6	3.1	3.7	3.9	3.8	3.7
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	3.0	3.1	2.9	2.8	3.3	3.0
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.5	3.7	3.8	3.9	3.9	4.0
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.3	3.1	3.3	3.4	3.6	3.6
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.0	3.2	3.1	3.4	3.3	3.2
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.5	3.5	3.6	3.5	3.4	3.2

FIGURE 4 Expectations of the role: comparison by employer. For each pair of bars, the first relates to the voluntary sector respondents, the second to the NHS respondents.

TABLE 6 'Top 3' items: frequency compared by stakeholder group

Question	Stakeholder					
	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
2.1 There is a shared understanding of the role of peer workers in the organisation	5	0	2	5	1	3
2.2 The peer worker role is clearly different to other roles in the organisation	0	0	3	1	2	0
2.3 Peer workers are expected to be as professional as any other worker in the organisation	4	2	1	3	0	0
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	2	0	0	2	0	0
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	2	1	7	1	2	1
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	1	1	2	0	0	0
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	1	2	0	0	0	0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	2	2	2	1	0	1

understandings might not be in place across organisational contexts. The data also suggested that shared understanding might be particularly important for some stakeholders.

We used the *matrix query* function of NVivo qualitative analysis software to generate a report that compared all data coded to the category *Differing understandings of the peer worker role* in data sources (interview transcripts) from cases where peer workers were employed in the NHS with those from cases where peer workers were employed in the voluntary sector.

We also generated a report that captured data coded to the same category, but just from transcripts of interviews with peer workers and their managers.

We studied those reports and, as the in-depth qualitative data seemed to reflect the structured data, we explored this issue further. We selected illustrative quotes and wrote a brief analytical narrative around those quotes. This is presented in *Chapter 3, Peer workers and lived experience*.

We repeated this process systematically across the whole structured interview schedule. This analysis is presented in *Chapter 3*.

Developing organisational learning

To develop organisational learning from our cases (our second aim) we conducted a more in-depth analysis of the data set that would draw out and illustrate the main organisational barriers to, and facilitators of, role adoption, both generic and context specific. This in-depth analysis involved moving beyond the categorical organisation of data described above to identify explanatory themes that cut across categories and began to theorise the processes under investigation.[72] As described above (see *The analytical framework*), as we carried out our iterative coding process we began to group categories together into a number of superordinate themes that offered possible explanations of peer worker role adoption processes.

This analysis was informed to a large extent by the service user researchers' wider insight into each case, gained while setting up cases and carrying out key informant and research interviews. We sought a wider validity to this emerging, in-depth analysis by carrying out two feedback workshops with the organisations involved in the case studies.

Feedback workshops

Feedback workshops attended by a broad group of relevant stakeholders have been shown to enable understanding of the wider validity and relevance of emerging findings.[68] All study participants were invited to one of two feedback workshops, one held in London and one in Huddersfield, south-west Yorkshire (enabling access for south and north of England sites respectively). We also asked case study site leads to circulate invitations to other people involved in the development and employment of peer workers in their organisation. A total of 35 participants attended the two workshops, from 12 different organisations, including seven of our case study organisations. Participants included peer workers, their coworkers and managers, organisational leads for peer working and one commissioner.

We presented eight emerging superordinate themes to workshop participants together with exemplar data (*Table 7* presents the themes; exemplar data can be found in *Appendix 8*), and answered questions from participants to clarify content and understanding of the themes. Groups of four to six participants were then asked to rank in order of importance a set of statements, one derived from each theme. Statements described 'things that need to be done to make sure that the peer worker role works well'. Each group was also able to nominate up to three additional statements and include those in the ranking.

Groups were asked to discuss their ranking decisions. A member of the research team joined each group to facilitate and make notes about discussions, and to report each group's ranking and discussion back to the whole workshop. Finally, the whole workshop discussed the relevance and prioritisation of our themes, and identified any further issues we might consider in our analysis.

TABLE 7 Emerging themes as presented to the feedback workshops

Theme	Content
Organisational structure	Recruitment; terms and conditions; job description; new team structures; new organisational partnerships
Supportive culture	Shared expectations (across team); mutuality; supportive management; disclosure; professionalism
'Peerness' and diversity	Sameness and difference
The language of peer support	Speaking the same language; peer worker or peer support?
The essence of the peer worker role	Differential knowledge; enabling/bridging/engaging; role modelling; being a team player
Support for the peer worker	Supervision; training; team support
Changing conversations	Within teams; thinking about language
Challenging boundaries	Peer worker–service user; conforming to boundaries; different boundaries

Feedback from both workshops broadly concurred that the eight themes we had identified did reflect participants' experiences of key issues that impacted on adoption of the peer worker roles. Most groups of participants at each workshop engaged with the task of ranking the themes in order of importance, although some groups decided to prioritise a smaller group of themes by placing them at the centre of a constellation of themes.

There was a broad consensus that two of the themes were most crucial for the peer worker role to be successfully introduced: developing a supportive organisational culture, and agreeing the essential elements of the peer worker role. Participants could not always agree which of these 'needed to be got right first', but there was strong agreement that work needed to be done to develop a supportive organisational culture before a new peer worker role was introduced. Although supportive organisational structures were necessary, most participants felt that this was a secondary challenge to the (organisational) cultural issues associated with introducing peer worker roles.

Participants made use of the opportunity to propose additional themes and placed them in their hierarchies or constellations of themes. A number of key issues emerged through this process which were all evident in our data, but which we had not prioritised, or identified as crucial, in our provisional set of themes:

1. The issue of resources and value was raised by a number of the groups at both workshops. It was suggested that though the introduction of new peer worker roles was constrained by the availability of resources, opportunities for development were created where a combined case of value for money and added value to the service was made (i.e. where the rationale for introducing peer worker roles appealed to the values of commissioners and strategic managers).
2. Two groups at the south of England workshop stressed that the need for a supportive culture was not just about enabling peer workers to fulfil their role, but also ensuring that peer workers' well-being was maintained (participants felt that this issue should not be neglected in the analysis).
3. The issue of risk was discussed in some depth at our north of England workshop. A view was strongly expressed that the introduction of peer workers offered new approaches and possibilities for managing risk, rather than just presenting managers with an additional risk to manage.
4. In the final discussion in the north of England workshop, there was agreement that caution needed to be taken to ensure that neither the introduction of formal structures to support the peer worker role, nor adopting a professional approach to the role, should undermine flexibility and responsiveness in the relationship with service users that characterised the role (notwithstanding that peer workers in peer-led organisations felt that they were working as professionals).

Examples of outputs from the feedback workshops are given in *Appendix 8*. Following the feedback workshops we adapted the content and arrangement of our themes. A final set of seven themes exploring the barriers to, and facilitators of, introducing new peer worker roles in mental health services in England is discussed in *Chapter 4*.

Changes to protocol

The only change made to protocol was a reduction in the number of cases from 12, as originally planned, to 10. This decision was partly pragmatic and partly methodological. In undertaking earlier cases, we found that a great deal more preparatory work was necessary in each case than anticipated. However, that preparatory work was also productive of important data about the peer worker role and organisational context within each case. Further, as early cases progressed, it was apparent that a commissioner should be interviewed in each case to explore the introduction of new peer worker roles from an overarching strategic perspective. Additional key informant and commissioner interviews at each site placed demand on our research resources. Thus, two cases where development of the peer worker role was at an early stage, and where there was little experience to draw on, were dropped with the approval of our steering group and the funder, enabling us to build up a more comprehensive data set around our 10 remaining cases.

Chapter 3　Peer worker roles in mental health services in England

This chapter reports our descriptive analysis of the data, reflecting on our framework for the introduction of peer worker roles (see *Chapter 1*, *Conceptual framework*), and identifying and describing patterns in the introduction of peer worker roles in different organisational contexts. We use the structured part of the interview schedule to organise this analysis, following the process described in *Chapter 2* (see *Synthesising structured and in-depth qualitative data*). We repeat that process item by item for each section of the interview schedule, reporting data below where the in-depth qualitative data further support the comparisons made in the structured data. We illustrate this descriptive analysis using quotes from interview transcripts.

Including all the output from the analysis of structured data here would not aid the readability of the report. The complete output can be found in *Appendix 4*. In the text below, we reference the figures and tables in *Appendix 4* that inform the descriptive analysis (e.g. *Figure 6*; *Table 8*). This chapter should be read alongside *Appendix 4* for an understanding of how the structured data were used to inform our pattern-matching approach, and the comparisons made between different organisational contexts and stakeholder perspectives.

We have endeavoured to anonymise all direct quotations by using participant identifiers, by replacing idiosyncratic terms with generic alternatives (see *Chapter 1*, *A definition of terms*) and by removing other references to people, places and events that might inadvertently identify participants. Participant identifiers all comprise three letters, the first signifying the type of case, and the following two the role. NHS cases are labelled 'N', partnership cases 'P' and voluntary sector cases 'V'. Roles are identified as follows: PW, peer worker; SU, service user; ST, (non-peer) staff member or coworker; MA, line manager; SM, strategic manager; and CO, commissioner.

Recruitment, job description and career pathway

Formal recruitment processes

Formal recruitment processes were widely in place – or at least partly in place – across cases (see *Appendix 4*, *Figure 6*). In the NHS, managers described recruiting peer workers as a similar process to that used to recruit all other staff:

> So we were interviewing people to come on the training. So we asked, that recruitment process was done very much like we would recruit staff, really . . . We had a series of interview questions which we tried to really ascertain a number of different things from what their motivations were to be a peer worker, what was their experience of mental health, how candidly would they talk to us about that? We gave them a few almost in-practice scenarios; what would you do if this happened? Just to kind of test their awareness around boundaries and risk management.
>
> *NSM*

Alternatively, this staff member from a voluntary sector case described how informal recruitment processes were more effective:

> Sometimes a whole formal recruitment process, you can recruit people that might not necessarily be that suitable. I think sometimes when you're being – I work very much with instinct. I think when you're working with instinct, personally, I think it's better . . . at this stage it's important because

essentially I suppose it's still kind of a long-term pilot project so we're still feeling our way through, and feeling with the people, I guess. Listening with our hearts.

VST

A number of voluntary sector and partnership projects recruited from people using the service, in part as a developmental or vocational opportunity for service users who were seen as ready to take on responsibility for activities offered within the service:

I suppose our situation is a bit different because we're not like an NHS Trust recruiting peer workers and that being outside what we normally do. And all our posts are recruited to internally first, so that's to help people progress through the organisation and to progress from employment and volunteering into paid work.

VSM

Peer workers and lived experience

The importance of peer workers having lived experience of the same, or similar services to those they are working in was the second most frequently identified 'top 3' issue, with more than two-thirds of participants who identified this issue being either peer workers or service users (see *Appendix 4*, *Table 35*). A service user from a community setting explains how peer workers having lived experience enables them to have empathetic understanding towards service users:

I would miss that empathic relationship . . . I think that that is at the end of the day the most important thing to know that people who have struggled, may still be struggling, and they continue to struggle, and yet despite those difficulties, are able to . . . fulfil their role extremely successfully.

VSU

The issue was slightly less likely to be identified as important in BME cases (see *Appendix 4*, *Table 20*). A peer worker from a BME setting described the importance of interpersonal skills, as well as having lived experience, when providing peer support:

There's something about peer support that is almost like a, you've got to want to do it, almost. It's not something that you can be trained to do. It's not something that you can learn to come to enjoy. It's got to be in you. So, even, just having a mental health experience doesn't qualify you. And I think even all the training in the world, if they can give you all the training, all the skills, but if it's not in you then it won't help . . . I think the greatest thing that's in you is real empathy and a desire to want to make a difference. That's what it . . . a desire to want to help and make a difference . . . And share. Use what you have been through, share what you have been through, what's worked for you, what hasn't worked for you, to help make a difference for someone else.

VPW

The issue of whether or not lived experience was sufficient to qualify someone for a peer worker post was often rated as a 'top 3' item, although less so in the NHS (see *Appendix 4*, *Table 33*), where participants qualified this by stating that though having lived experience was important, peer workers also needed to be able to maintain professionalism (see also *Formal one-to-one line management for peer workers*, below):

I think there needs to be a credibility around peer support work and I think that links again back to that and therefore having had experience of mental health issues is not enough. Actually people need to have skills and capabilities . . . beyond the lived experience and they might be very similar, similar aspects, similar features to what one would be selecting in professionally qualified people. So some sort of, you know, it's tough work. Some sort of robustness, some ability to separate oneself and one's own emotion state out from the work. All the sorts of things you might look for in selecting

anybody, really. But the main thing, of course, would be the training. It's not just for anybody who's had an episode of mental health problems can then become a peer worker.

NSM

Elsewhere, having good self-management skills and coping strategies were recognised as important qualities:

. . . it doesn't really tell you in your job description that you'll, like, go home feeling a bit crap . . . I'm not sure what kind of skills you would call that exactly being able to be detached and have good coping strategies in place already . . . to deal with certain, like, bad energy, if you want to put it that way, because you kind of need to be almost like an energy dynamo, converting negative energy into positive energy, in a weird way.

PPW

Clarity of job description

Clarity of job description for peer workers was rated as important by all stakeholders (see *Appendix 4*, *Table 26*). Job descriptions were slightly more likely to be in place in NHS cases (compared with partnership or voluntary sector cases; see *Appendix 4*, *Figure 6*), although clarity was sometimes reported as having been achieved through trial and error as the role evolved:

When peer workers started in the organisation we had a very generic job description. Now, what's happened is the role looks very different, whether it's in a community or in inpatient settings. So again we're tweaking some of those job descriptions, to make sure that it's more applicable to the area of work . . . Part of me thinks in hindsight it would have been better to be more prescriptive about the roles earlier on . . .

NSM

Equal pay for similar work

The importance of peer workers receiving equal pay for work similar to that done by others was often identified as a 'top 3' item (see *Appendix 4*, *Table 32*), and was rated as important by all stakeholders (see *Appendix 4*, *Table 26*). A strategic manager from an inpatient NHS site explained why pay parity was important where peer workers had similar levels of responsibility to other staff:

They're banded according to Agenda for Change, which is about the level of responsibility, I suppose, so in that sense I guess they're paid the same as someone else carrying a similar level of responsibility but in a different job. That's how Agenda for Change is supposed to work . . . it's the big NHS pay and conditions, it's the framework for that . . . Before that time, the different disciplines, different professional groups in the NHS all had rather separate pay scales and arrangements. So in that sense, probably, it's the same banding as other kinds of support workers, [support, time and recovery] workers. They would be on band [X], so, yeah, I think the answer to that is yes, really. They're paid the same as other people who are not professionally qualified but who have clinical work to do. And, of course, it's important that there is equity, yes.

NSM

No participants indicated that equal pay for similar work was currently in place in community settings (see *Appendix 4*, *Figure 18*), with very little equal pay reported in partnership cases (see *Appendix 4*, *Figure 12*). Equal pay was rated as less important in these contexts (see *Appendix 4*, *Tables 14* and *20*). An NHS

manager in a community setting described how equal pay for peer workers was difficult where the initiative was not fully established:

'Are peers paid the same as other people in an equivalent role?' Well, with our budget and a small pilot we haven't been able to pay people a really good wage but, yeah, I think you definitely have to ensure that's in place in the future. But I think all of that's going to take a bit of time.

NMA

In one of our partnership cases, where peer workers were employed as volunteers, participants explained that it had been difficult to organise payment for peer workers because of the impact on welfare benefits they received:

The pay thing. Well, obviously because . . . Um, they're on benefits. They can't get paid and it's very – there's some resistance in organisations to actually give people permanent employment. You know, which is not a good thing. We've tried it twice here and it's failed twice. But it doesn't mean you should stop trying.

PST

Access to trade union representation

Access to trade union representation was seen as important across stakeholders (see *Appendix 4*, *Table 26*) and contexts (see *Appendix 4*, *Table 14*). Actual access was reported as better (but still limited) where peer workers were employed in the NHS compared with the voluntary sector (see *Appendix 4*, *Figure 6*), where union membership was not always thought to be relevant. Access was worst in partnership cases and community settings (see *Appendix 4*, *Figure 12*):

Normally I would have thought peer workers were in charities and is there a need for a trade union in a charity? Because, really, charities are governed by the funding they receive, so if anyone had a grievance against the charity, if they were a member of a trade union it wouldn't really be the charity they would have the dialogue with it would be the funders, and, really, you still haven't got a leg to stand on with funders. So I'm not sure about that . . .

PPW

Opportunities for promotion

Opportunities for promotion for peer workers were rated as highly important by all stakeholders (see *Appendix 4*, *Table 26*), in all contexts (see *Appendix 4*, *Table 14*). Peer workers employed in the voluntary sector were reported to have much more access to promotion than those employed in the NHS, although in a number of our cases this specifically referred to a progression route from using the service, to working as a volunteer and then into a paid role as part of a clear developmental process:

. . . right from the onset, even if we have somebody that comes in to our service, we can say to them, you can get involved in your own support, from being in our service, but then you can also go on to be . . . part of the service user involvement team . . . When you move on from that you can become a volunteer. If you don't want to become a volunteer you can actually go on to paid work and be a peer worker. So you're giving . . . you're establishing that hope from the onset, that actually you can recover and here's an example because we've got people that are already doing it, and I think that just . . . it just encapsulates what all mental health services should look like.

VST

For an individual, I'd like to see them grow in confidence through the training and then become a successful [peer worker], evidenced by our observations of them supporting other people, of them dealing with difficult situations well, of them telling us that they're enjoying being a [peer worker]. And of them in the longer term, medium to longer term, being discharged from [the organisation] into

a voluntary role or a paid role or returning to college or just engaging in society and have a fuller life because of – partly because of what they've done as a support worker.

<div align="right">

PSM

</div>

It was suggested that although the NHS Agenda for Change framework promoted equal pay for peer workers employed in the NHS sector (see *Equal pay for similar work*, above), it did, however, also restrict peer workers' opportunities for promotion:

I probably wanted the peer workers to be paid on a higher band. In terms of Agenda for Change I wanted them to be, and wrote the job description, for them to be paid on a band [X]. Agenda for Change came back and said that they were on a band [Y]. Um, support roles within the NHS are a band 2 to 4 . . . 'There are opportunities for promotion of peer workers in the organisation.' Yes, although that is quite limited. What we've introduced, which is quite good in the role, we've just talked about a band [Y]. We've introduced a band [X] peer worker, which is quite unusual.

<div align="right">

NSM

</div>

Expectations of the role

Shared understanding of the peer worker role

Shared understanding of the peer worker role was more widespread where peer workers were employed in the voluntary sector than in the statutory sector (see *Appendix 4*, *Figure 7*). This was perhaps a reflection of role development being more mature and better established in many of our cases where a voluntary sector agency was the employer (including our partnership cases). The need for a shared understanding was frequently selected as a 'top 3' issue, primarily by peer workers and their line managers (see *Appendix 4*, *Table 35*):

I mean, in the beginning it was a nightmare because I didn't know what I was doing, what I could do and what I couldn't do. Um, so I was – I think in the beginning people were just telling me, 'Could you do this? Could you do that?' And I'd just be doing it. You know, and I felt, 'This is not what I came here to do.' This is not what I wanted to do and what my purpose was to come here.

<div align="right">

NPW

</div>

. . . we'll be overlapping. I'll be doing your job. You're doing my job. It isn't good for the [service users]. It isn't good for the organisation. The time is being wasted. The person will get confused and the person that was supposed to be helping might have a double – how do you call it – a double-edged sword that they do not know which one to believe. 'She said this to me. He said this to me. Which one's true?' To avoid confusion, we need to have . . . We must be focused for one issue or whatever issues we are talking about.

<div align="right">

PMA

</div>

In the NHS, managers highlighted different understandings within the team about what the role entailed:

I'm not convinced at the moment that there is [shared understanding]. I think different people see the role, you know, in completely different ways. You'd think we were talking about two different job descriptions. So there needs to be clarity and clarity about expectation and how it benefits the service user [and] the team. Once you've got that, once there's consensus, then I think it will work much more effectively.

<div align="right">

NMA

</div>

There was a sense that although shared understanding could evolve as an initiative progressed, a lack of shared understanding might underlie tensions at the outset:

> *. . . it was just the sort of vibes you'd get off some staff. I think some staff thought that you weren't really doing a proper job . . . Like, you know, you're just sort of there to have a chit chat, a chin wag with a cup of tea and they thought that you were just dossing about. Getting paid to doss about, sort of thing. So I think there was that sort of hostility, where they sort of looked at you and thought, 'Well, what are you doing?' But I think they understood it a bit better sort of a few months into it. I think it got better.*
>
> *PPW*

The need for shared understanding of the peer worker as a formal role was seen as less important in BME settings (see *Appendix 4*, *Table 21*), where in-depth data suggested that informal forms of peer support were more highly valued:

> *. . . the issue of peer support came up and some people were saying, 'But that's like, that's what – we need professionals to support us. We don't need each other.' The idea that, you know, a peer is someone that could offer some support was really – it seemed alien to this person. They were just like, 'Well, what do you mean? What is this thing?' You know. And I think through others talking at that meeting that this person began to see, 'Oh, okay, that's what you mean . . . But I didn't know it was called that.' [To them] It was friendship. It was just, you know, you've got someone's back . . . Yeah, so there is work to be done around encouraging or explaining or offering our members examples of where peer support has helped someone because not everyone knows that or is convinced by it or thinks that, 'Actually, that's what paid professionals are supposed to do so why are we doing it? Because we're ill. So we won't know how to support people.'*
>
> *VSM*

Distinctiveness of the peer worker role

The peer worker role was identified as more distinctive – compared with other roles that peer workers worked alongside – in partnership cases than in NHS and voluntary sector cases (see *Appendix 4*, *Figure 13*), perhaps because the peer worker might be working to a different set of organisational policies and procedures than their coworkers. A staff member in a partnership case described how different the peer worker role was from his own role:

> *So they've [peer workers] got a chance for working more closely with somebody. Whereas we don't have time to actually . . . When I run a . . . group I might have eight or nine people in. I couldn't devote the full session to each individual otherwise it would have to be eight sessions . . . So I get [peer] workers in to work closely with who I think they will work well with. I've got an old chap . . . and he's a [peer worker], and he's fantastic with young 'uns, with kids because they look at him like a granddad . . . And he gets tons out of them and they help him make things and, you know, they wouldn't do it for me but they'll do it for him.*
>
> *PST*

There was also greater role distinctiveness in inpatient settings than in community and BME settings (see *Appendix 4*, *Figure 19*), where distinctiveness was also rated as most important (see *Appendix 4*, *Table 21*):

> *I think it is . . . extremely important because we're meant to be more with the [service users]. That's really why we're here, isn't it? Not to be dealing with paperwork so much. I know we've got to do some, but, you know, that's not really why I wanted to be a peer support worker.*
>
> *PPW*

However, that distinctiveness could be eroded when the ward was short staffed, with peer workers becoming increasingly involved in tasks that were normally undertaken by health-care assistants:

I still do things because I am part of the team and if we are short staffed and things like that, if we have four [service users] on observations and we've got one staff member off sick . . . ward round, medication, we go around with a bed board every hour to make sure everybody's safe, that's all manpower that you need. If they're short staffed . . . I'm happy to do it because it's all part of the team . . . but sometimes it can have an impact on my role . . . if there are [service users] that really wanted one-to-one with me and I've not been able to do it because I've spent three hours up at the hospital escorting just the one person . . . that is frustrating.

PPW

Service users were more often seen as having different relationships with peer workers than with other workers in inpatient settings, compared with both community and BME settings (see *Appendix 4*, *Figure 19*). Participants talked about service users sharing different things with peer workers from those that they would share with other staff, and reported that they talked in a different way:

Because she [the peer worker] was the first person that knew that I'd torn all the ligaments in my ankle because I hid it from everybody until I kind of couldn't take the pain anymore and then I had to, because I tried to climb over the fence but failed . . . But she was the first person that I was able to tell because I thought, 'I need to tell somebody and I don't know who to tell, I don't know who to speak to.' And I just grabbed her and said, 'I need to talk to you.' And that's when I told her what I'd done and stuff and she kind of helped me approach the nurses and approach the doctor and just helped me like initially say, 'This is what I've done. I've messed up.' But you kind of felt that she was, like, standing shoulder to shoulder with you.

NSU

Our data suggested that the role was more likely to be defined by a specific set of peer worker skills and competencies where the peer worker was employed in the voluntary sector (see *Appendix 4*, *Figure 7*):

. . . in the job description, you know, they ask certain things about your skills and competency, your experience of mental health services, your ability to empathise with service users, your ability to understand, you know, the needs and expectations and the barriers.

VPW

In inpatient settings, having a specific set of peer worker skills and competencies was seen as more important than in other settings, but at the same time, there was a tension with the need to make any job description in the NHS fit with an Agenda for Change job profile:

. . . there are specific skills, competencies in relation to each job . . . The only way you get a banding for a job . . . we can design all kinds of job descriptions, and then it takes ages to go backwards and forwards, because they're then trying to fit this odd job description into the Department of Health manual.

NSM

Professionalism and the peer worker role

There was a high level of agreement across cases, whether peer workers were employed in the voluntary or statutory sectors (see *Appendix 4*, *Figure 7*), that peer workers were expected to be as professional as any other worker in the organisation. However, professionalism meant different things to different people and in different contexts, including maintaining confidentiality, managing risk, getting on with the job despite personal issues, adhering to job description and organisational mission, taking the job seriously and

keeping appropriate boundaries. In both the voluntary sector and NHS, working professionally meant 'doing the job well' and reflected the value of the peer worker role:

. . . professional means doing what you're supposed to do, doing a job, doing it as well as you can, and if you can't do it as well as you can sometimes because you're not very well, well that's fine but you're trying to do as well as you can and you're a professional person. You've got your qualifications, you've got your experiences therefore you are treated as somebody who can do that job. Why shouldn't you act professionally?

VST

. . . being professional about how you do it is also important. So getting reward for it but also, you know, having a standard about what you do is equally important for it to be taken seriously and to sort of demonstrate that we're – it is a really valuable role.

NMA

Expectations of professionalism were higher in inpatient settings compared with community or BME settings (see *Appendix 4*, *Figure 19*), with one ward manager suggesting that keeping to boundaries (see *Managing boundaries*, below) was an important aspect of professionalism in the peer worker role:

I had to sit and listen to her you know telling me about her problems, and . . . you know I don't want to hear her life history and you know and then we had to be quite sort of sensitive in saying, look, it's okay for you to disclose things, but there's things that are appropriate for you to disclose and things that aren't, and although you know your experiences are very valuable, you also need to keep a professional boundary.

NMA

Professionalism was often seen as one of the most important aspects of the role, although it was rated as more important in inpatient and community settings compared with BME settings (see *Appendix 4*, *Table 21*), and by managers compared with service users (see *Appendix 4*, *Table 27*). A manager working in a community setting associated professionalism with responsibility, while a peer worker in a BME project articulated tensions between peer and professional expectations of the role:

I think it is a position of responsibility and I think there are some hard things they have to do, like if somebody is, in their opinion, at risk to themselves or others, then they have got a duty to pass that on. Um . . . And they have got a duty not to go gossiping in the pub about, you know, private information that somebody's given to them. So there's a lot of aspects. You know, the expectation is the same. And I think that's all right to have that high expectation of people. Yeah.

PMA

Um, well, I think, for me, it was difficult managing those expectations because, on the one hand, you still wanted to be accepted as a service user, as a fellow service user, as a peer. And on the other hand you also wanted to show that you had the capabilities to do a job, to be professional, in a sense . . . So it's a very difficult balancing act. And I'm not sure that I managed it very well. How I managed it – like I said, for me, the way I managed it was always seeing myself as the service user first, the worker second.

VPW

Several participants in voluntary sector cases were concerned that professionalism might undermine the peer worker role if it imposed a sense of formality on the relationship with the service user:

It's an important issue that they're not as professional, as a normal worker . . . Because they're casual. They can – I'll use the word infiltrate, but they can infiltrate, like, the patients a lot easier than a normal person can. They can relate to what they've been through and stuff. If they were formal they

would have a completely different, like, appearance and approach to things than if they were informal, so . . .

PSU

I think being professional, because often, sometimes, the person can lose sight of being compassionate and being human and hence being themselves as well. I think being professional is extremely important in a peer worker's role, but what's just as important is not losing sight that, actually, I am a human being as well, how we connect with people on a basic, human level, really.

VPW

In the NHS, service users could associate professionalism with distance, and although they thought that might be appropriate in a clinical role, they valued the peer worker role because that distance could be transcended:

If you're taking, like, the people at [CMHT], the CPNs [community psychiatric nurses] . . . They're more professional. Peer support are for the people that they . . . I think they understand more because they've been through it . . . Than, like the [CMHT] are professionals . . . They're more distant . . . They can't . . . 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.

NSU

Expectations of disclosure

A requirement for peer workers to disclose their personal mental health history to service users as part of their work was seen as less important in voluntary sector cases (as opposed to NHS or partnership cases) and in BME settings. In voluntary sector cases, in-depth data suggested that it was important that peer workers chose whether or not they disclosed their mental health history:

Are they expected to? It's not really, you know, as part of your work that you're expected at every twist and turn to disclose, it's not really expected.

VPW

. . . people normally, like, I've used my experience, in, like, I've mentioned like times of my own experience during supporting people. So, but I'm not expected to do that.

VPW

There were some examples in the voluntary sector where not actively disclosing which staff had lived experience of mental health problems was seen as a positive demonstration of capability:

I don't think people individually do need to know who is and who isn't. I think it models something far stronger just the fact that some of us are and some of us aren't. Actually, it doesn't really matter and we are both equally capable. And that's kind of the ethos that we're hoping people will then subliminally when they're thinking about the expectations themselves.

VPW

There were greater expectations of disclosure in NHS cases, where disclosure was closely associated with the rationale for the role, although this needed to be measured and appropriate:

I think if we had a peer [worker] who felt that they couldn't talk about their personal experience of mental health, it would . . . you know, you would question what they were doing in the role really, because it seems like a very vital part of . . . that accessing that and being able to talk about it . . . [disclosure] seems very important, because that's why we're employing people.

NST

They certainly have to be able to disclose that they've had mental health problems . . . but I think telling your deeply personal story to . . . Again, it just depends. It just depends. It's about judging what's going to be helpful to other people, isn't it? . . . And it being about the other person's needs and not about your needs to tell.

NCO

Managing boundaries

Participants variously associated 'boundaries' with professionalism and responsibility, procedures around health, safety and risk, boundaries in the relationship between peer workers and service users (including issues of confidentiality, levels of contact and availability) and the consequences of not maintaining those boundaries, both for the peer workers and for service users. Data suggested that boundaries between peer workers and service users were most likely to be clearly managed in voluntary sector cases and that this was least likely in partnership cases (see *Appendix 4*, *Figure 13*), where working to two different organisational value systems might underlie a lack of shared understanding:

I think people really need to understand their boundaries and what the boundaries are, because it's easy to get caught out when you're in that informal – because it is informal here . . . So it's about boundaries for me, to be able to . . . People need to know what the boundaries are and stick to those and not get sort of pulled in.

VCO

Well, staff are told, as professionals, that they shouldn't be friends with service users . . . Now, that's fair enough and [peer] workers are encouraged not to be friends. But what are we saying? You know? What are we saying? . . . You're ghettoising. The danger is if you take that too far you ghettoise people with mental health problems . . . I know there have to be boundaries. I'm not saying I don't believe in boundaries, but I'm not saying that – if you go too far the other way you have a very impersonal 'them or us' culture . . . And we have to find a line between the two . . . You know, because there are professions who have built their boundaries so tall and so high and so thick that this sort of thing threatens it a bit.

PSM

Management of boundaries was rated as highly important across cases (see *Appendix 4*, *Table 15*) and stakeholders (see *Appendix 4*, *Table 27*), although this was more often chosen as a 'top 3' issue in voluntary sector cases (see *Appendix 4*, *Table 33*). Half of all participants who selected 'boundaries' as a 'top 3' issue were non-peer staff working alongside peer workers (see *Appendix 4*, *Table 35*):

Because I think from my perspective I think there can be problems with peer workers and service users becoming too close because they share the same experiences. I think then if you're bonding on that level you kind of forget that actually you are staff still and you are managing a process. And this is my experience, if you become overly friendly with somebody then to pull away can issue in all sorts of rejection triggers which you wouldn't want to happen. So I think that's quite a curious one because it's got to be handled so sensitively.

VST

Staff and managers talked about supporting peer workers to develop boundaries in the way they worked:

Boundaries. Yeah, so that feels really important for a number of reasons. I think some of the workers have struggled with those boundaries where either they were previously a member and then were appointed as a peer worker . . . So managing that transition for themselves but also how then the members see them. So, you know, particularly where there were friendships. They're suddenly in a different role now . . . And I think it's felt, for some peer workers, quite isolating. It's kind of, you know, wanting to still be seen as a friend and, you know, talk to people at weekends and evenings but, you know, I think it's been confusing for some of the members. Or maybe less confusing for

members, 'Okay, you're a worker now.' So, you know . . . The friendship isn't the same. So I think managing the relationships isn't something that always gets talked about but it feels important to talk about it because I know it has had an impact on some of the peer workers.

VSM

Owing to the importance of boundaries to participants, we return to the issue in *Chapter 4* (see *Challenging boundaries, changing conversations*).

Managing crisis

Peer workers employed in the voluntary sector were more likely to be reported as having the necessary skills to provide support for service users who were experiencing a crisis, compared with peer workers employed in the statutory sector (see *Appendix 4*, *Figure 7*). Voluntary sector participants often talked about this issue in relation to peer workers knowing their limits and handing over the matter to the appropriate people or agencies to deal with, and in terms of their having the appropriate training and skills to support a service user in crisis. One of the voluntary sector case studies was set up specifically to manage people in crisis, so all workers were skilled in this area:

. . . a couple of weekends ago I came to [the Crisis Service] and I wasn't very well mentally and they worked with me. They worked very, very hard with me and they ended up obviously getting other services involved and that's a good job to me because they could have quite easily let me leave this building at half past one and gone and done something. But no, they worked very, very hard, very close with me and actually got the help I needed. Got me assessed by the appropriate people that I needed to be assessed by. So that's a good job for me. A good job done.

VSU

Peer workers were reported as less likely to have those crisis management skills in NHS and partnership contexts (see *Appendix 4*, *Figure 13*), and in the NHS it was made clear that it was not considered the peer worker's responsibility to support a service user experiencing mental health crisis:

But there's always a risk with these things that one person gets left sort of holding the baby, as it were. And that shouldn't, certainly shouldn't be a peer worker.

NCO

However, the need to have the skills to support crisis was rated as more important in inpatient settings compared with community settings (see *Appendix 4*, *Table 21*), where knowledge of techniques such as de-escalation and breakaway was discussed:

Unfortunately, mental health it happens, you know, as a matter of – if they're working with someone that's getting, for example, mind hallucinations, you know, and they come to the peer supporter and say, 'Okay, the voices are telling me that I need to go and stab someone.' You know, obviously you have to take all these things quite seriously because if they did go and stab someone, you know, it's a lot about risk management despite sort of, you know, us working with them. It's part of what we do as well. So it would be important for them to identify when further help is needed.

NST

Peer workers and diversity

All our participants answered the questions about diversity, and some of those not working in a culturally specific service understood the word 'community' in the structured interview schedule to mean a number of things: a community of people with similar lived experience of mental health problems (e.g. experience of personality disorders), or a shared sense of community resulting from living in the same area, as well as

being from a similar cultural or ethnic background. The data below reflect those different understandings of community:

> *But I think from the ethos of the organisation, you know, it's all about inclusion and I guess if that's from being from an ethnic background, that's great. But actually even if you're from British background it's just all about embracing the fact that, you know, we're connected through, you know, [personality disorders] and, yeah . . .*
>
> *VST*

> *We're trying to get lottery funding to run this service two nights a week from one of their centres which is right in the heart of [a] multi-cultural [area] . . . it's where the Caribbean community . . . but also where all the refugees and asylum seekers . . . are. It's the area where I live in. It's like the most, it is a totally diverse area, whereas this is a really white area.*
>
> *VSM*

Community leadership

The importance of leadership for peer work coming from within the community or communities that organisations provided a service to was more frequently reported as a 'top 3' issue in cases where the peer workers were employed in the voluntary sector (see *Appendix 4*, *Table 32*):

> *. . . we're always looking to the people, the peers, the service users, to have a large say in the service that's provided. In fact, to be at the centre of the whole service. So, yes, leadership comes from the service users and I think that is extremely important.*
>
> *VPW*

Community leadership was seen as less important (see *Appendix 4*, *Table 22*), and was happening less often, in community settings compared with inpatient and BME settings (see *Appendix 4*, *Figure 20*). Here, a manager in a community setting explains how a wider awareness of community issues is necessary to inform a leadership role, rather than that leadership coming directly from the community:

> *I don't think you have to live within the community to do the role and obviously, as I'm moving on soon, you know, it will be somebody different. So I don't think it's a prerequisite. I think I do know a fair amount about the local community because I live and work in it . . . Um, but whether that would be reasonable to say, 'You've got to have that to fulfil the role', I don't know. It's just an awareness, really. Yeah, social economic factors as well as ethnicity and cultural norms and . . . I think in any work with people that kind of background awareness and knowledge is helpful.*
>
> *PMA*

In one of our BME cases, the strategic manager, who clearly thought of community as cultural, spoke of the benefits, particularly for service users, of leadership coming from within the cultural community:

> *. . . how we deal with different peoples' perceptions of mental health, certainly from different cultural backgrounds, to have some folk who've lived it, walked it, and understand it, from all different aspects in between, so to have a service user who is from a white British background is very . . . delivering a service is very different from having a service user from another background delivering a service, and I think that we benefit from that in the same way as we benefit from having workers from different backgrounds, different class backgrounds, different genders, it's just the diversity stuff, the diversity stuff isn't easy, because . . . peoples' norms, understandings, values, clash against each other, all the time.*
>
> *VSM*

Commissioners saw the issue of community leadership as more important than other stakeholders (see *Appendix 4*, *Table 28*), and recognised the challenges this might present:

> *So some of those factors come into play in ways that you wouldn't necessarily expect and what you get is you get certain really quite powerful individuals running service user networks. Sometimes they're service users, sometimes they're not. And sometimes it's great and it works fine. Other times it doesn't . . . And so when you're trying to introduce something new, like peer workers, your act of doing that can really put the cat amongst the pigeons. I'm not saying it's a bad thing exactly but you've obviously got to make sure that you don't get your peer workers sucked into whatever is going on.*
>
> *NCO*

Language and the peer worker role

The language used to describe peer worker roles was more often reported as relevant to the community or communities receiving the service in partnership and voluntary sector cases (see *Appendix 4*, *Figure 14*), although our in-depth data indicated that the need to use the right language around the role was spoken about quite a lot in NHS cases:

> *. . . obviously 'language' can mean lots of different things, can't it? You know, jargon et cetera. It can mean one type of language. And I think I'd hope that we know it as jargon free. We try and make everything jargon free and sort of not have medical terms in it, et cetera. So I think 'yes' would be the answer to that part of it, but in terms of whether it's multi-lingual, which our community is, then 'no' would be the answer.*
>
> *NMA*

> *. . . language is something that we talk a lot about on the course. You know, the disparaging challenging language that we hear when people go into teams which make it very evident the kind of 'us and them'.*
>
> *NSM*

In a BME project the connotations of the term *peer worker* itself were felt to undermine the core, peer dimension to the role:

> *I personally don't feel very comfortable with the term 'peer worker' . . . the reason being because, for me, it started off as peer support, which is something I think I've been engaged, involved in, been part of ever since I was diagnosed with a mental illness. And peer support, for me, is about people with similar experiences of mental health sharing, supporting each other in various ways . . . on a very informal level . . . It's not a contract. There's no written rules about how it should be done. There's no dos and don'ts . . . I was quite comfortable being a development worker, a project worker, because within that there was more to it than just the peer element of it.*
>
> *VPW*

In addition, where languages other than English were spoken within a community, the peer worker was able to act as interpreter, both of the language itself and of the concepts around mental health:

> *We all discuss it because in English or in [our mother tongue] they different meaning, yes, sometime the same word? . . . So maybe they don't happy when they start, if they have problem they don't like to see this word. When we translation, yeah, how to translate the mental health? In mental health you translate strict in [our mother tongue] word like 'crazy' or something . . . The project is using the very simple words to make them understand what is mental health . . . after the training they say, 'Oh, this more easier to understand what is mental health, how to help people, yeah, how you help a friend'.*
>
> *VPW*

We take up the issue of language and the peer worker role in more detail in *Chapter 4* (see *Who is a peer worker? Identity and language*).

Recruiting peer workers from the communities they work in

Recruitment of peer workers from the communities they provide a service to was taking place, and was considered important in all cases (bearing in mind the various definitions of 'community' that people applied; see *Appendix 4*, *Figure 12*). A strategic manager from an NHS inpatient setting explains how their organisation advertises peer worker jobs through a wide range of community and service user groups, and voluntary sector mental health organisations:

> *I guess peer workers can be recruited from anywhere, really. I mean, we would advertise on NHS Jobs. But also we would put adverts in local community groups, service user groups, you know, the Job Centre it goes in as well. We send it to partner organisations, such as carers' groups, MIND organisations, Rethink, etc. So, all areas where we believe service users will 'hang out' really.*
>
> *NSM*

In a BME case, a manager stressed the importance of recruiting from the community:

> *And I think it is important to recruit people from the community that you're trying to work with. These posts are difficult to recruit members to, these posts, these projects, and I think that you have to be mindful that it's important that, you know, you have to build trust and relationships very, very quickly and that helps if you're from the same background . . . You'll have those links as well it's communicative. You'll be able to share, you know, the right words and language that's used . . . it gets access to the members and keeps you in touch with what the issues are really within the community. Where are people going?*
>
> *VSM*

In some cases peer workers were recruited through the organisation itself as a vocational or developmental opportunity. There was a sense that the people using the service were part of a community:

> *So when we recruited . . . [who] has had, you know, been unemployed because of mental health problems and we recruited her from being one of our volunteers. So she is from within the mental health community and that's who we're serving.*
>
> *VSM*

Training and support

Specifically designed peer worker training

Although specifically designed peer worker training was widely in place across cases, it was slightly less well established in partnership and voluntary sector cases (see *Appendix 4*, *Figure 15*). Specifically designed peer worker training was the most selected 'top 3' issue, with half of all participants who selected this issue being peer workers and service users (see *Appendix 4*, *Table 35*):

> *I think that is very important both for the well-being of the peer supporter, as well as anybody being supported by that person. So you need to have the skills to be able to be helpful as well as it's quite difficult if you're supporting people who have got emotional problems or problems and they are confiding in you it can be a lot to take in and it's very easy to take on other people's problems. So if you haven't had the training or the experience or the skills to kind of separate yourself I think that's very important, definitely.*
>
> *PSU*

This issue was identified as slightly less important in BME settings (see *Appendix 4, Table 23*):

> *You can offer people training around all the stuff that they need to know about developing and managing but you can't really, you know, get someone to be committed to peer support unless, you know, they've got to feel it. They've got to know it, they've got to feel it.*
>
> <div align="right">*VSM*</div>

Purpose-built training supported peer workers to do a good job, to learn about different aspects of the work, to understand what other workers around them were doing, and to increase their confidence and maintain their well-being. There was a sense that not providing specifically designed training would be a barrier for peer workers:

> *And if you don't provide those people with the training for that you're being negligent . . . Worse, really, you're setting people up to fail . . . Which could lead to a relapse or it could lead to them not supporting others very well . . . So that is, I think, absolutely vital.*
>
> <div align="right">*PSM*</div>

> *I think it's important that people feel that they're equipped to do the role. We include a lot of discussion in the training so there isn't necessarily a right or a wrong answer to something. But it gets people thinking round, 'Okay, this might be lots of shades of grey. I need to be flexible enough to work within that. It is about using judgement. I may need to ask somebody else's advice or use them as a sounding board', et cetera. So I think all those things are very important.*
>
> <div align="right">*PMA*</div>

Some participants thought that it was not necessary to have training specifically designed for the purpose; others talked about getting experience of the work through doing it on a voluntary basis first or described more 'on-the-job'-style training, while the economic climate had an effect on access to training for some:

> *Now, increasingly, when people apply for a role as a peer worker, they've usually had some experience of the work probably on a voluntary basis. So training is not as important as it may have been originally.*
>
> <div align="right">*PMA*</div>

Where purpose-built training was established, training packages had often been locally designed as part of the role development process:

> *. . . I feel for us that's been our real success. We've had really good feedback from the training. For me, on a personal level, it's been probably one of the most enjoyable elements of it . . . I've loved the peer training, it's just . . . You've just seen people grow so much in that period . . . And I do think it's important that they offer – that the training is offered and it is tailored to this role. A mixture of things [have made it a success]. I think one has been that the training has been delivered by a multitude of people that have been clinicians by background. And also people that are employed in the Trust but have lived experience and known different roles and also people in the second cohort, it was peers themselves did a lot of the training.*
>
> <div align="right">*NMA*</div>

Sometimes where training had been specifically designed for peer workers it did not necessarily prepare them for the setting they would be working in:

> *. . . it's very effective at training you in peer-related skills. But it doesn't prepare you to work in mental health services. So there's lots of skills that need to be developed . . . we learnt that the hard way, by people going into roles and then people really struggling, with lots of different things, and colleagues struggling with lots of different things as well . . . we reviewed it with team managers, the peers, and*

others, to kind of look at what was needed, and so we've set out a whole kind of programme that people will go through as they come in to post. So the peer training is as it says on the can actually. It teaches you how to be a peer. It doesn't then tell you or teach you how to work on an inpatient ward or how to work in a community team . . . and so that we've kind of pulled that together. [It gives] . . . a lot of orientation to services, systems, language, acronyms . . . specific skills say in relation to kind of working on wards, in relation to kind of physical health-care skills . . . which may involve things like taking blood pressure for people . . . interpersonal skills around problem solving, interacting skills . . . How you facilitate often difficult conversations.

NSM

Externally accredited peer worker training

External accreditation of peer worker training was not considered an issue of great importance compared with other support needs (see *Appendix 4*, *Table 11*) in terms of the quality of care that a service user received. However, there was some suggestion that it might be important for peer workers' career development and in moving on to new jobs:

A certificate from somewhere isn't always what we're after, but we love internal training and we do a lot of that and we ask the team constantly, 'What do you want?' And we try monthly to do something and we bring people in – if we can't do it ourselves, we bring people in.

VMA

'Peer worker training is externally accredited . . .' Yeah, we've got from the Open College Network, so that's a 'yes'. And I think it's quite important . . . Because then people can recognise it if you were to sort of move on to another job . . . I think that's handy, yeah. It's not totally like extremely important, but I think it is quite important if you did want to sort of build up on your career a little bit . . . Then you've got something to go with.

PPW

Training in NHS core competencies

Overall, there was little evidence to suggest that peer workers received the same training in core competencies that NHS mental health workers received. Those who did receive such training were employed in the NHS (see *Appendix 4*, *Figure 9*) and worked in inpatient settings (see *Appendix 4*, *Figure 21*). Peer workers talked about doing breakaway training (Prevention and Management of Violence and Aggression) and the same trust induction training that non-peer staff were expected to do:

. . . that's like a two-day breakaway training. It was on site here at [the hospital] . . . and it was like quite hands-on because you have to sort of learn techniques to break away from situations like bear hugs. When people come up to you and give you a bear hug, because people try and like strangle you from behind or whatever, if you've got a badge with a tag thing on it, you know. What else was there? Just techniques to sort of get away if there's any comeback, if they're coming or grab you from behind or something. Give you a bear hug from behind, just sort of grab away. It was all really interesting, but I think I need to do that again because I've forgotten it, most of it . . . because you're on the ward quite a lot of the time like the nursing staff are and they're required to do it so I think it's very important to do it quite early on.

PPW

. . . there are specific skills, competencies in relation to each job . . . The only way you get a banding for a job . . . we can design all kinds of job descriptions, and then it takes ages to go backwards and forwards, because they're then trying to fit this odd job description into the Department of Health manual.

NSM

Similarly, training in NHS core competencies was seen as more important in the NHS (see *Appendix 4*, *Table 11*) and in inpatient settings (see *Appendix 4*, *Table 13*), and by front-line staff and commissioners (see *Appendix 4*, *Table 29*) rather than service users and strategic managers. Away from the NHS, some service users were concerned that such training would undermine the peer worker role:

> *. . . if they did have the same training as the NHS mental health workers it might be too much. Some of it might not be relevant, some of it might actually be moving away from being a peer support worker because then you're not, you've become more of a mental health worker rather than a peer worker.*
>
> PSU

Training for other staff in working alongside peer workers

There was little evidence of training for coworkers in working alongside peer workers. This was more likely to be happening in voluntary sector cases compared with NHS and partnership cases (see *Appendix 4*, *Figure 15*), and in BME and inpatient settings compared with community settings (see *Appendix 4*, *Figure 21*). Training the team was seen as more important in inpatient cases (see *Appendix 4*, *Table 23*):

> *[Training other staff in working alongside peer workers] is definitely what I advocate. I would advocate people doing it when they're recruiting for a peer worker and creating an open conversation where people are not judged either . . . Because you need people to be able to say that they're scared of people who have got a mental illness in order for you to be able to do anything about it. If they feel like they're going to be judged on the fact that they've got fear about it, it's going to go back inward and you're never going to deal with what it really is. So when someone comes in and they say something that someone else feels is completely crazy then what are they – how are they going to make sense of that for themselves?*
>
> VMA

> *We decided that we weren't going to do kind of blanket training, and we would make it kind of team specific . . . and what is involved is going to teams and, two parts really, trying to get to teams when they're in that kind of contemplating stage of having a peer, and sitting down with them and just talking about the generic job description, and then kind of saying, talking about what the role could be, might be, etc. and getting the team input into shaping of the role . . . So that they don't feel its actually being done 'to' them . . . And this person's going to turn up . . . Actually, they've shaped it . . . So then it gets signed off to be able to . . . and with that then kind of teasing out peoples' fears and concerns, and because you're making it kind of as context specific as possible, you're trying not to talk about this kind of global concept of peers . . . and actually tailoring it to their team.*
>
> NSM

Participants said that training for the team helped relationships between peer workers and non-peer staff, reduced conflict, increased understanding of and value ascribed to the role, reduced fear and stigma around mental health in general, and reduced any sense that peer workers were the next 'flavour of the month' and 'a bit of an add-on'. Training also allayed existing staff fears about peer workers replacing non-peer staff jobs:

> *And it also allowed the staff to say . . . 'Are they here to do me out of a job?' . . . 'Are they going to take my role?' So, you know, 'What if this, and what if that?' So we were able to address all that. And I can honestly say that we haven't had a power struggle or there hasn't been any conflict. Yeah, I can say that a hundred per cent.*
>
> PMA

Support to access advice about benefits and welfare rights

Although there was agreement across cases (see *Appendix 4*, *Table 17*) and stakeholders (see *Appendix 4*, *Table 29*) that this was an important issue, peer workers were more likely to be supported by their

employer to access advice about benefits and welfare rights in partnership and voluntary sector cases compared with NHS cases (see *Appendix 4*, *Figure 15*), and in community and BME settings compared with inpatient settings (see *Appendix 4*, *Figure 21*). Several participants in partnership and voluntary sector cases said that their organisations had links with other agencies that came to give service users advice about benefits and welfare rights, and that this support was easily accessible to peer workers:

And I think this is important because you get a lot of people coming in as peer workers, project workers, who have experience of mental health, have been unemployed for long periods in their life . . . And suddenly they're going back to work after being long-term unemployed, being on benefits, not sure about how it's going to affect them financially and their rights . . . So I think this is extremely important and I'm glad to say it is something that [Host organisation] takes very seriously and they do provide support and I would say, again, that's extremely important for the reasons I've just said.

VPW

Access to independent, external mentoring

Peer workers were not likely to have access to independent mentoring from outside the organisation (or participants often did not know if that was the case), except in BME settings (see *Appendix 4*, *Figure 21*), where this was highly valued by one peer worker:

It not only supported me to be able to do my job better but to cope, to have an outlet, and it was something that [in meetings with my line manager] we identified that might be useful and helpful for me and they put it in place, which worked very well for me . . . [the difference between supervision and mentoring is] for instance sometimes in supervision you wouldn't go into supervision saying, 'Well, actually, this project that we're working on right now, or this piece of work, I don't think I can do it. I'm not coping very well.' You know, you'd have that fear, you know, that I don't really want to admit that I'm not coping. 'I don't understand. I can't do it.' You know, because it's supervision and you think, well, it might affect your job, you know. Whereas in the non-supervision, the non-managerial support, you could mention all those kind of things, you know . . . And sometimes, like, if your line manager, you know, you won't say to them, 'Actually, I think you're giving me too much work.' . . . And you can go into these meetings and say, 'I think I'm getting too much work.'

VPW

Access to mentoring was not rated as very important overall, except in inpatient settings (see *Appendix 4*, *Table 23*), and was rated as least important by strategic managers (see *Appendix 4*, *Table 29*). Issues were raised about managing contracts with independent mentoring organisations and the challenges of how to assure the quality of mentoring:

There's always something different that people can get from independent mentoring. Um, I mean it's another take on things. It's another perspective. Do I think that you shouldn't be setting up a peer support scheme unless you can guarantee independent mentoring? No, I don't. It would depend very much on the sort of support that the organisation was offering and whether there was somebody in a peer leadership role, for example, that would be doing that which wouldn't be independent if they were in the organisation . . . And then you could have, potentially, not if you're Health because they don't do it, but if you were us, you'd get into all sorts of argy-bargies about contracts with independent mentoring organisations and the whole thing would become a complete nightmare . . . No, so sometimes I think – again, it would depend – if you did it, you would have to be able to assure the quality of the independent mentoring . . . And sometimes that kind of thing is quite difficult to do.

NCO

Teamworking and management

Peer workers receiving support from other members of the staff team

In the large majority of cases, peer workers were reported to be supported by other members of the staff team, with slightly more consistency in voluntary sector and partnership cases (see *Appendix 4*, *Figure 16*). Support from the team was one of the most selected 'top 3' issues (see *Appendix 4*, *Table 32*):

> *Everybody's approachable. If I'm having a bad day I just grab any member of staff . . . and say, 'Have you got ten minutes? I'd like to have a chat' . . .*
>
> *PPW*

Voluntary sector participants described a wide range of mechanisms of support available to peer workers, including debriefs after events and intensive one-to-one peer working, the potential for peer workers to call upon colleagues and a team approach to dealing with difficult issues. A supportive culture underpinning the organisation was often referred to:

> *Well, I guess there's a culture to have things like pre-meetings, postmeetings/briefings, debriefs . . . I think it's important to reflect on what's happened . . . sometimes you can check things out and then leave it all there and not carry it home with you . . . It's the sort of gentle but firm teamworking approach that it's the team that holds things rather than with individuals.*
>
> *VSM*

Service users said that knowing peer workers were well supported and had space to debrief and reflect reassured them that it was acceptable to draw on them for support:

> *. . . if I've come in and I'm feeling really low, suicidal thoughts . . . if I sit down and talk to a peer worker . . . then they've got something to offer us . . . and they know they've got support rather than taking all that home with them. They can actually go to their management and be able to talk through it and then decide then what's actually going to be done for support for themselves and for the person who's been talking about their difficulties.*
>
> *VSU*

In some NHS settings staff felt that supporting the peer worker was not their job.

> *We're not here to look after the [peer workers] . . .*
>
> *NST*

The advantages and challenges of staff working supportively alongside peer workers whom they had previously cared for when they were unwell were also described:

> *I think there's a challenge for the staff and for the [peer worker]. For example, if the [peer worker] has been previously a service user in your hospital . . . and I think for some people, NHS staff, that could be a challenge, to see them in a different light and to try to forget about any past occurrences and to be able to support them and work alongside them. Which I think they all do very well, but I think it can be a challenge for some people.*
>
> *PMA*

Formal one-to-one line management for peer workers

In most cases, provision of formal one-to-one line management and management support for peer workers who were unwell were happening at least partially (see *Appendix 4*, *Figure 16*). About half of all participants said that peer workers received formal one-to-one line management from team managers,

although this was less so in partnership cases. The importance and value of this line management and supervision was described in detail by managers:

> Yes, I think it's very important that the peer worker does not feel isolated because they can face situations in their work which can be demanding and distressing and trigger things for them. So I think it's important there's a supportive team but within – but I do think there's a role for the line manager to – so that the peer worker knows there's somebody they can lean on and there's somebody to whom they can look to for, look up to, to some extent, look to for advice which the teamworkers together may not be able to do . . . I think it's important that the line manager offers the one-to-one support that does that.
>
> *PMA*

Lack of clarity about who to access for consistent management support was noted in one partnership case:

> I'd say that's extremely important really because you do need someone to kind of offload on to, in a way . . . the peer workers, we're all quite close in a way . . . we all know what's happening with each other and if there's anything wrong that we're really worried about then we'll ring each other up . . . So we kind of support each other but there's no actual kind of independent person that we can all go to. Like, we have our supervisor but she's not particularly well herself at the moment . . . so I think we have to report to [other manager] now, who will be probably taking over the role.
>
> *PPW*

There was evidence that managers learned about the peer worker role through having to line manage a peer worker:

> When I first arrived here I met up with [the peer worker] every two weeks because, as I say, I've never had experience of working with a peer worker. So that enabled me to gain a better understanding of their role.
>
> *NMA*

Peer workers themselves clearly valued the one-to-one space they had with their manager:

> I look forward to supervision. I only have it once a month, but it soon comes round and it's always enjoyable . . . And I always find if I have any queries that they're answered properly and fully in supervision.
>
> *PPW*

Peer workers valued the support their managers might provide if they felt unwell, and managers generally thought that this was part of their role (the issue of providing support for peer workers' mental health in the workplace is discussed in more detail in *Chapter 4*, *Supporting the peer worker role*):

> [The manager] did provide support once we knew . . . to all of us, really. [One peer worker] requested to see [our manager] . . . he . . . went up to see her and then he came back and told us . . . just to make sure that we were all okay and felt that we could approach her ordinarily, like we would do.
>
> *PPW*

> But we've had incidents when peers have been, that I've needed to make a decision about speaking with somebody and guiding them home safely . . . I guess that would apply to any member of staff, maybe, so they're not particular to peers but the way I do it for peers would be perhaps be a little bit more differently . . .
>
> *PMA*

Specific skills for managing peer workers

There was mixed evidence that managers had specific skills for managing peer workers. More people in cases where peer workers were employed in the voluntary sector (see *Appendix 4*, *Figure 10*) and BME-specific sites (see *Appendix 4*, *Figure 22*) thought that their managers had specific skills, whereas in the NHS this was often assumed to be a general skill set for managers:

> *. . . there is basic people management skills, that any manager would need, you know, managing a small team. So the, you know, the ability to treat everybody as an individual and, specifically with the peer roles, you know, where people have been, um, employed for their mental health experience and still actively experiencing mental health difficulties, the challenge has been in supporting people . . . I suppose in maybe a different way than traditionally you would.*
>
> *NSM*

Having the right manager for the job could be seen as a luxury where the realities of implementation were more constrained:

> *. . . in an ideal world would you want to have team managers who have particular attitudes to how they deliver and to the involvement of service users and the development of peer workers? So I think you would want that. But I don't think we're in the luxurious position of being able to pick and choose at the moment.*
>
> *NSM*

There was recognition that the manager needed specific skills to support peer workers coming face to face with experiences that they identified deeply with, and dealing with the emotional and personal effects of this:

> *But, so, for line management, you know, for line management of a peer support worker, it's someone knowing how to – how to support someone with the emotional fallout of dealing with quite intense work like that. If someone shares something really, you know, hard with you, how you deal with that.*
>
> *VMA*

> *. . . we're asking our peers to do something extremely different so you need some really skilled management and supportive team members to do that . . .*
>
> *PMA*

Managing tension between differing perspectives in the team was also seen as an important management skill in one NHS case:

> *The negative is that . . . [the peer worker] will often get hostility from other team members and then my role is to help each individual see it from, you know, a different perspective and get the point across. So there's . . . It can be a challenge at times.*
>
> *NMA*

> *I think managers need to know how to relate to peer workers and understand what challenges they might have on the team and things. So . . . I think it's not just about making sure that managers are on board with the idea. I think it's making sure that managers can actively support the peer worker and things.*
>
> *NPW*

Colleagues informed of peer workers' mental health history

It was widely seen as unimportant that colleagues be informed about the specific mental health history of the peer workers they worked alongside (see *Appendix 4*, *Table 18*). Some participants stated very strongly

that it was inappropriate for staff to be told of their colleagues' mental health problems and that the choice should rest with peer workers themselves:

Absolutely not. It's up to the peer worker if they want to share anything about their own mental health. So they're not told, 'This person is a peer worker and they've got a diagnosis of da-da-da.' The peer worker may choose to share that with their team; may not.

NSM

Informing colleagues of peer workers' mental health history was rated least important by people in inpatient settings (see *Appendix 4, Table 24*). Although people in BME-specific settings did rate this issue as important, in-depth data indicate that they felt this disclosure was unnecessary or inappropriate:

No, completely unfair. That's like someone coming up to you and asking you what all your bullshit has been over the last ten years! What relevance has that got? If people want to disclose what's happened, they can disclose what's happened. I happen to know that one of our workers here has [specific history]. If he wants to tell me that, great. If he doesn't want to tell everybody else . . .

VMA

I think this is extremely important because not everybody is comfortable about the whole office knowing your mental health history. You know, yes, it's one thing knowing that you have a history of mental illness but the specific mental health history I don't think is absolutely necessary. And I think, also, it should be down to the individual how much they want their colleagues to know about their mental health history.

VPW

Some staff and managers in the NHS suggested said that it would be appropriate to know the peer workers' specific mental health problems so that they could look out for warning signs of the peer worker becoming unwell:

. . . if we know they've got bipolar or something you'd need to know whether they're going to get stressed or, you know. I know if they take the medication . . . then you know they're going to be on a level. Yeah, I suppose it is quite important to know what illness they did have or still got but kept in control . . .

NST

I'd probably say that as a line manager they need to know something but . . . I think you've got to be careful not to focus on it . . . you wouldn't want to become too care co-ordinatory about it . . . you need to know that person's health problems, just as you would any other member of staff who might have mental health or physical health problems as well because you need to understand any adaptations that are needed or support or flexibility. But I guess it's kind of, you don't want to be too hung up, though, I think on, especially particularly a diagnosis . . .

NMA

Cover by other members of the team

Overall, about half of participants said that cover was provided by other members of the team; this was more likely to happen where peer workers were employed in the voluntary sector (see *Appendix 4, Figure 10*). Voluntary sector participants described flexibility in the team to cover for peer workers if they were ill at short notice:

. . . when it did happen it was a matter of the person saying to one of the other [team members], 'I really can't do this, I need to go home.' And go right okay. And then they just take themselves away and we just quietly let the other [team members] know that, okay, we're that person down, that's fine.

VPW

However, this was not always the case in projects with very small teams or where the peer workers in BME-specific projects were the only ones working with that group of service users. In this case work was postponed:

> He'd become very unwell, and we had to postpone the training, and that's what I'm saying about flexibility.
>
> *VST*

In multidisciplinary teams where there was a single peer worker, cover might be provided by a non-peer. The importance of having the work covered by another peer worker was not always recognised:

> . . . because all the service users that our peer worker would work with, they would always have a care co-ordinator. So if our peer worker was off then there's always, there are always care co-ordinators, so there's always somebody in the background.
>
> *NMA*

Peer workers described the importance of cover, understanding and flexibility in difficult periods of life for their well-being and continuation in work:

> I think it enables people to be honest about what's happening in their own life. If, for instance, all the jobs I've been in, I never felt able to go and say, 'Look, I'm going through a really bad time could I adjust my hours?' Whereas at [this service] I would feel confident to go and say, 'I'm going through a very bad time, everything is happening, could I adjust my hours for a short time?' and I would feel confident that, you know, if it was possible they would do that . . . And I think that does make a difference to – well, it has made a difference to me in the past to me being able to carry on working.
>
> *VPW*

Difference of function within the team

The importance of the distinctiveness of the peer worker role was highlighted above (see *Formal one-to-one line management for peer workers*). The functionality of the role was seen as underpinning that distinctiveness, especially in cases where peer workers were employed in the NHS; here, difference in function between peer and non-peer colleagues was more often selected as a 'top 3' issue (see *Appendix 4, Table 32*):

> Well, it's very important, isn't it? They stick to their job and we stick to ours.
>
> *NST*

Inevitable overlap between roles within clinical teams was acknowledged, but this emphasised the need to identify exactly what peer workers did that was different to the rest of the team:

> I mean, there's a sense in which all clinical roles overlap to a certain degree and then there are . . . the more specialised bit . . . And so for peer workers that will be true too. There's a sort of central set of responsibilities which will be the same for everybody . . . I think it is important that they have a clear sense of what it is that they do that is different.
>
> *NSM*

In one NHS case the peer worker roles were seen as analogous to existing NHS roles, such as health-care assistant, and many of the tasks that peer workers would do were seen as similar. It was understood that peer workers would bring an added dimension to the role by using their lived experience to work more

collaboratively, empathetically, non-judgementally and so on (these different relational qualities are discussed in more detail in *Chapter 4*, *The essence of the peer worker role*):

> *. . . [peer workers] are carrying out roles which would be consistent with duties you'd find in health-care assistants, support worker, support time and recovery workers, type of roles, etc. in terms of the kind of tasks and functions, with some additional elements, which only a peer can carry out . . . it is in the person specification, or the job description, that peers will disclose and talk about their experience of recovery . . . it then infuses everything else that you do. So, even if you are carrying out the same duties as other roles that exist, actually you're doing them in slightly different ways, you're doing them in a more collaborative way with people . . .*
>
> NSM

Where peer workers were employed in the voluntary sector – including in partnership cases – a functional difference was identified, in the in-depth data, between peer worker and NHS roles:

> *We're not here to fix, we're here to support.*
>
> VMA

> *They are not to prescribe, 'This is how I'm going to work with you. This is what we . . .' . . . they're there to listen . . . and then follow what the person wants and work around that. That's the real difference.*
>
> PMA

In some cases, peer workers were given more time in their working day than NHS staff to do one-to-one relational work with service users:

> *. . . the nursing staff are usually . . . quite busy and quite rushed off their feet . . . Perhaps the nursing assistant that's on observations . . . may have a little bit of time to spend with a few more patients and sit down with them if they're just checking if they're okay . . . but most of the rest of them are quite busy . . . whereas I've got that time. I can . . . freely go round the ward and . . . have a chat with everybody and see how they're getting on.*
>
> PPW

In the same partnership case, not having to undertake distinctly clinical tasks was seen as helping to mark that functional difference:

> *. . . they are different because I think some people . . . don't like [the ward staff] because they have to give medication all the time and they're like, 'Oh, here he or she comes again with my injection' or whatever . . . I think that's important, though, very important because it makes us separate, like, in the sense that we're not clinical workers.*
>
> PPW

However, that difference could be eroded where the peer worker ended up having to undertake tasks that were associated with a more clinical function:

> *I'm really concerned about the degree of creep that there is in some organisations that [peer workers] are becoming just like say a nursing assistant or a day centre worker, and while it's great to employ those people who have lived experience, the whole . . . the ethos is very different about the power balance again. Somebody in those roles is reading notes, writing in notes, feeding back, whereas the peer relationship should be more equal than that, somebody shouldn't be feeling 'uhhh the [peer worker's] going to go off and write every word I've said in the main notes and everyone's going to pathologise it.'*
>
> PSM

Conversely, in voluntary sector cases (see *Appendix 4*, *Figure 16*) functional difference from other members of the team was sometimes reported as not relevant, with equality within the team being seen as empowering:

> *'The peer worker role is clearly different to other roles in the organisation.' No . . . I think it's extremely important that it isn't, actually, because then it means everyone's equitable.*
>
> <div align="right">VST</div>

Issues of role distinctiveness will be returned to in more detail as we explore the 'essence' of the peer worker role in *Chapter 4*.

Peer workers replacing non-peer jobs

It was uncommon for peer workers to be employed in posts previously occupied by non-peers (see *Appendix 4*, *Figure 10*). This issue was not seen as being as relevant in voluntary sector cases (see *Appendix 4*, *Figure 16*), and was referred to most often, in the in-depth data, in NHS inpatient settings. In one NHS trust this was intentional, and aimed at improving skill mix, changing organisational culture and improving services:

> *It's getting the balance right isn't it, within teams, and we have so many mental health professionals who are doing non-mental health professional working issues in teams . . . It's readdressing of the balance. And actually kind of thinking about . . . what are the skills experience that you actually need in the mental health team, as against a traditional approach in services, is it consists of a doctor, handful of nurses, a couple of social workers . . . What are the skills that . . . expertise that you actually need in the population of people you are serving . . .*
>
> <div align="right">NSM</div>

In other NHS-based cases the worries of mental health workers were expressed, and there were concerns about competition for jobs with those on similar rates of pay:

> *. . . I think routinely, throughout the Trust, there was some concern when the peer workers were starting to be introduced, I think nursing staff, and especially health-care assistants or nursing assistants, had got classed at the same banding. Even though it's a completely different role . . . they didn't really like it . . .*
>
> <div align="right">NST</div>

Peer workers and the organisation

Strategic support for peer worker roles

Strategic support for the employment of peer workers was seen as important across all contexts (see *Appendix 4*, *Table 19*) and was frequently picked as a 'top 3' issue, with three-quarters of participants selecting this as a 'top 3' issue being either line and team managers, strategic managers or commissioners (see *Appendix 4*, *Table 35*). Strategic support was seen as more likely to be in place where peer workers were employed in the voluntary sector, compared with the NHS (see *Appendix 4*, *Figure 11*). The message that peer worker roles were supported at the top of the organisation fed down through the staff team and was recognised by peer workers and service users:

> *. . . there were quite a small but very committed group of people at a quite high level in the organisation who pushed this through, particularly, actually, our previous chief exec, who originally went to Arizona, saw it, came back, 'Do it,' and then there were other people around her . . . I think it would never have got off the ground particularly in such a big way without that commitment. I'm sure it wouldn't, actually.*
>
> <div align="right">NSM</div>

I think the planning of how – I think you actually have to do a certain amount of work of, 'How will that look in our organisation?' And I think almost that's the most important bit, and then once you've decided that, then it's the specifics of, 'Okay, well, how are we going to do it and where are we going to get them from and what do we need to be aware of?' So I think that and I think the fact that it has to come from the top and it has to be, um, it has to be supported and valued all the way through, because people know if it's not really but we just have to do this. And managers pick up on that and the people under them pick up on that and then the person hiring the service user and then the service user picks up on it. It's got to be all the way down or else you're just on to a loser from the start really.

VPW

However, regular turnaround of executives at the top of the organisation could be disruptive to efforts to consolidate support for peer workers throughout the organisation:

. . . we will be moving to our fourth chief executive since deciding as an organisation we're going to have peers . . . And with each chief executive they like to rewrite the visions, values, aims and objectives . . . The most current version . . . and we have an interim chief executive, and the interviews for the permanent chief executive are this coming Monday . . . But we've just been through, the last three or four months, the redoing of the vision and values etc. Our recovery is still at the heart of that . . . And with that will be peers . . . So we're still kind of there but the nuts and the bolts of how that translates down is still being redefined and we will have then another chief executive, our permanent chief executive, who will start, I guess, July or August time . . . who will then have their own views and opinions about staff and we'll have to go through that again . . .

NSM

Wider strategic fit and the peer worker role

This sense of the peer worker role having good fit with the wider strategic objectives of the organisation was reported in all contexts (see *Appendix 4*, *Figure 17*) and was highly rated by all stakeholders (see *Appendix 4*, *Table 31*):

. . . they're rebuilding, if you like, all their community services, about how we start to look at staff and skill mix and who fits in that group. And so they're going to have a recovery team and sitting in that recovery team, for me, is probably the most ideal opportunity to start off more formal peer support in community mental health services.

PCO

There was better reported strategic fit in inpatient settings (see *Appendix 4*, *Figure 23*), where it was seen as slightly more important compared with community and BME settings (see *Appendix 4*, *Table 25*):

. . . it's at senior management level, and even director level where – or maybe senior management because I think director-level people think it's going on, or want it to be going on, and will champion it, of course they would, but then they've given it to someone else. And I think I would like to see it driven, you know, so that staff – so every member of staff knows the certain standards and they need to hit the certain documentation they need to be doing but not every member of staff knows the importance of recovery or peer support work.

PST

Introduction of peer workers in the NHS was facilitated where it was seen to support mandatory strategic drivers:

. . . if you look at the Care Quality Commission outcomes there's a recovery thread that goes right through that, promoting independence, choice, you know, making sure people have information to make an informed choice, that sort of thing . . . so the organisation has adopted recovery, which is,

ultimately, people have as much control over their life as possible, wherever they are in the service . . . Then the role of peer support worker is to ensure that that happens. It's a way of validating that they've adopted the recovery approach by, one, recruiting people who have had lived experience.

NMA

Valuing peer workers across the organisation

The need for the peer worker role to be valued across the organisation was seen as highly important across contexts (see *Appendix 4*, *Table 19*), and once again was reported as more likely to be the case where peer workers were employed in the voluntary sector (see *Appendix 4*, *Figure 11*). Whereas 'strategic support' was most likely to be selected as a 'top 3' issue by managers and commissioners, 'valuing peer workers' was much more frequently selected as a 'top 3' issue by service users, peer workers and the non-peer staff who worked alongside and managed them (see *Appendix 4*, *Table 35*):

I think that budget is making everybody a little more focused on maintaining what is seen as the central and critical services, the crucial ones, and I think there's a danger at this moment in time that peer support may not be given the applause it deserves and if it's not respected and even if there's a six-month gap you're going to have people who will become ambivalent, people who have been involved in it, and they're going to just feel another project, guinea pigs . . . you know.

NST

There was some acknowledgement in the NHS that the peer worker role was not valued as highly as others within the team, potentially undermining the peer dimension to the role:

It can be a very definite, different theme or different approach but it still needs to be integrated with the bigger picture. So we had to almost – we had to ask to be involved in meetings with the care co-ordinator, you know, that the service user had with the care co-ordinator. It wasn't an automatic part of how it worked. The difficulty of that is then that there's a danger that the uniqueness of the peer being, you know, being able to offer the peer perspective can get lost because there might be times when it doesn't fit as well or possibly even runs a bit contrary to what the rest of the needs of the – you know, rest of the care team. So its independence could be sacrificed.

NPW

In contrast, in one of our voluntary sector cases – a peer-led organisation – valuing the peer aspect of any role underpinned the value system of the whole organisation:

Staff can only treat others with kindness and compassion and warmth if that's what they're receiving. So as the manager of this service, the staff are very important to me . . . it's my role to look after them so they can look after the [service users]. 'Look after' sounds a bit parental and paternalistic. I don't quite mean it like that, but the staff can only give the conditions they're receiving. So the therapeutic approach that the whole organisation uses is the person-centred approach . . . our belief is it won't be a person-centred service if we don't manage our staff in a person-centred way . . . I think one of the things that's probably quite defining about being a [peer]-led service is that because people are employed here because of their own experiences we're all very personally invested in working here.

VSM

Specific issues and challenges around shared values were recognised in the context of partnerships between the NHS and voluntary sector:

. . . where you're going to go to in partnership, in this case an inpatient ward, it has to be a number one issue for that environment and it has to be supported from the top otherwise you'll go on to the ward and the staff will go, 'What? What are you doing here?' You know, that has to come from the

modern matron, from the director, from the board down. It has to be as equally as important to that host organisation as it is to the organisation providing the peer support.

PCO

I mean, for instance, the Chief Executive with the Trust may be aware, because he takes quite an interest in this place, that we have peer workers. But I couldn't say that for definite.

PMA

Championing peer worker roles

There was some ambivalence about the role of champions of the peer worker role (see *Appendix 4*, *Figure 11*). In the voluntary sector, champions were identified as individual peer workers who, through their example, championed the role. It was noted that being a 'peer worker champion' could put additional pressure on the well-being of the individual concerned:

. . . to say to such a wide community that these small group of people are who you have to aspire to being and that's the level of wellness and if you don't match that, you're not well enough or whatever. At a level when people may be really struggling I think it can be incredibly hard to make the leap between 'I'm here, I could be there' . . . where does that leave everyone who is just not like that? And also what happens when that person leaves? . . . it's a lot of pressure on that one person or small group of people that they have to be the poster person for being well . . . And then you've got all the confliction of what if they're not, what if I have a little slip up one day? Have I still got the right to be there being Little Ms Healthy? You know, that's a really dangerous position to put any small group of people in.

VPW

In NHS cases, champions were seen as members of the management team who advocated the peer worker role within the organisation, especially at start-up and to ensure sustainability. This brought its own challenges where there was resistance to the introduction of the role:

People have left, the personnel have changed but there is still – I think there is still a little core who are keeping an eye on the whole project and championing it. I think it's got even tougher because the financial situation – I mean, it's all been tough – but it's even tougher now . . . And of course there are attitudes now being expressed about, you know, 'Why should we be offering jobs to the newly trained peer workers when we're having to make our regular staff redundant.' Not that we are making people redundant but, you know, it's on the horizon for the NHS . . . know, 'How can you ask us to give these people jobs when we're losing professional, qualified people all the time?' So it's got much, much tougher, actually, I think. And I think that makes it tougher for people to champion it because, you know, it's a really difficult situation we're in. So I think to initiate the project it was essentially to have that very high-level, very committed, very driving smallish group of people and you clearly need that ongoing to maintain the whole project. But I think it's going to get harder and harder to do, being realistic.

NSM

Peer workers, policies and procedures

Policies and procedures that made specific reference to peer worker roles were more likely to be in place in inpatient and BME settings, compared with community settings (see *Appendix 4*, *Figure 23*). A strategic manager in a community setting described the difficulties of creating policies and procedures for peer workers:

So we kind of, I would say we've got some policies but we haven't got all of them. But we're in a process of creating them . . . It might be very hard-line and hard-faced in other organisations but we're dealing with a population of people who come from a very unwell history and acknowledging that the work can make people unwell. How do you incorporate that into a policy but ultimately not to get

the piss taken out of it? And is [it] also legally sound? So that's a big challenge in getting a policy that's right.

VSM

Strategic managers rated specific peer worker policies as less important than other stakeholders (see *Appendix 4*, *Table 31*), and expressed some cynicism that introducing policy was the best approach to integrating peer workers into the staff team:

I can just imagine someone coming in and wanting to make things more robust . . . And put in lots of procedures and, you know, bring in the risk management coach and it would just be such a disastrous waste of everyone's time and really boring and no one would benefit from it really apart from the organisation feeling that little bit safer, which doesn't really do any good to anyone . . . What would be lost is staff feeling that they can be trusted to run this system . . . Because they can be trusted and I know they can be trusted because I manage them, and have done for quite a few years, and I do trust them. And I just [laughs] I'd just like it to be allowed to carry on without undue interference from people who probably think they're doing a good thing but, really, would just be getting in the way, frankly . . . I mean, I don't interfere with the support worker system because it works. I'm not saying we can't improve it . . . But usually the best way of improving things like that is listening to the support workers, not to some guy or woman from outside who says, 'Oh, you need to have these structures in place and da-de-da-de-da.'

PSM

Chapter 4 Peer worker roles and organisational change

This chapter reports our in-depth analysis of the data, drawing out learning for mental health service organisations planning to, or in the process of developing and introducing new peer worker roles. We draw out a number of important themes, and develop a new conceptual understanding of the organisational change issues around introducing peer worker roles in mental health services that moves on considerably from the original framework we developed at the outset of the study (see *Chapter 1*, *Conceptual framework*). We focus here on more conceptual issues that often transcend organisational contexts and service delivery settings (as distinct from the very context-specific findings we discussed in *Chapter 3*).

In this chapter we use our deeper analysis (see *Chapter 2*, *Developing organisational learning*) to discuss our findings in seven thematic areas, represented diagrammatically in *Figure 5*. Issues around the peer worker role, the individual peer workers themselves and the organisations within which they worked were inter-related. We begin by discussing in detail the essence of the peer worker role and then explore two 'routes' through our analysis. First, we explore the question of who the peer worker is, and how alike peer workers are to the people they support. Second, we consider the support that peer workers need, not just to do their job well but also to remain well themselves. We consider how organisational structures need to change to support role adoption. We then show how both identity issues and structural issues have an impact on organisational culture in two key ways: boundaries in mental health service practice are challenged, and the way that mental health and mental health care is talked about – in mental health teams – begins to change. As our feedback workshop participants suggested, organisational culture needed to change to support emerging peer worker roles, and our analysis kept returning to evidence of cultural change in our cases as new roles were introduced. Accordingly, we placed this sense of an 'evolving organisational culture' at the heart of our analysis, as a key facilitator of peer worker role adoption.

We discuss each element of *Figure 5* in the sections that follow, comparing our findings with the wider literature on peer worker roles and the organisational role adoption literature that underpinned our conceptual framework, as well as newer literature that has emerged since our study began. We use our discussion to highlight barriers to, and facilitators of, the introduction of new peer worker roles, with a view to informing organisational learning in mental health services in England (see *Chapter 5*, *Learning from the research: future development of new peer worker roles*).

The essence of the peer worker role

Participants identified several aspects of the peer worker role which made it distinctive and different from other, non-peer staff roles, in either the same organisation or other mental health organisations in the locality. Organisational literature indicates that the distinctiveness of a new role is an important factor in determining whether or not the role will be successfully adopted.[59] The 'uniqueness' and value attributed to the expertise, moreover, will determine the status and authority of the role,[73] and the extent to which role incumbents are able – or are enabled – to bring power to a new role has long been indicated as a key criterion of successful role adoption.[25]
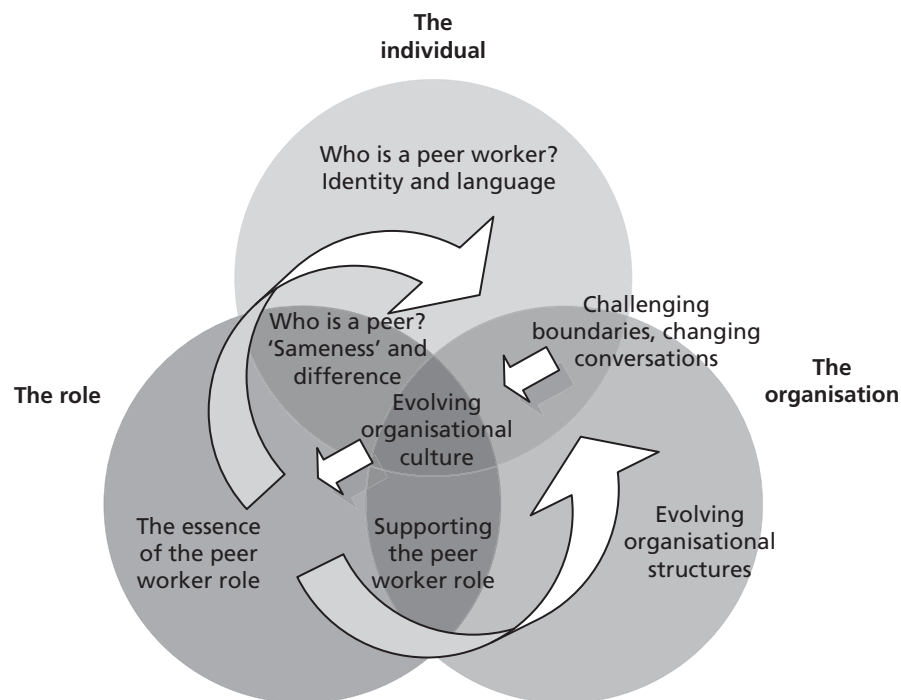
FIGURE 5 Introducing peer worker roles: a new conceptual understanding.

Differential knowledge

Peer workers were often described as making use of a different knowledge in their work than other, non-peer staff. This knowledge was gained from their own personal experiences of having mental health problems:

> *I think it's important that you have the lived experience, actually, thinking about it. That's very important. Not necessarily to have stayed in an inpatient setting but to at least have had some sort of lived experience . . . I think it gives you a better understanding, a ground foundation understanding sort of thing . . . So it helps you to relate to people better.*
>
> *PPW*

As Mead and MacNeil[19] have described, this kind of lived knowledge can be expressed 'through common values and stories that have been formulated through participation in a shared historical community – in this case that of being persons who have received mental health services'.[19] This experiential knowledge was compared to the more book-based, academic knowledge of other mental health professionals:

> *It means a lot because you know, when you're actually sat talking to somebody in a one-to-one session, that they actually understand what you are going through. They've actually experienced mental health and not just read it from a textbook. They haven't come fresh out of university without suffering any mental health issues. These people here have actually lived and survived through mental health and that's the difference.*
>
> *VSU*

One non-peer staff member in a NHS case summed up the difference in knowledge bases:

> *The difference is, I know what schizophrenia is. I don't understand it. They do. That's basically it in a nutshell. You know, I don't know what depression is. I know what the word is. I don't know what it feels like. They do.*
>
> *PST*

This differential knowledge was sometimes seen as being of direct value in terms of being useful to the non-peer staff member themselves or to the organisation as a whole:

> . . . a [peer worker] within a team because they've lived, you know, maybe they've gone through mental health themselves therefore they're the expert. And they're able to sort of guide professionals. Sometimes professionals can't really see from the point of view of the service user. However, the [peer worker] might be able to look at things differently and maybe suggest working with service users in a different way or maybe try different ways to sort of deal with certain things.
>
> NST

> It's about saying this is an organisational need, and you've got some skills that will allow us to be able to meet that organisational need, most usually in a way that we would find hard to do if you didn't have some of your background, so that could be that you get a more quick rapport with somebody, or it could be that you bring to bear a whole bunch of experience or that you bring with you a sense of credibility with you, or that you bring some . . . understanding which is hard-wired and we want to exchange . . . for the money . . . training and the respect of your peers . . .
>
> VSM

The importance of consensus on role expectations, vis-à-vis a lack of shared understanding, for potential integration of new roles into an existing team has been well demonstrated in both the generic and role-specific literature.[74,75] In some cases, differential knowledge was devalued by a lack of understanding and acceptance of its validity by the wider staff team. However, differential knowledge worked well where it was acknowledged and valued by non-peer staff who worked alongside peer workers:

> And so it's almost like it's hard to explain to, I've had to explain to some workers that the experience they [peer workers] bring is personal experience and that is the qualification. [The issue is] people still . . . I don't want to be too strong. Not accepting, I think it's as simple as that, really.
>
> PST

> . . . people feel more understood, a great sense of validation, it's more person-centred, 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.
>
> VST

Different relationships (enabling openness)

Many participants talked about how the nature of the relationships between peer workers and service users was different from those between service users and non-peer staff. Relationships were described as being 'non-judgemental' and 'non-directive', and more 'genuine', 'honest', 'equal' and 'person-centred':

> It means being someone who can advise someone, someone who can be a confidante, as it were. You know, someone that a [service user] can tell things to that they might not tell someone else. Someone who is easy to interact with. You know, not like makes you feel uncomfortable . . . someone really, you can't talk about certain things with. You know, just a no go area or whatever, like, they won't react well. So somebody you can talk to anything about, in a lot of ways.
>
> PPW

There was a clear perceived difference in the relationship service users had with peer workers when compared with their relationships with other members of ward staff in this inpatient setting:

> I mean we're just left on the sofas . . . and the staff just come and wander around making notes, checking – I mean, they only really check if we're awake, asleep and alive. I mean, if anything kicks off then they all rush to pin you down and inject you, but they don't really – they don't really sort of care, really. That's a bit unfair on some of the staff but they're just floating around doing whatever they

want. They don't really, like, come in to have a chat with you. They wait for you to chat with them but [peer worker] will kind of, she'll come in and sort of say 'hi' to people and sort of say, 'Look, I'm here.' And pick up a conversation with you and such.

<div align="right">

PSU

</div>

The authentic nature of this different relationship was understood and valued by other staff and managers as beneficial to service users:

I think the fact that they're not nursing staff, seen as nursing staff, is that I think that they probably provide real respite to people when they are with them, because the individual can just be completely themselves because they're talking to someone that has been there, that has been through the services and I think they become like sort of, well, they become really quite good friends and confidants, really. So I think that's nice. That's a more human, natural relationship.

<div align="right">

PST

</div>

Service users feeling able to open up more to peer workers was seen to be useful to staff members in terms of hearing honest feedback on their practice:

I want them . . . to have a different view on things because I make mistakes and I want them to be able to say, 'That weren't clever.' You know? And I want somebody [service users] to speak to somebody. If they don't feel like they can speak to a member of staff . . . Quite often they'll speak to support workers who will feed it back to us. So it is important that they are different just to get that little bit of extra information that can sort of help.

<div align="right">

PST

</div>

In an NHS context, this peer worker found her clients were open with her even though they knew that peer workers would share what they had been told with the multidisciplinary team:

I was sitting with a [service user] in one of my rooms and we were having a discussion and then her care co-ordinator walked in and she just completely shut down . . . and then when the care co-ordinator 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 . . . they tell me a lot more things that they don't tell their care co-ordinator. I'm sure some of them know that we all communicate anyway and we have to write our notes on the computer but it might just be that actually they feel more comfortable telling me certain things . . .

<div align="right">

NPW

</div>

Role modelling (sharing lived experience, realising hope)

The ability of peer workers to embody hope by directly modelling wellness and recovery was another distinctive aspect of the peer worker role (see also Brooker[76]). This was valued by service users and managers:

. . . I think it's to know that you can have life beyond that and this is one example of life beyond that so I think, as part of my . . . and others' ongoing recovery, 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.

<div align="right">

VSU

</div>

And also, 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.

<div align="right">

NMA

</div>

Using lived experience to demonstrate recovery was seen as distinctive from other, non-peer roles:

> *. . . if a psychiatrist is talking to you or a mental health nurse you sort of think, 'They don't really know. They're just telling you what they've read.' It's not a living experience. Whereas somebody else who has had mental health difficulties and they've come through it when you hear about that, like, especially things like depression. 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.*
>
> *PSU*

Managers in the NHS – reflecting our findings on expectations of disclosure in *Chapter 3*, *Formal one-to-one line management for peer workers* – thought that peer workers should be actively telling their 'recovery stories' in order to do that role modelling work:

> *You're not wanting people to go through a catalogue and chronology of their personal history. It's actually the recovery part of that experience that you're actually wanting people . . . you're trying to kind of help people to move forward, so . . . you may disclose your diagnosis . . . but actually it's the hope part, which is the kind of key part . . .*
>
> *NSM*

Training and exploring the sharing of recovery stories was considered important:

> *And that's partly why, in the training, we really looked to people developing their recovery stories and exploring what they're comfortable with sharing and what that means to share your experiences and stuff. I think that's a really important part of the training because somebody might want to support someone and someone might have their experiences but they might not be at the place where they're willing to really open up and share their own. And I think that is a key element to peer support.*
>
> *NMA*

Finally, as found in a study of 31 peer providers,[48] the role modelling aspect of the peer worker role served as an important motivating force that enhanced the peer worker's commitment to, and satisfaction from, the work. In several of our case studies, peer workers talked about wanting to make a difference to other people with mental health problems through sharing their lived experience:

> *I think the greatest thing that's in you is real empathy and a desire to want to make a difference . . . and share. Use what you have been through, share what you have been through, what's worked for you, what hasn't worked for you, to help make a difference for someone else.*
>
> *VPW*

Bridging and engaging

An important aspect of the peer worker role was that it could act as a bridge between service users and the team, and enable service users to engage with, and so better access, mental health services:

> *. . . they've got to have a relationship with the staff and they've got to have a relationship with the [service users]. They're a bridge. And to be that bridge I think you're going to have to be a kind of a pretty astute person.*
>
> *NSU*

. . . it's like another step in between. I mean, with [non-peer staff member] there isn't a problem. You know, I could talk to him about anything but not everybody can. So you've got [the peer worker] in between.

<div align="right">*PSU*</div>

Sometimes the bridging aspect of the role was grounded in the language that peer workers used. That aspect is considered in more detail in *Who is a peer worker? Identity and language*.

Trust in relationships was seen as another bridging quality, and peer workers were often seen as having trusting relationships with both service users and non-peer members of the staff team. The bridging aspect of the role was therefore seen as a connecting force:

They do view [us] as 'us and them' sometimes but . . . [the peer worker] sort of smooths that . . . he has a laugh and a joke with all of us. I mean, he's forever ribbing [non-peer staff] and the relationship between them is absolutely brilliant, but the relationship between [peer worker] and ourselves is absolutely brilliant and it brings it all together.

<div align="right">*PSU*</div>

A further aspect of the bridging role was that peer workers could give voice to issues important to service users that might otherwise be lost, in a way that is recognised and acknowledged by the wider staff team:

. . . what she does is, she raises it in a forum . . . Whereas, it may have been that a service user may have said it to another person or a nurse . . . and that the information gets lost. What she will do is take that, put it in context, present it at forum and say, 'This is how people are feeling.' She'll put it in a much more formal, structured way.

<div align="right">*NMA*</div>

Non-peer staff clearly valued this bridging role and described how it helped the staff in the service as a whole to build up trust and engage with service users:

. . . it's just another way in for us to sort of give us more things to work with . . . it feeds down so that trust develops a little bit quicker for us . . . They've got a chance for working more closely with somebody. Whereas we don't have time to actually . . . So I get [peer workers] in to work closely with who I think they will work well with . . . and then once they've got that trust he can say, 'Well, tell [the non-peer staff member]. He'll sort it out for you.' And then because he's said it they trust it's going to happen, you know, because he's developed a closer relationship than I can do.

<div align="right">*PST*</div>

We found positive examples of where peer workers were able to help service users engage in a service by overcoming some of the inherent tensions:

Some people, probably especially our generation, tend to have a real problem with authority of any kind . . . and find it easier with the peer relationship.

<div align="right">*NPW*</div>

Being a team player: the peer worker role and generic task

For peer workers in the NHS there was an element of engaging in generic tasks that were shared by the whole team. Our data suggest ambivalence towards this; undertaking a certain amount of generic task was seen as an aspect of being part of the team, but too much generic task could erode the distinctiveness of the role (see also *Chapter 3, Formal one-to-one line management for peer workers*):

I still do things because I am part of the team and if we are short staffed and things like that, if we have four patients on observations and we've got one staff member off sick . . . but sometimes it can

have an impact on my role . . . if there are patients that really wanted one to one with me and I've not been able to do it . . . that is frustrating.

<div align="right">*NPW*</div>

The peer worker role was sometimes seen as an opportunity to focus on relational work with service users rather than having to spend time on generic tasks:

. . . it's unfortunate that the rest of my colleagues have an awful lot of paperwork that they need to do for several different things and I'm sure if they had the chance and opportunity they would love to spend an hour, two hours, with a client. But they have all this stuff that they need to do that prevents them from doing that. And I think whereas my role I do have that opportunity to do that.

<div align="right">*NPW*</div>

We found a number of examples of peer workers routinely taking on tasks for service users or for mental health professionals that were not intrinsic to the peer worker role. The wider organisational literature suggests that where new roles become the repository, for the existing team, of low value, unwanted tasks, the role becomes 'ghettoised' and is less likely to be successfully adopted as a distinctive role:[77]

Some peer workers get treated like another staff member where they're like, 'can you go into the office and get me something from my box.' Or, 'can you open up this room for me?' And that's like a basic help, you know, practical help and that's fine . . . That's what the [service user] might ask the staff to do.

<div align="right">*PPW*</div>

. . . in the beginning people were just telling me, 'Could you do this? Could you do that?' And I'd just be doing it . . . things like, 'Oh, can you fill out this application form.' 'My [service user] needs to go and buy some curtains, can you go with them?' Yes, okay, I'm willing to go with somebody to buy some curtains, helping them, but that's not my sole purpose of what I came here to do.

<div align="right">*NPW*</div>

Who is a peer? 'Sameness' and difference

Who is a peer?

In our cases the question of 'who is a peer?' seemed to be fundamental to the introduction of peer worker roles. Peer identity implies a 'point of connection' or 'sameness' between peers. Peer support refers to relationships and interactions between people who are peers; support that is 'peer to peer'.[78] It is that point of sameness which must be understood and experienced for a peer worker role to work. In services for people with mental health problems, the point of connection or 'peerness' is primarily around shared lived experience of mental health problems. Repper and Carter[17] state that 'the peer support "approach" assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation'. Our evidence suggested that where there is felt to be enough sameness or 'peerness' on offer – adequate point of connection or identification with the worker – this acts as a foundation for building trust in the relationship:

. . . 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.

<div align="right">*VSM*</div>

There was broad consensus that peer workers should have lived experience of using similar services to those they are working in (see *Chapter 3, Formal one-to-one line management for peer workers*). However, there were some differences of opinion on exactly how similar those experiences needed to be. There was some feeling that sharing a more general set of experiences associated with mental health

problems was important (e.g. social exclusion and stigma, and loss of opportunity, education, family life, friendships, choice and power):

> *Is personal experience of mental health issues sufficient? And my answer to that would be kind of 'no' . . . and actually is having African Caribbean background, is that sufficient? And my answer again would be 'no'. Actually it's about the everything that somebody brings . . . It's those challenges and adversity that happens to people . . . a loss of identity, loss of finances, stigma. It tends to be those things where people, there is that almost thing in common, though the situations, their culture can be different, you know, you don't have to match a peer to somebody the same because there seems to be a common thread, that pulls through, of understanding.*
>
> *NSM*

Where services were more specialist the view was often expressed that the peer worker needed to have shared lived experience of the specific problems of the people they were supporting (e.g. severity, symptoms or diagnoses):

> *. . . we've seen some lovely evidence of one of our peer workers who has had eating challenges going on our eating disorder ward . . . so she can really use her lived experience. Now, if we'd have had a generic peer worker who may have come with issues around perhaps anxiety, depression. They may not have been able to kind of link in and engage with that person because they wouldn't really know about those challenges. They may have links in terms of anxiety or depression but it won't be specific challenges around eating.*
>
> *NSM*

> *. . . what some service users do like to have is that similarity . . . perhaps a peer worker has been detained under the Mental Health Act . . . and then the service user that they're working with has experienced that as well. So you've got that similarity. So you sort of have cemented that sort of professional working relationship.*
>
> *NMA*

Similarly, where a service supported a distinctive population the view was expressed that it would be beneficial for peer workers to reflect that population. Points of connection could be sociodemographic and cultural, as well as related to lived experience of mental health problems:

> *. . . there's no point having an old person working in a first episode psychosis team as a peer . . . age, gender, to a certain degree. Basically whatever the kind of profile is of the service. So actually if you're in a CMHT which is 70% working with people who are from black and ethnic minority backgrounds, then actually it's probably quite helpful to have somebody reflecting that profile of the service.*
>
> *NSM*

> *. . . if you sent someone, like, middle-class in to do some effective work with a group of Somali elderly women, like, that's not going to work in the same way that it would if we sent one of our older Somali women to go and work with them, or one of our younger Somali women to go and work with them in their language. Because, first of all, one of the things they're going to say is, 'This person is like me.' . . . So already . . . they're going to be more likely to relate to that person. And they would be more likely to find points of commonality between them. Like, the cultural references and that kind of thing and it's about the language, of course.*
>
> *VMA*

Sometimes points of personal identification were valued as demonstrating that connection, alongside shared lived experience of mental health problems:

. . . if they can be themselves . . . and then you can . . . I believe that . . . She's a lesbian, same as me. So we hit it off straight away and, with, like, depression and self-esteem we were the same, I think. And I think that's why I could talk to her.

NSU

Bott[79] suggests that it is important for each individual to be able to choose a peer worker, citing examples of people willing to travel out of area for support from a peer with a close match of experience. We found evidence in our cases of services trying to make a range of peer workers available to facilitate that choice:

. . . the diversity is . . . we provide a service . . . for everybody, different ethnicity, different ways, different . . . sex . . . also the peer worker also can be from different community . . . they can speak different language.

VST

. . . when I think about all the peer workers, we're a mixed bunch really, we're not just one type of person . . . we're all different ethnic backgrounds, practically. We're all different shapes and sizes . . . the peer workers have always been female . . . there are a couple of guys . . . but like we're all very different. We all do different things with people on the wards. So I think people can expect different things from us . . . I think we've all kind of developed the role according to who we feel we are personally.

PPW

Sameness and difference

Although being a peer is about there being points of *sameness*, by definition there is *difference* inherent in a role where the peer worker is providing support and the service user is receiving that support. Davidson and colleagues[80] discuss differing shifts in reciprocity towards 'giver' and 'receiver' of care relationships across a range of peer support roles. In the cases in our study, there was an expectation that peer workers would be at a different stage of recovery from the people they were supporting, but that some sense of reciprocity must not be lost if the relationship was to remain peer to peer:

. . . when I first started using the service, I was in hospital . . . so that was very important that I knew that at least some . . . of the peer workers had experience of being in hospital themselves, which . . . at the time was even more important than just knowing that they had lived experience of mental health problems . . . and I think . . . for me as well, it was important in terms of recovery and hope, that I could believe that this person was doing that role had progressed so far in their own recovery that they were able to actually be part of an organisation that was providing . . . a very useful and important service for other people. And so that gave you a kind of reassurance and encouragement for the future really as well . . .

VSU

One peer worker felt that the fact that peer workers might still need support from mental health services themselves maintained that point of connection:

I don't see there's a big difference between me and a service user. Obviously there is, but I'm there as a service user as well as a [peer worker] . . . I'm there to help everybody else, the bigger group, as well . . . I'm there for myself as well as everybody else.

PPW

Mead and colleagues[50] pointed out that formalising peer support by offering payment, training and titles will inevitably lead to power differences – even if these are minimised. Here, one peer worker acknowledges that difference, most demonstrably in the payment they received for their work:

> *I think there is a difference. Like, obviously the people who work here are able to come to work and hold down a job and obviously they benefit from that financially. And a lot of the people that actually use the service have disability living allowance, they aren't able to work because of their kind of enduring mental health problems. So there is a sort of two-level thing going on.*
>
> *VPW*

The advantages of a formal, paid role – bringing consistency and status alongside other roles – have been considered alongside the potential risk of invalidating the mutuality and equality in the peer-to-peer relationship.[81] Debates around the benefits of, and concerns about, professionalisation of the role are ongoing.[82] One peer worker in our study was concerned that reciprocity or peerness might be lost if the role was overformalised:

> *I personally don't feel very comfortable with the term 'peer worker' . . . the reason being because, for me, it started off as peer support, which is something I think I've been part of ever since I was diagnosed with a mental illness. And peer support, for me, is about people with similar experiences of mental health sharing, supporting each other in various ways . . . on a very informal level . . . It's not a contract. There's no written rules about how it should be done. There's no dos and don'ts . . .*
>
> *VPW*

At times peer workers had to contend with an element of mistrust from the people they sought to support, and these challenges have also been seen in another recent, qualitative exploration of the peer worker role:[83]

> *I know there's people in here that probably wouldn't appreciate having a talk with [the peer worker] because they just see [the peer worker] as another member of staff.*
>
> *PSU*

> *Occasionally, even from a person on the ward, I would get negative, like, 'Oh, you're working for the other side now.' But very, very rarely.*
>
> *PPW*

As we have shown previously (see *Chapter 3*, *Formal one-to-one line management for peer workers* and *Being a team player: the peer worker role and generic task* in the present chapter), ensuring distinctiveness between peer worker roles and other (non-peer) roles on the team in our partnership and NHS cases went some way towards protecting peerness and the connectedness in the peer worker role:

> *. . . other members of staff, particularly the trained staff, if they have to give someone medication or something that the person doesn't want to necessarily accept, they're very sort of anti that member of staff and getting quite cross with them. Whereas someone like the peer support worker, they don't have anything really to do with that role.*
>
> *PPW*

Sometimes it was important for managers to enable peer workers to maintain the distinctive qualities of their role:

> *. . . in some teams it's been hard to keep the uniqueness of the peer worker role. So they have almost fell into, like, a support worker role . . . So what we have to do is keep pulling them back and saying, 'Okay, so how do you ensure that you're keeping the uniqueness of your role? . . . are you sharing your lived experience?' You know, is there a difference between a peer worker and a support worker?*

If not, why not? What can we do to make sure that there is that difference? . . . [or] we're not getting that 'peerness'.

<div align="right">

NSM
</div>

Who is a peer worker? Identity and language

In the previous section we discussed the particular qualities of being a peer that were necessary to embody the peer worker role. However, it was noted in *Chapter 3* (see *Peer workers receiving support from other members of the staff team*) that shared lived experience of mental health problems was not seen as sufficient to qualify an individual for a peer worker role; other personal qualities were also seen as necessary. In this section we explore other aspects of the peer worker identity and consider the importance of language and the peer worker role.

Identity and the peer worker role

As in previous research,[82] the value of peer workers identifying with and even being identified as service users – acknowledging and making use of their own vulnerability, humanity and lived experience in their role – was recognised:

I don't see it as a, 'them and us' type thing . . . I'm a service user so when I say service user I'm talking about myself and I always think if it were me what would I like to happen or what would I like somebody to do for me. Because it has been me so therefore it could be me again.

<div align="right">

PSM
</div>

As has been recognised elsewhere,[84] potential peer workers needed to be motivated and to feel ready to reconcile their mental health identify with a job of work:

And I thought, 'Well, actually, you know, I'm quite settled with my mental health. I've come to terms with my mental health. I'm okay with my mental health.' And then I felt, well, actually could I not do this as a job?

<div align="right">

NPW
</div>

I think peer workers must be more dedicated . . . I think when [peer workers] do it it's got to be more than just a job.

<div align="right">

NSU
</div>

There was strong concern about being identified solely as 'staff'. Having a staff identity could work against the notion of 'peerness' or of 'being like you':

I get accused of being staff sometimes. So I just say, 'I'm not staff, I've come here. I'm very much like you, apart from I know a bit more about computers than anybody else here . . .'

<div align="right">

PPW
</div>

Mead[50] describes peer support as a context in which people are enabled to move beyond their 'mental patient' identities. In many of our cases there was a perceived progression from being a service user to being a peer worker:

I think the essence is the amount of hope that it gives to other service users, that, from being a service . . . I mean having this label of 'service user', you might one day be able to be a service user worker.

<div align="right">

VSU
</div>

In previous research we identified the complexities of balancing 'dual roles' or identities, especially when people found themselves between roles.[23] Described elsewhere as 'role conflict',[82] we found evidence of similar tension here:

> . . . on the one hand, you still wanted to be accepted as a service user, as a fellow service user, as a peer. And on the other hand you also wanted to show that you had the capabilities to do a job, to be professional, in a sense. So it's a very difficult balancing act. And I'm not sure that I managed it very well . . . for me, the way I managed it was always seeing myself as the service user first, the worker second.
>
> *VPW*

For some of our participants, being a peer worker was more than a role; they identified themselves personally with working from a peer perspective:

> . . . our whole organisation is [peer]-led . . . it's difficult to describe because it's who we are . . . it's not what we do it's who we are. Because the organisation was set up by campaigning mental health service users and valued across the organisation, it's one of the aspects of our service that [service users] most value, that people who have been in crisis themselves who work here.
>
> *VSM*

Some participants acknowledged, or felt personally, that they might not always want themselves to be defined, through their work, by a service user or peer identity:

> I've kind of joked with people over time about, you know, 'I am allowed to stop using services and they won't kind of sack me from my job' . . . people have a 'patient' identity . . . a 'service user that's involved in stuff' identity . . . [it's] been a joy in the past to have a role where it's explicit and I can draw on my lived experience but is that something I always want to have? . . . there is a danger that it's a new identity for someone, but it's still an identity that is predicated on using mental health services. And is that a lifestyle choice and a lifetime goal? I don't know.
>
> *NSM*

> . . . there may come a point when you don't want to be defined by that any more. Because by coming to work in [a peer-led organisation] you are outing yourself as someone with mental health problems. And you may at some point want to move on from that identity and not be immersed in the world of mental health . . . there's something about becoming a professional service user that I think might be limiting to individuals . . . we see it as putting our crap experience to good use. Yeah, but there are times when I've thought, 'I'm not sure I want my life to be defined by trauma forever.' Sometimes I think it would be nice to work in a library or do something that's not about people's miserable lives.
>
> *VSM*

Who is a peer worker in a peer-led organisation?

Many of the voluntary sector organisations in our study were peer led and, as we noted in the methods section (see *Chapter 2*, *Recruitment process*), it was sometimes hard to identify who was working in a peer worker role in an organisation where all or many of the staff team were bringing a peer perspective to their work. In one peer-led organisation, being a peer was left undefined in terms of which specific lived experiences contributed to it. The emphasis was on commonality:

> . . . there has to be a sense of equality. A sense of something shared. Obviously, that's very vague but I think it has to be vague in a way because you're not going to share necessarily, I mean, I suppose all that we might have shared is some sort of pain or some sort of distress and an understanding of that

> *. . . we're quite a big team and I really think that most of us don't know how or why we would describe each other . . . most of us don't know much about each other's history yet. But, yet, we feel we're peers.*
>
> <div align="right">*VMA*</div>

One member of staff working in a specific area thought that they might be considered a peer worker if they worked in a different role in a more generic mental health organisation:

> *So if I was working in a general mental health organisation I could be considered a peer worker . . . I guess it's very blurry, because I don't even know if I'm, do I consider myself to be a peer worker? I don't know. And in my work I'm not considered a peer worker. But if I was in a different organisation maybe I could be.*
>
> <div align="right">*VST*</div>

In one organisation it was seen as quite powerful that it was not clear who was working from a lived experience perspective and who was not. However, service users did not always find that approach helpful:

> *I don't think people individually do need to know who is and who isn't. I think it models something far stronger just the fact that some of us are and some of us aren't. Actually, it doesn't really matter and we are both equally capable.*
>
> <div align="right">*VPW*</div>

> *I think I would quite like to have known, from the beginning, who was and who wasn't, somebody with a similar lived experience to me . . .*
>
> <div align="right">*VSU*</div>

Language and the peer worker role

Part of the process of introducing peer worker roles was about settling on the language used to describe the role (see also *Chapter 3, Specific skills for managing peer workers*). There were as many terms for peer worker roles as there were roles across the cases. Some described their functional role: recovery *coach*, peer *trainer*, *support* worker. In some cases it was the term 'peer' that felt like jargon and needed explaining:

> *The peer worker only started recently. Suddenly this word 'peer workers' came.*
>
> <div align="right">*PMA*</div>

> *. . . the two guys that interviewed me were quite surprised that I had my own . . . mental health lived experience and then I had to explain to them exactly what the peer bit of peer working was. It hadn't been explained to them, or they hadn't cottoned on anyway to how that . . . And I think maybe there had been an assumption . . . that everyone knows what you're talking about.*
>
> <div align="right">*NPW*</div>

In peer-led services the term peer worker was not often used, as people throughout the organisation used lived experience in their work:

> *As a peer worker, no, as somebody with a shared lived experience . . .*
>
> <div align="right">*VST*</div>

The issue of an appropriate label for the role was particularly pertinent in BME cases:

> *I think that flexibility is key because every community has a different way that they like to be approached and asked about things . . . when we did the advertising for the Chinese community, they wanted to be called activists . . . they were going to make a change, whereas we were very aware of*

the political and social understanding of that word, activist, in the Irish community . . . [they] said, 'yes, don't do that, people might not be interested, but you know if you use community health educator then that explains exactly what we're going to be doing' . . .

VST

There were also varying terms used for the people with mental health problems whom peer workers worked alongside. In some settings, using the term 'patient' or 'client' was seen as inappropriate. In other settings, their equal peer status was emphasised; for example, 'inpatient peer'. Sometimes the term 'service user' was used, whereas others saw this as unhelpful. Calling people 'members' or 'visitors' appeared to emphasise choice in receiving support:

I try and say 'people receiving services' . . . but other people, they're used to calling themselves, calling them 'patients'. They're used to perhaps not having as hopeful an approach to them.

NPW

. . . we don't, of course we don't call our members 'clients'.

PPW

. . . in terms of labels and things like that, being called a service user, it's not always to everyone's cup of tea . . . we use the term, 'service user' as someone that kind of identifies as having that lived experience but we are aware that it isn't always a nice term that people are comfortable with . . . we understand that it can be also stigmatising . . .

VST

Mead and MacNeil[19] assert that the language of mental health plays a crucial role in distinguishing peer support roles from traditional mental health care. They state that where peer workers feel the need to use language that 'fits in' with that used by the existing team, this neglects the unique personal experience of the peer, which they are in a position to capture. The issue of peer workers challenging language used in mental health services that they experience as stigmatising is considered in detail in *Changing conversations* below.

Finally, as noted previously (see *Chapter 3*, *Specific skills for managing peer workers*), peer workers used language in specific cultural contexts to convey meaning around lived experience of mental health problems that made cultural sense. NHS Modernisation Agency[85] guidance recommends valuing workers' cultural awareness and communication skills in effective involvement. This was doubly important in a setting where English was not the first language of either peer workers or the people they were supporting:

. . . when we deliver mental health, we think about what kind of example and also . . . what they will understand when we're talking about something about mental health, they understand what is said.

VST

Supporting the peer worker role

In previous research undertaken by the team we found teams and managers working hard to support peer workers, but peer workers did not always feel that that support appropriately addressed the essential peer elements of their role;[23] as a result they did not always feel supported. Our findings here suggest that support to undertake specifically peer elements of the role was also supportive of the individual peer worker's well-being.

Support for staying well

The wider peer support literature has noted that peer workers can experience role-related stress in their work.[86] Managers and peer workers in our study noted the possibility that peer workers might become unwell, and that this might be related to the challenging, relational aspects of the role (noted in *The essence of the peer worker role* above):

> *. . . but there are times when, say, sickness has been quite high and I don't think that's because they're not doing it well . . . I don't know, their stress levels are higher or they're not able to balance things at that point as well or things at home are more difficult or what exactly. But there are times when we suffer in that way, when sickness is higher.*
>
> *VMA*

> *. . . the job that we do is . . . it's incredibly intense, it's incredibly emotive. Yes, we get paid to do it but also it's quite personal to us . . . and we, you know, we care . . . You care but you have to have that line which is crucial for your well-being . . . but the amount of time that we spend with peers is probably a lot more than most other roles.*
>
> *NPW*

Good self-care skills were seen to facilitate peer workers remaining well in the job:

> *But if you don't have that insight that your personal problems could affect someone else you're not going to be able to, you know, to perform and support someone. You have to have the knowledge and insight to say, 'I can't do it right now.'*
>
> *VSU*

> *I think it's extremely important. I went to help out with a workshop . . . and when it actually got there I couldn't face doing it and I had to say to [my manager], 'You're going to have to step in and do this. I can't face it.'*
>
> *VMA*

Support from other peer workers also seemed crucial to maintaining wellness:

> *. . . you do need someone to kind of offload on to, in a way. Like, we kind of, the peer workers, we're all quite close in a way, like, we all know what's happening with each other and if there's anything wrong that we're really worried about then we'll ring each other up. We've got each other's numbers . . . or like if we're in on the same day then we'll generally have a lunch break together.*
>
> *PPW*

In some cases spaces for peer support for peer workers was provided, but peer workers were not always enabled to make use of them:

> *There was one time where I had a peer support forum which was only every month and it's really crucial. We only get an hour-and-a-half. But you go and you sit together with fellow [peer workers] and it's your time to be supported . . . It's so invaluable. It's really important. But, and I remember this one time I hadn't been allowed to go the time before, I asked for this time if I could go. On the morning that I was due to go I was then told I was needed to do [a therapy] group. And that if I went to that it would mean that the patients wouldn't get their therapy group. Now, hello, what am I going to choose? Myself or the [service users]? So you stay and you do the group. Absolutely appalling.*
>
> *NPW*

We noted previously how staff teams were generally supportive of peer workers (see *Chapter 3, Cover by other members of the team*). In some cases there was an acknowledgement that additional, role-related

support might be needed to work in a peer capacity, taking account of the individual peer worker's mental health needs:

> . . . we wouldn't necessarily share mental health history but we'd say perhaps that so-and-so . . . is having problems or issues with such-and-such . . . we'll always say, 'How are they now? And how's that bit of their history going?' You know, 'how has that been? Do we need to watch that bit?' . . . it's not formal . . . but we're all very open, authentic and honest about it. So things will be talked about anyway, so people will talk about their own history if they want to as well.
>
> *VSM*

Team support worked less well when the response to a peer worker's mental health needs was medically determined:

> I have noticed her mood has gone up and down and there were comments from other staff, nursing staff, saying to me, 'Oh, she's bipolar,' which obviously we don't sort of . . . I don't tend to want to diagnose or, you know, stick a label to anybody because we're obviously trying to sort of eliminate sort of mental health stigma . . . But it's being aware of moods up or down, how she then functions in her role here and I think sometimes it has been where she's been full pelt at times.
>
> *NST*

Line management and supervision

It was also important that managers understood the peer worker's mental health needs in the context of their peer role; that their lived experience of mental health problems was integral to the role:

> . . . he constantly has visual and some auditory hallucination. They're there and he's a great, you know, he gets on with his role very well. What we discussed in his mini WRAP [Wellness Recovery Action Planning] was when he becomes more and more distracted and that's okay for me to flag it up . . . you could have somebody that's kind of like, if he was to say to me, 'These are the visual hallucinations I have,' I might go, 'Oh, my God, this person's really unwell. Should they be at work?' You know, if they put it out of context, if that makes sense? . . . But actually it's about, that's something he's learning to live with . . .
>
> *NMA*

Managerial support came partly in the form of one-to-one supervision. Supervision came in different forms and frequencies across our case study sites. What was common was that there was a supportive person available to talk through issues with the peer worker when the need arose, often specifically to deal with having engaged directly with sometimes difficult personal experiences:

> I understood that, it's part of kind of every role here. You talk about things that are quite difficult and you're listening to stories that are difficult, heart-wrenching and if you don't use supervision, the support of the team, then you become like . . . [a] sponge where you're just soaking up everything and you eventually need to be squeezed out a little bit otherwise you're not going to soak up anything else, really.
>
> *VPW*

The one-to-one support was needed not just in planned, regular supervision but sometimes on an ad hoc basis:

> . . . I always find if I have any queries that they're answered properly and fully in supervision . . . [my manager] likes to do everything formally in supervision. But there are occasional things I will say to her at any time, which I feel pressing and I have to talk to her before the next supervision. And she's fine . . .
>
> *PPW*

Supervision worked when it was a place to talk about the demands of the role and the peer worker's well-being. In one voluntary sector case, one-to-one support was split into task-orientated supervision and a dedicated space to talk about those role-related demands:

> *I had management supervision and non-management supervision, so it was perfect . . . for me that was extremely important because it helped to deal with issues. It helped to look at things from a different light and, you know, again, also helped to put things in perspective. It helped me to remember that sometimes I need to stop and think about my own mental health . . . You know, because sometimes in the work environment you tend to forget . . . And you tend to say, 'Well, I can't afford to worry about my mental health now. I need to meet this deadline.'*
>
> *VPW*

Some cases used a specific tool to keep supervision focused and ensure that issues around personal well-being were not neglected:

> *. . . in some ways a good tool has been the mini WRAP because it's about keeping the mini WRAP work-related day . . . it's kind of keeping the focus on the relevancy of your wellness in work rather than getting too much about your general wellness and life and too much then becoming a kind of trying to sort someone's life out sort of thing. You've got to keep it focused.*
>
> *NMA*

The potential challenges of the manager role were noted; of slipping into clinician mode if the peer worker needed additional support, rather than providing support as a manager:

> *Managers often just kind of feel they lack the confidence [to manage peer workers] and we try to be clear with them that, from day one, their job is to be a manager, not become the clinician . . . your job is to work out can a person do the job, will they fit in etc. . . . The same if they've got concerns about people's mental states, it's not there to do the mental state examination . . . call the right support bit as you would for any other member of staff . . . and it's just building that confidence actually of managers.*
>
> *NSM*

In some cases it was felt that the line management tasks and support for the peer worker's mental health needs should be kept separate:

> *It's very easy, when people are distressed, for people to get, to lose perspective, I think, because they want to help and there should be another team of people kind of doing that helping . . . the manager should be helping in relation to the job and not really get sucked into all the other stuff. Which is much easier said than done . . . you've got to think that it is the role of a manager is to manage the individual. It's not to support them through their mental health crisis . . .*
>
> *NCO*

Training

It was noted previously that role-specific training was available across all our cases, and was highly valued (see *Chapter 3*, *Colleagues informed of peer workers' mental health history*). Training worked well when peer workers felt that they were properly equipped to confidently carry out the essential peer aspects of their role:

> *We do quite a bit on listening skills, which I think's very important in this role. We look at skills around looking after ourselves, keeping ourselves well and dealing with stress. So again, I think that's very important. Just how to be available to people without trying to become a friend or being too aloof and there's challenges there, of course, because people have been here a while, often, when they come into the role, so they will have made friends already and they may have exchanged phone*

numbers, as friends, so it's looking around all of those kind of issues which is not easy and there's not an easy answer to. But it's just trying to raise people's awareness, really.

PMA

Peer workers valued learning the tools to be able to maintain their own wellness in the job:

And I think a big part of what I've learnt through the training and through looking at self-help tools is at some point you've got to, you know, you've got to find a way of taking some control back.

NPW

Learning interactively from other peer workers was also supportive of the role:

It's very interactive training. So that was the other element. It's not a classroom . . . the [peer workers] become trainers of each other in a lot of that . . . The whole time they're sharing experiences with each other and they're learning off each other . . .

NMA

The training was not so successful in supporting introduction of the peer worker role when it did not set the peer workers up for their tasks, or for the setting in which they were working:

Because we're in an inpatient setting in this hospital and when we got trained for peer mentoring it was more sort of out in the community. It made it feel like it wasn't ever in a hospital setting. And although it was good training, I'm sure it would have been great throughout the community and it still is good, we can still take some elements of it and use it, definitely, I'm sure we did. It just was a shame that it wasn't specifically for inpatient settings or hospital-based sort of settings, or something around inpatient acute hospital settings.

PPW

. . . we were almost blind when we actually did come out . . . I think because from the course to actually doing the job it's, the two are completely different. So I kind of came here thinking, 'Right, so what do I do? . . . I don't know what I should be doing'. I could have said, 'Well, I've had training,' but actually I didn't, you know, because it didn't relate to actually working in the community, what is it going to be like?

NPW

Evolving organisational structures

In our cases we observed organisational structures evolving to better support new peer worker roles. Some of this structural change was planned and some was reactive. Organisational change encompassed the recruitment process, training, team structures, and commissioning and strategic priorities.

Team structure and the peer worker role
There was recognition in our NHS cases that a critical mass of peer workers needed to be introduced within teams or services to facilitate cultural change:[25]

. . . putting a [peer worker], on a ward, is not going to have any impact, beyond the individual relationships that they have with the people on the wards . . . a single band 3 post, is not going to transform the culture of a ward . . . to really make it work . . . a [peer worker] in a team with a dozen to 15 other qualified professionals, it ain't gonna to change things. It'll shift things but it won't deliver on that expectation of really changing . . . the culture of the organisation or more importantly people's experience of the organisation.

NSM

. . . there's still quite a culture change required, I think. And I think where there are people who, in the past, have been, you know, had their own lived experience and work in the services and they've not always had support to share that . . . if you get to a point where it's quite a number of peers working within the services and it's actually seen as a positive resource . . . I think it's probably going to be a bit of a snowball. We're in that quite hard – hard getting it started stage but once it gets momentum I think, yeah, it will take over.

NPW

We saw above how establishing the distinctiveness of the peer worker role alongside other roles within the team was important (see *Being a team player: the peer worker role and generic task*). One NHS commissioner saw dangers for sustainability of the peer worker role in not clearly defining the place of the peer worker in the team:

I think for sustainability . . . the peer workers will get pulled in all sorts of directions. 'Look, here's a pair of hands, they can do this.' And obviously you don't want it to get precious either but it's about finding that right place.

NCO

In the same case a manager noted the dangers, in moving beyond a pilot phase to wider implementation of peer worker roles, of trying to fit the role into existing structures. This is reflected in literature describing the implementation of new roles getting 'stuck' at the interfaces between professional groups:[87]

I think in the future it would be if you developed more formally, I think very. I think that's the danger of it is actually if you develop more formal roles that you try and wedge it into the inflexibility of what exists in some current, the way services are . . .

NMA

As was illustrated in *Chapter 3* (see *Peer workers receiving support from other members of the staff team* and *Formal one-to-one line management for peer workers*), the Agenda for Change structure in the NHS constrained both the distinctiveness and the scope of the peer worker role. It was acknowledged that more work needed to be done to provide further opportunities for peer workers, including higher-banded roles, once they had gained experience in existing roles:

. . . there wouldn't be any other role that I can see in the Trust that a peer worker could be promoted to . . . I think there needs to be more avenues once a peer worker has worked in the CMHT for two years . . . that there are then further opportunities. But currently they're very, very few and far between.

NSM

Workload was an issue for some peer workers, which could have an impact on a team's capacity to provide peer support across its caseload:

I've definitely worked with two [service users] at a time and there have been times when I've been ready and able to take on more at a time but I don't know how many more. I've been quite careful to be quite gentle with how I've sort of stepped up the work . . . for my own well-being.

NPW

In some cases, there was a high degree of flexibility built into the approach to assigning tasks within the team, in order to respond to the needs and capacities of each peer worker at the time. This need to adapt

working patterns to support peer workers was also identified in an earlier study comparing peer and non-peer-based teams:[88]

> *Within the night there are different roles you can do and at the beginning of every shift we all go round and say what roles we want to do. So there's the co-ordinator role, which is basically like planning the night, the logistics, that kind of thing . . . in that role you wouldn't be directly supporting anyone so if people weren't feeling good they could do that role . . . And we all swap round so there are times when I've thought, 'Actually supporting someone tonight. I can't give what I want to give and it would maybe cause me to feel worse,' so if I'm the co-ordinator I can just be, like, 'Right, you're doing this at this time.' So that's good . . . then there's also, like, you can work on the phones or face to face or you could be the socialiser and be around in the social areas. And that's a bit different because people won't be as kind of, the support won't be as direct, intense, one hour's support.*
>
> *VPW*

In one NHS case in an inpatient setting, the peer worker had their duties changed to take account of particular duties that they found personally distressing:

> *. . . we had two incidents where patients had ligatured . . . the first time was a bit of a shock. I wasn't on one-to-one observations with the person but I was second on the scene and it was a bit of a shock because I hadn't really seen anybody like that before. The second time I was actually on one to one with this patient and they asked me to go and do something, which I did. When I came back, they'd ligatured themselves. So I pulled my alarm, did everything right and stuff . . . But it was at that point that it became apparent that it was too personal to me. It was too close to home . . . so it was discussed, and I had full backing, and it was decided there was no way I was going to do observations again . . . I have since done a few, but only with people that are not at high risk . . . and that's fine.*
>
> *NPW*

The importance of managers who understood and supported the peer worker role was crucial to enabling peer workers. One peer worker reported how a lack of awareness of the role by her manager initially severely inhibited her ability to work in an explicitly peer role:

> *. . . it seemed like the team knew nothing about me as a [peer worker]. They knew nothing about what it is that I do . . . we had a manager then who didn't quite understand . . . also a support worker left at that point so they thought I replaced her . . . I was trying to tell them, 'No. I'm a [peer worker], which is completely different.' And I explained to them I had mental health issues myself and that I'll be explaining that to my clients . . . the manager at the time, when I actually spoke to him and said 'look, this is what a [peer worker] is' . . . he said, 'well I wouldn't tell the team that you have mental health issues'. So I said 'well, actually I can't really do my job unless they know, because that is the whole concept of my role'.*
>
> *NPW*

The wider organisational literature highlights numerous examples of organisational change being 'blocked' at the middle-management level.[89,90] A strategic manager in the same NHS case suggested that successful adoption of the peer worker role could be blocked at a middle-management level, even where there was good support from the top of the organisation. Front-line managers were not able to support the introduction of peer worker roles where their managers were not supportive:

> *So it's your kind of middle level of organisations, where . . . which always block change . . . So ground-level people can be really up for doing stuff . . . And at a very high strategic level they kind of say, yes, this is a good thing, we should be doing . . . And it's like mass of say general managers and things like that in the middle . . . there will be some front-line staff that will be team managers, but actually . . . that kind of leadership bit, actually, should come . . . filter through the entire organisation.*
>
> *NSM*

Commissioning priorities, values, outcomes and funding for peer worker roles

The importance of a good fit between new peer worker roles and other strategic agendas was recognised (see *Chapter 3*, *Difference of function within the team*) as a key facilitator in sustaining peer worker initiatives, especially in securing funding. In one of the voluntary sector cases we observed, the initiative to date had taken place independently from the NHS. To sustain the work beyond the start-up funding, the organisation had developed a version of the project to be funded by, and delivered for, a mental health NHS trust:

> *We're going to pilot a specific version of it for young people for a trust next year. So there's work, people want it. If it wasn't worthy then people wouldn't spend the money . . . The other thing is, I mean, I guess, from a financial perspective the money for our current [project] ran out but because we value it so much in the organisation we continue to fund it through the resources made elsewhere in the organisation . . . We would have, like, 'Right, the money's gone. Let's finito.' . . . So we value it very well and try to sustain its life through some of us doing endless training and consultancy . . .*
>
> *VSM*

In another voluntary sector case, offering an alternative space outside of statutory mental health services provided the rationale for the ongoing work:

> *. . . well it's really crucially important and it came out of a deep dissatisfaction with statutory services . . . 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 to that so that people had a choice. So most service users do use statutory services but they have a choice.*
>
> *VSM*

In NHS sites there was more of a focus on demonstrating evidence of successful organisational outcomes to secure ongoing funding. Managers struggled with demonstrating both quality and cost outcomes:

> *. . . it's about providing services, really, with good, clinical outcomes but for less. So it's about innovation, efficiency, you know, the absolute best clinical outcomes for service users . . . The organisational aims are to be person centred and I think crudely, you know, more for less with even better outcomes . . . They're not as expensive as maybe other members of the workforce and however unpopular that might be, I think I'd want to be really clear that we don't see peer workers as the replacement . . . for all mental health workers I think it's about balance and that it's a solution for a difficulty that we've, as the NHS find ourselves in . . . Which is to continue to provide the outcomes but with less resources . . .*
>
> *NSM*

The relational [see *Chapter 4*, *Different relationships (enabling openness)*)] and engaging (see *Chapter 4*, *Bridging and engaging*) aspects of the peer worker role were seen by commissioners to offer value for money by improving the potential productivity of the system:

> *. . . because you can broker relationships very quickly, and because people have that additional element of trust, that they open up quicker and then potentially they access therapy quicker than they would have done previously and therefore their needs are addressed faster and then they get through the system quicker . . . So it's not about booting them through but it's about helping those initial discussions and be smoother . . .*
>
> *NCO*

One strategic manager recognised that productivity and improved experience of care were the primary drivers for employing peer workers, but thought that evidence of cultural change in the staff team should be an aim of rolling out the peer worker role more widely:

So there are things about the further development, perhaps, of the way that teams think about the work they're doing and the services they're delivering and, you know, I would expect to be able to measure some kind of shift in some of those beliefs and attitudes . . . But obviously the primary outcome you're looking for is an improved experience for our current service users . . . And maybe improved outcomes in terms of shorter admissions, shorter episodes of care . . .

NSM

The same manager also saw reputational gain for the organisation as an important driver, with benefits of being seen as at the forefront of delivering on key policy agendas:

. . . it's all around that support for the recovery model and improving our overall sort of thinking about services we deliver and to our service users and improving our reputation. Reputation is important these days . . . I want us to be seen as in the forefront of the recovery and peer worker movement . . . because that drags lots of things along with it.

NSM

Commissioners clearly saw the 'value for money' argument in terms of being able to collect demonstrable evidence that the cost of employing peer workers was outweighed by reduction in the use of other services:

. . . collating evidence, really, about, you know, the impact because that's something that no-one's doing either, really. It's happening but nobody's measuring it if you like. 'Is it costing us double or is it actually saving money because people are becoming well and going on their way', 'Is the peer support group in crisis having an impact on people's rate of crisis use of hospital, calling of ambulances . . .'

VCO

We collect that information because we've got to see if it's value for money. Is it doing what it says on the tin? When I talk about value for money I'm talking about, you know, we spend however much we spend on peer support in this inpatient services, I'm talking about does that really, is it valuable in recovery?

PCO

There was an additional challenge for partnership projects of negotiating a more complex commissioning environment. In this case, the mental health NHS trust had been developing its own peer worker roles in parallel to the commissioning of peer workers from the voluntary sector partner:

. . . the commissioners have obviously commissioned it in conjunction . . . but the Trust did actually recruit its own peer support bank workers . . . to be employed by the Trust . . . but it has been difficult to find them work because I think managers will tend not to recruit a peer support worker mainly possibly because they're not sure what they do and what their role is . . . It's important because it gets a bit tricky and political because we had already recruited our own peer support workers . . . then the PCT [primary care trust] commissioners came up with this project and didn't communicate with my clinical supervisor who was leading on peer support workers for the Trust.

PST

Policies and procedures

As noted previously (see *Chapter 3*, *Difference of function within the team*), having peer worker-specific policies and procedures in place was not a primary concern for most stakeholders. The arguments for and against formalisation in the management of change are well reported. Although it is acknowledged that

formalisation is essential to the efficient functioning of a large-scale organisation, formal rules and procedures applied inflexibly are seen as a major barrier to change.[57,91] There were examples where organisations felt that having appropriate policies would provide some additional security around introducing peer worker roles, especially as initiatives expanded. One voluntary sector organisation acknowledged that, as it grew, it would need to have a more comprehensive set of formal policies and procedures in place to ensure the safety and accountability of the services it provided:

> *But as we get bigger, and therefore people come on board to something that's already operating, you have to have a system that people are singing from the same hymn sheet I think . . . Because otherwise that's when you've got the potential for things to go wrong and there's no accountability and, you know, you need to tell people what the expectation is so that then they make a conscious choice whether or not to deviate from that . . . especially as the organisation is growing at the moment I think as we go forward, I think that's incredibly important for everyone in a general sense to feel sort of safe but potentially in case, you know, things get tricky.*
>
> *VPW*

One commissioner thought that policies and practice around looking after employees with mental health problems were better in the service that we studied – compared with many other organisations from which they commissioned services – precisely because the service was peer led:

> *. . . lots of our organisations, you know, have got, you know very positive policy about supporting people who are, you know, unwell at times. But I still think it's different if you don't have that peer understanding. I think it's – I see it in the local authority, you know, if you look at big employers. No way as a local authority, who are one of the biggest employers in the city, over 30,000 staff, you know, we've got policies and processes in place but people are still really scared of saying . . . you know . . . I'm not okay.*
>
> *VCO*

The importance of having risk management policies and procedures in place in inpatient settings – where levels of risk were higher – was acknowledged:

> *. . . on an inpatient ward that's absolutely essential . . . not more so, differently so, to some of the other environments that people work in but with this particular project that's really, really important. But that's where our biggest dilemmas have come. Not about normal risk around, you know, people maybe expressing suicidal thoughts and all of those sorts of risks, I think the training covers that really, really well. It's the dilemma risk around balancing aggression for people . . . It's a kind of sudden way around crossing the line.*
>
> *PCO*

Risk issues were raised around some of the open access services delivered by peer workers in community settings in the voluntary sector:

> *I mean part of things like numbers of [peer workers] or debriefing is all around risk management . . . it's about the risk of the staff and the risk of the service users attending . . . in an insurance broker's eyes to be our most risky activity of the organisation . . . Because we have no idea who might turn up and what their histories might be. Whether they're active with drug or alcohol, they could be current or ex-offenders. All of that we pay a premium on our insurance in terms of risk, public and staff risk.*
>
> *VSM*

However, peer workers were also seen as an asset in managing risk, bringing differential knowledge to the team on how to assess risk and think creatively about reducing risk:

> *. . . staff can sometimes struggle particularly around engaging service users in their own risk assessment and management. There's almost this kind of mystique that exists. That risk assessment and management is something that only very experienced, qualified clinicians can do because it's some magic art . . . And actually service users can't contribute to it and whatever. And then we wonder why we have the incidents that we have . . . So there's almost something about peers, um, kind of being able to challenge that and be able to have, perhaps, more open and transparent conversations with service users around them owning their own risks . . . Because actually, probably if you've got to the point of being a [peer worker], probably somewhere down there you've had to navigate your way through some risks?*
>
> *NSM*

Alternative approaches to managing risk were often highly developed and supported by training and procedures in established voluntary sector services:

> *We have policies and procedures that deal with things like risk, working with risk, but it's not the risk of having peer workers . . . The risk-taking in [a peer]-led service. So I guess really it's about holding a level of risk which you are perhaps more able to hold if you're not obligated by a statutory kind of guideline. That seems very rigid and kind of, I mean, obviously, we have like a moral and an ethical responsibility to people but we don't have a legal duty of care, which allows flexibility . . . Obviously we take very seriously the kind of risks that people present and we would never be like, 'Oh, well, we're going to hold that risk and see what happens.' . . . I think here we're very much like we'll always take seriously the level of risk that you're presenting. And we'll always discuss it and part of the person-centred approach is that congruence. And if you feel like there's something, kind of, troubling you about what people are saying you can say, like, 'That's uncomfortable to me because of this . . .'*
>
> *VPW*

Challenging boundaries, changing conversations

Our research suggested both that the introduction of new peer worker roles had an impact on organisational culture, and that culture needed to change to support the adoption of peer worker roles. Cultural change was felt in two main areas. As found in our earlier work,[23] the introduction of peer workers into existing teams challenged conventional practice boundaries (between individual service provider and service user) and, in turn, the different boundaries that peer workers might work to were challenging for existing teams. We noted above how peer workers might use language differently in their work (see *Who is a peer worker? Identity and language*). This was changing conversations in the teams that peer workers joined, and having a further impact on the culture in mental health services.

Challenging boundaries
The challenge to conventional boundaries which we observed seemed to be underpinned by essential differences between peer worker/service user relationships and mental health professional/service user relationships (see *The essence of the peer worker role*). Primarily, because lived experience of mental health problems was explicitly used by peer workers – and demonstrated experiences shared in common with service users – the dynamic of the relationship was more complex than the unidirectional provision of professional support:

> *The [peer worker] is still a paid professional whose job it is to provide some kind of care intervention, whatever it is, to the service user, so the direction of the relationship is primarily in that direction,*

which is true for any professional . . . [but] for peer workers, because of the self-disclosure aspect of it, you may get a bit of it coming back the other way . . .

NSM

. . . by the nature of the relationship and the way it's set up actually . . . there isn't the kind of power differential that there is with other staff . . . and I think, from the start, it's set out as a kind of collaborative process rather than a member of staff trying to change what you do and how you do it.

NSM

One non-peer coworker explained how it was the act of making the lived experience explicit that distinguished the peer worker role from the professional who might also have lived experience of mental health problems:

. . . a professional . . . that may have mental health issues that they don't, or . . . can't say that to patients because then it would change the professional boundaries, or the patient might see the professional . . . differently . . .

NST

As such, the boundaries maintained by peer workers were often referred to as personal, rather than professional boundaries:

It's just a kind of case of what you feel, like, everyone's got their own different, like I'm a pretty open person. I will generally talk about literally everything I've been through and not worry but some people don't like doing that, and, like, our supervisor always says it's all about your own personal boundaries . . .

PPW

It was the personal, rather than professional quality of these boundaries that was challenging for established practice. Peer workers themselves exercised a personal control over the communication of their lived experience to the service user, in contrast to the clinically determined communication of professional expertise. The importance of allowing peer workers that personal control and discretion over how they managed their boundaries was seen by many participants as a vital aspect of the role:

Because it's about her lived experience. That's sometimes why that's been picked up. So it's not a case of, 'Yes, these are the boundaries. These are how we do things. This is the reason why.' . . . She would disclose about her experience and she would talk to them more as a friend . . . She does keep her boundaries. She does say, you know, 'If there's anything that you tell me that, you know, harms you or others, I might have to tell.' . . . but she's able to be more, I want to say freer, but it's just different.

NMA

It was suggested that a different skill set is necessary for managing personal, rather than professional boundaries:

I think it's going to be difficult for some people so it does need to be managed. It's quite important that it's managed because some people don't have the ability to be able to do that so it needs to be learnt . . . thinking about when would be appropriate to . . . tell a [service user] that you've had mental health problems . . . that's down to judgement, that's down to knowing the person you're working with, being able to get a rapport or a relationship with them, a professional relationship but an honest, genuine relationship and understanding what they're going through and if it would be helpful or a hindrance for them.

VPW

The challenges to boundaries presented by friendship in the peer worker/service user relationship were acknowledged, especially in cases where the route to becoming a peer worker was through volunteering within the service the individual regularly used. Negotiation of appropriate boundaries in relationships which are 'like a friend' is discussed in current literature on development and practice in wider professional roles.[92] However, it was also felt that there were opportunities in pushing those boundaries:

> . . . if both people feel comfortable with that relationship it would seem churlish to say 'no you can't', and then 'well they're allowed leave, so I'm going to meet them in the shops', 'fine, in a public place', we say, 'that's fine', and then somebody went . . . they decided, having met in the public place, they'd go back to eat at one of their houses and spent hours there, and that crosses a line, as far as I'm concerned, because for both their safety . . . it was just sort of bending those rules a bit, or pushing those rules a bit, really.
>
> *PST*

> . . . if they become a member of staff, for example, it's possible that they may become aware of issues of some of the people that they've previously been peers with . . . it's hard to get your head round . . . the renegotiation of boundaries and friendships and I get a bee in my bonnet about friendships, because I think friendship's a good thing and it's worth trying to traverse that grey area . . .
>
> *VMA*

There were widespread concerns, in all organisational contexts, about the potential dangers inherent in this permeable boundary where there is a two-way exchange of personal experience. There was evidence, as there is internationally and more recently in the UK, that teams wanted peer workers to work to existing, clinical boundaries:[19,93]

> . . . there can be problems with peer workers and service users becoming too close because they share the same experiences. I think then if you're bonding on that level you kind of forget that actually you are staff still and you are managing a process.
>
> *VST*

> . . . there is a possibility of them sort of feeding into each other. And then that relationship could possibly get quite sort of enmeshed and quite worrying.
>
> *NMA*

It has been shown elsewhere that existing communities of practice can be resistant to the introduction of new ways of working, arguing that new approaches do not demonstrate the required professional standards and good governance inherent in that more established work.[63] Perhaps as a result of this challenging approach to managing boundaries, and the perceived risks associated with them, resistance to this differently boundaried practice was encountered within staff teams.

> . . . by having the peers in teams on wards, you naturally get all the kind of anticipated kind of anxieties or worries or concerns . . . you can get concerns around 'will they be professional, the issues around boundaries, you know, they actually could make everything much worse, they don't really know what they're doing' . . .
>
> *NSM*

> . . . staff are told, as professionals, that they shouldn't be friends with service users . . . and [peer workers] are encouraged not to be friends. But what are we saying? . . . You're ghettoising. The danger is if you take that too far you ghettoise people with mental health problems . . . if you go too far the other way you have a very impersonal 'them or us' culture . . . and we have to find a line between the two . . . my worry is that people will see the [peer worker] system and think, 'Oh, there aren't enough boundaries. Let's construct some quick!' . . . I'm sure this will be one of the issues that

comes up. You know, because there are professions who have built their boundaries so tall and so high and so thick that this sort of thing threatens it a bit.

<div align="right">

PSM

</div>

There was evidence of teams working through the issue of where those new boundaries lay:

And then there was debate around, sort of, smoking . . . do [peer workers] smoke with patients? And, you know, some people have a very strong feeling, no, because we don't. But then other people thought, well, yeah, because part of their role is engaging with someone and if it means you do that over a cigarette then that's okay . . . In the end, I think we went with yes, it's okay for them to smoke. So we've teased things out and got there.

<div align="right">

PST

</div>

The potential value for the organisation of challenging existing boundaries was recognised, with the introduction of the peer worker role seen as an opportunity to change organisational culture:

. . . all we're doing is just rearranging the deckchairs . . . that won't change the organisational culture. That won't change patient experience, which are the kind of key parts around why are we looking at employing peers, not because we're desperate to give people with mental health problems jobs . . . we need to improve the quality of our services. We believe peers will do . . . because of the different relationships that are being had with people . . . slightly different boundaries, being actually focused on what is it that people want, how can we help you, rather than us telling you what you need, and what you need to stop doing, and start doing.

<div align="right">

NSM

</div>

Changing conversations

We also found evidence that the way mental health was talked about in teams could change when peer workers joined the team. Changing discourse – where discourse is understood as practice manifest through language, or action-orientated talk[94] – has been shown to be linked to change in practice, or the emergence of a more 'moral' discourse of mental health practice.[95] Like the challenge to boundaries, this change in conversation was a dynamic process within teams and services, and as such was an important aspect of the evolving of organisational culture that we observed. Many of the data below come from our NHS cases, or partnership cases where peer workers were working in NHS settings, where new peer worker roles were introduced into pre-existing teams. Sometimes that change was in response to habitual use of stigmatising language in mental health service teams:

. . . people again work in a high-expressed emotional environment so an inpatient unit works two-fold; one is you are bombarded with very stressful bits of information, culture. So you will hear, 'Oh, she's in again', unfortunately still, maybe you've got an agency staff. You know, everybody has the odd staff member. 'A bit of a nutter.' We've had all of these things. You still hear it.

<div align="right">

PCO

</div>

Sometimes just having a peer worker address a sensitive issue was enough to destigmatise a conversation:

. . . they have the lived experience of mental illness and recovery . . . it's the fact that people know that and that it breaks down the barriers of stigmatism . . . makes mental health not a dirty word if you like, you know, people will actually say, 'here I am, I've been mentally ill, I've recovered, I'm working' and for people to see that that is possible, and that is normal.

<div align="right">

PMA

</div>

Some peer workers saw themselves as addressing issues of stigma by example, through talking openly about mental health:

> . . . so breaking down the stigma, it's a slow and cautious process . . . but by being open and when people see that when you're well you just act normally, they can see that when someone has a mental illness it's only when they're unwell that their behaviour might seem strange but the rest of the time they're just normal people and it can happen to anyone. So that's what I mean about breaking down stigma.
>
> *PPW*

On other occasions peer workers felt the need to directly challenge the way mental health was talked about in the team. Recent research has referred to both 'the challenge of being a challenger',[84] and the judgement that peer workers have to make in deciding whether or not to respond to discriminatory words or actions:[96]

> . . . on this particular handover, this patient was being discussed and the nurse that was actually talking about the patient said that she'd ended up in A&E [accident and emergency] and obviously taken an overdose and then she said . . . 'I do hope they gave the person charcoal', because that makes them throw up violently afterwards . . . I said 'and you know that I'm a [peer worker]' . . . I make the team all aware of what's happened with me because they need to know and I don't mind sharing it, I've got nothing to be embarrassed about. I said, 'but I just need to address something that's just been said . . . I have tried to take my own life three times, two times of which were overdoses, as we're now discussing.' And they looked at me and I said, 'and I'm just so glad that the nurse that looked after me on both of those occasions did not have that sort of attitude . . . and that I was not given charcoal' . . . the nurse afterwards did apologise. And I've done it on numerous occasions . . . if they're talking about something, sometimes the conversations are dehumanised. They seem to forget that they're talking about a human being . . . but by me being part of the team . . . by me occasionally saying, 'Well, actually when I was really unwell and I tried to take my own life I felt like that' . . . it brings them out of it . . . I've had some very interesting conversations afterwards with staff, where they've actually said, 'Oh, you know, you've really made me think.' And I'm like, 'Excellent, have I? Great' . . . it just brings them back down to earth again; it just makes it real again.
>
> *NPW*

One peer worker in the voluntary sector saw working outside the NHS as enabling them to provide a space where it was both permissible and empowering to have conversations about mental health that challenged medical understandings:

> I think, because we work in a non-medical model, a lot of the things that maybe are core ideas in the NHS would be challenged maybe by the way that we work. For example, particularly diagnosis. We don't work with diagnosis . . . a lot of the time people are actually very distressed by the diagnosis they've been given. They don't understand, it's not explained to them properly, they don't want to have the diagnosis and then saying to their worker or their CPN, like, 'Oh, I don't want this diagnosis. It's on my medical records, it doesn't apply to me', they're kind of, like, 'Well, that's part of your diagnosis, not wanting to recognise it.' . . . because we're there . . . to listen and we're not part of the system . . . of the NHS, we would kind of encourage people to see advocates or kind of challenge things that they weren't happy with, because it is about empowerment to the individual.
>
> *VPW*

Sometimes NHS teams resisted the challenging conversations that peer workers instigated, as if reasserting their professional jurisdiction over clinical work:[56]

> *I think it's because they were challenged. I think they felt, you know, this person will challenge us for what they saw as areas that maybe shouldn't concern her. But that was the whole point of the role, was that you should be bothered about areas that you feel don't concern you . . .*
>
> *NMA*

On occasions peer workers reported being silenced or 'put in their place' as they attempted to engage in conversations about their work:

> *. . . I said to him, 'Oh, I'm just about to go on the ward and ask anyone if they wanted to come down to this such-and-such group. Is there anything I should be aware of? Anything that I should know? If I can't take a patient down or whatever from a section or something.' And he said, 'No, I don't think, it's not as if you're responsible for the patients, is it?' And he just sort of snapped at me . . . I just walked off. I didn't want to challenge it to anybody I just said, 'Right,' and just walked off . . . I think that was at the beginning, though, where it was a little bit hostile from some of them so that could be why that happened.*
>
> *PPW*

Peer workers in the NHS noted the need to have the confidence and courage to speak up and challenge mental health professionals:

> *But you should be able to have the strength in you to actually not just sit back and let it go, you know, to be able to actually challenge things . . . I remember sitting on the first post that I did in the other ward, sitting there on a ward round thinking, 'Oh, my word!' But I'd only been there a week so I didn't say anything. But I was making notes, copious notes, about what I was hearing and what I was seeing and things. And then it only took me a couple of weeks before I got into the team and they got to know me and I got to know them, that I then thought, 'Right, now I'm confident enough to say things.'*
>
> *NPW*

Sometimes peer workers needed to be empowered to be able to challenge language used in the team:

> *I don't challenge much here . . . other members of staff about what they say because I feel, sometimes I don't feel able to do that . . . the changing of language. You can't expect someone that's been working in mental health for 20 years, you can't come along and say, 'Now you've got to use different language here.'*
>
> *NPW*

> *They have to be really empowered to say, when someone on the ward, and I'm not saying they would do it purposely, but a busy acute admission ward says, 'Could you just go and help [the service user] go to the loo, please?' I'm not saying that's not a valuable task but it's not what they were there for. It was so important for all of us to ensure that people had a real valuable role that was very well understood by the worker, by the people they work with and by the partnership organisation.*
>
> *PCO*

In one team it was necessary to explore the language used by the team that was experienced as stigmatising by new peer workers. Although this was challenging for the team the process facilitated culture change:

> *They got in there and said, 'Let's knock this out. Why do you feel this way?' And then actually challenged and said, 'Well, is that not stigmatising for you? Do you not think that you're being cruel*

to someone because they have mental health issues?' . . . these are caveats we have to put in place when employing individuals who have or have had mental health issues. And they were the main issues around when someone didn't turn up to work . . . I think once they actually had that discussion and they were challenged and, I think an open and frank discussion is necessary because people will always stereotype and they will always see things as unfair until it is challenged. So I think it's natural human behaviour and I wouldn't want to do the service any disjustice because of that, because I think they are great staff, it just happened to be that it really did confront some of their preconceptions potentially . . . I think the teams would also say, especially those who did have some potentially negative views initially, which they weren't aware of, it was great to actually bring them to the forefront and challenge themselves. So I think it's really driven a culture shift.

<div align="right">*NST*</div>

Sometimes culture change was brought about by peer workers voicing things that were left unspoken:

. . . they bring an indirect challenge actually, that they expose all kinds of things which are being buried, not spoken about, and I don't mean that in a sinister way, but just that nature of, 'well we've always done it like this . . . why would you do it any differently' and all of a sudden they're really questioning why . . . and it just starts that kind of rumble of noise . . . there was one on a ward who just could not understand any of the nursing staff, and would say, to the team manager, in an appropriate space rather than challenging the nurses, I don't understand how your nursing staff can walk past somebody who is crying and not acknowledge them in any way, and just leave them . . . this kind of real small basic things, things that, in the everyday kind of scheme of things are happening and just get ignored . . . day in day out, in services, which others kind of just indirectly collude with.

<div align="right">*NSM*</div>

In one partnership case it was the experience of peer workers coming into the ward, alongside a pre-existing NHS team, that first challenged and then changed culture on the ward:

. . . obviously as an inpatient unit risk is obviously high on our agenda . . . and it's not so high for [peer workers] . . . it's almost like, ideally we'd meet in the middle somewhere. I think sometimes we can be too driven by risk, that it compromises our relationship, our therapeutic relationship, because that's all we're thinking about. But then at the other side of things sometimes my observations is with [peer workers] it doesn't even come into their head and it needs to . . . so it's sort of bang in the middle . . . I think something that possibly ward staff may have struggled with in the early stages. I say in the early stages because, in all honesty, now, it works pretty well . . .

<div align="right">*PST*</div>

Outside of formal partnership arrangements, voluntary sector organisations also suggested that their peer-driven approach shaped dialogue with their NHS counterparts and might be productive of cultural change:

. . . as a consequence of having these roles and I think that it's an opportunity to break down barriers, inside or outside of services. I think it's a way of challenging staff and also challenging people with experiences of being treated by staff and it helps to challenge mutual misconception and mutual misunderstanding and allows for that parity of esteem . . . to come about.

<div align="right">*VSM*</div>

Evolving organisational culture

The overwhelming message that emerged from our analysis, reinforced through the feedback workshops, was that cultural change at team and organisational level was both a key facilitator of peer worker roles,

and an outcome of introducing peer workers into existing services. The learning for mental health service provider organisations works both ways: peer worker roles will not be successfully adopted (or will be diluted in their essence) where the culture of the organisation does not change; and where the role is successfully adopted, culture within the organisation will inevitably change as a result. This inescapable relationship between successful implementation of innovative practice and cultural change within the organisation has been noted elsewhere.[97] Employing peer workers is about more than adding a skill set to increase the capability of a multidisciplinary team.[98] Mental health services where peer worker roles are core to delivery are potentially fundamentally different services. In our study, commissioners understood the issues that might arise where culture does not change as part of the process of introducing peer workers:

> *I think it's crucial if you're going to employ peer workers . . . the organisation's got to fully understand what that means and what their support needs might be without it being a patronage in a sense. And also I think that the organisation needs to look at its own potential for prejudice and stigma because I think that we all do carry prejudices, whether spoken or not, but they do leak out in different ways, so you've got to challenge yourself as an institution as to how do you work with someone who's very open about having a mental health problem . . . So I think organisationally you've got to understand your philosophy and your ethos, particularly if you're recruiting new people into that ethos . . .*
>
> *VCO*

> *. . . it's a series of philosophical and strategic steps that an organisation takes about mental health in its organisation . . . practically, the best way of expressing that is to say a mindful organisation would be one that clearly is very responsive to the needs of its employees but from this point of view, actually gets people jobs who have lived experience.*
>
> *PCO*

However, there was still a sense that the dominant culture within our NHS and partnership cases was underpinned by a medical approach, and that resistance could result:

> *They're still a bit medical model, you know. Nowhere near like it was a few years ago. I think we're gradually, gradually, it's taking a long, long time to change but, yeah, it's definitely so much better than it was. But I think it's a whole shift in thinking, really. A recovery approach. I think unfortunately recovery is still sort of viewed a bit as an add-on rather than central model to base all practice on.*
>
> *PST*

> *I thought sometimes it might collide with the values of the NHS and that people that have been long established here, and unless the processes was really explained to them may feel very challenged by it . . .*
>
> *NPW*

Nonetheless, culture change did happen even where that resistance was felt:

> *I think it's a hangover from the past, you know, that this sort of hierarchy of professional and patient, if you like is invisibly there still and on one level I'm impressed with how little that's around in our team.*
>
> *NMA*

> *I think the teams would also say, especially those who did have some potentially negative views initially, which they weren't aware of, it was great to actually bring them to the forefront and challenge themselves. So I think it's really driven a culture shift.*
>
> *NCO*

We found a lot of evidence of alternative organisational culture in our voluntary sector cases. There was an understanding that having peer workers by itself was not enough, and that a process of constant reflecting on the role and the organisation was necessary:

> . . . you can have peer workers in an organisation can't you but it's still got all the standard hierarchy and they're just shifted in at the bottom to do this . . . because our organisation is sort of service user, peer, user led . . . we're constantly sort of refining the role and sort of looking at it and understanding it and reflecting, which I think is really, really important . . .
>
> *VPW*

Earlier research recommends espousing peer support in organisational mission statements as an effective strategy for introducing peer worker roles.[75] In a number of voluntary sector organisations, employing peer workers was at the centre of the organisational ethos. Equality between different staff in different roles was seen as a vital characteristic of a healthy, caring organisational culture:

> 90% of the organisation is people who might be classed as a peer worker or someone from lived experience . . . that is the mantra and vision of the organisation. So people, when the organisation kind of started and has evolved has had that at its very heart . . . We believe quite strongly in collaboration and working together on an equal basis with professional counterparts or ourselves . . . So it's about working in a way that's healthy. That's one of the things we really insist upon, especially when we're working in collaboration with other professionals or professional organisations.
>
> *VSM*

> . . . it's kind of been the ethos that underpins everything that the organisation does . . . it kind of permeates through everything. And it's kind of a lot of it is empathy, unconditional positive regard, congruence. And how that supports me is that's how I kind of feel as part of the organisation, for example, that, you know, I get a feeling of genuineness of working with people that I work alongside here and then, you know, so it's all the kind of things that you would hope how the visitors and users of the organisation get from here you'd get the same kind of thing as staff. So what permeates through externally, as it were, permeates through internally with regards to the staff. So I think you get positive regard from the staff for one another. There's a massive kind of belief in well-being between the staff . . .
>
> *VPW*

However, the need for culture change in the voluntary sector was also acknowledged, especially in BME settings. Not being explicit about mental health was often seen as a way of removing barriers at the front end of a service, but could also undermine the peer worker role where a lack of openness about mental health pervaded organisational culture:

> I think that my experience is that peer workers have not always, the notion of them in an organisation has never really been talked about. It's been a bit tokenistic. Yes, it was great to employ someone with a lived experience in our organisation, it's fantastic, but the thinking doesn't go beyond that. And only a few people in the organisation are involved in that discussion about those peer workers. So other staff within the organisation kind of have a vague idea that they may have that lived experience and they're peer workers but don't really understand what they're doing or are they really different to us? . . . it's quite ironic because some of the work we did was, you know, with external bodies about, you know, 'This is who I am. I've had mental health problems. This is what I do.' But it didn't happen within the organisation . . . [it] would be helpful for them to feel valued or included in the organisation.
>
> *VSM*

Explicit awareness of the need for culture change within the organisation seems to be key to the successful adoption of peer worker roles. A wider organisational literature suggests that organisations need to

demonstrate a 'readiness' to change for innovative practice to become embedded.[99] Where that readiness was lacking, we found evidence of resistance and dilution of the role. Other new mental health roles have also faltered where the emerging role has been subsumed within the prevailing organisational culture and not enabled to assert its distinctiveness.[61] Our analysis suggests that if the peer worker role is required to adapt to fit prevailing culture (often referred to in both our statutory and voluntary sector cases as the professionalisation of the role), rather than the culture evolving to support the role, then there is a real risk that the 'essence' of the peer worker role will be somehow lost:

> I get a bit uncomfortable about this whole shift towards trying to professionalise peer support . . . and turn it into a profession which takes away from what it really is, it's about people with shared needs, shared experiences, supporting each other . . . I think what can protect that is basically if service users retain or keep hold of that sense of ownership of peer support . . . it should be something that comes from service users, is led by service users.
>
> *VPW*

> I'm talking about professionalisation and whether professionalisation somehow takes away . . . so that you then become part of the order . . . there's an advantage about being employed as part of the Trust, but there's also a problem with it . . . you're part of the establishment . . . and then do you lose the bit that . . . the whole point about peer workers, it seems to me, is having this not being so much part of the establishment, but is there a way, by professionalising it, that we actually make people part of an establishment.
>
> *NST*

Chapter 5 Discussion and conclusions

Generalisability

The potential for generalisability of findings from a comparative case approach to research lie in two main features of the comparison: first, that the criteria used for comparison are generally relevant and meaningful (i.e. that the contexts compared generally exist in the environment outside of the study); second, that it can be robustly demonstrated through the analysis of data whether the conditions observed apply across contexts or are context specific.

New peer worker roles are actively being introduced in mental health services in England, in mental health NHS trusts, in the voluntary sector and through partnership arrangements between sectors. That process has continued since this study began. The Implementing Recovery through Organisational Change (ImROC) programme, hosted by the NHS Confederation, is building on the piloting and demonstration work of PSW roles from its first phase, and is now offering a consultancy package to mental health NHS trusts in the process of developing new PSW roles. Through the research team's involvement in a voluntary sector-based, peer-led peer support collaboration we are aware of the development of new peer worker roles in the voluntary sector, including in the larger UK mental health service provider charities. We are regularly contacted by mental health NHS trusts for advice on new role development, especially where that is taking place in partnership with local voluntary sector organisations. In all those different organisational contexts new roles are being introduced in inpatient, community and BME settings. New roles are also being introduced in other specialist settings, for example forensic mental health services. Findings from this study would not necessarily apply to those other specialist settings.

The pattern-matching approach that we used in this study,[65] and specifically our use of structured qualitative data to make direct comparisons, has enabled us to indicate where we observed common organisational conditions across contexts, and context-specific conditions of peer worker role adoption (see *Chapter 3*).[64] We were able to show where facilitators of role adoption – identified in the wider international literature on peer worker roles, and in the organisational role adoption literature – applied across case study contexts and could therefore be said to be widely generalisable. For example, the importance of shared understanding of peer worker roles to facilitate successful role adoption was generally acknowledged as vital. We were also able to show where there were particular challenges to role adoption in specific contexts. For example, although peer workers in our partnership cases were able to build different relationships with services users than could their NHS counterparts, they were faced by additional challenges of managing boundaries where they found themselves working to different organisational value systems. As a result, in the conclusions below we are careful to specify where our findings are general and where they are context specific.

The extent to which a study's sample reflects the population from which it was recruited also has an impact on the generalisability of findings. We have made it clear that our collection of structured data was part of our qualitative analysis strategy, informing the pattern-matching case study approach, rather than a statistical analysis. Nonetheless, it is important to reflect on our sample to consider the generalisability of qualitative findings. We asked site leads to identify potential participants from a range of stakeholder groups on the basis that those individuals would inform our understandings of both the challenges and successes of introducing peer worker roles. This purposive approach to sampling has been described as an effective strategy for selecting 'information-rich' cases for in-depth study.[45] Our interviews elicited detailed data on both challenges and successes, and from across stakeholder perspectives. As such, we might reasonably conclude that a comprehensive, if not exhaustive range of data informs our findings, and that any selection bias resulting from decisions made by site leads about who to approach did not result in findings that were either overly positive or overly critical.

In addition, site leads reported very few instances of potential participants being unwilling to take part in the study (where this was the case, this was due to problems around availability). As such, bias to the sample resulting from self-selection (or rather, of selecting out of the study) was minimal. We have noted that three participants did not complete the structured Part 1 of the schedule, two of whom were service users in BME cases, and that one other service user participant in a BME case struggled with the language of Part 1 items. Representation of participants from BME groups generally reflected the populations that case study projects served, and across the sample as a whole this was boosted by the inclusion of two BME-specific cases (approximately one-third of the whole sample was from BME groups). Nonetheless, it is important to note that BME service user perspectives might be under-represented from the Part 1 analysis. However, this observation is in itself an important finding of the study. As we indicated above, our Part 1 schedule was indicative of a particular pattern of peer worker role introduction implicit in the conceptual framework developed in *Chapter 1*, *Conceptual framework*. Although we made efforts to contextualise that framework for participants through the interview process, we were keen to explore whether and how that pattern was a fit with their experiences of the peer worker role. Non-completion of Part 1 therefore, in part, informed our pattern-matching approach to analysis. We pursued this issue of fit with our original framework or pattern – in these and other qualitative interviews – and have presented a wealth of data in the preceding chapters around the use of language and conceptualisation of the peer worker role, in BME and other cases. As such, where we observed, across our various data sets, alternative patterns of peer worker role introduction (for example, in our BME cases and/or for BME participants in other cases), we draw specific, rather than general conclusions.

Given the age profile of the sample (see *Table 3* in *Chapter 2*, *Recruitment process*) – noting that our sample was of a range of stakeholders and not just service users – it would be reasonable to suggest caution in assuming that findings here necessarily generalise to service settings that are specific to younger or older adults, even though our case study services were open to younger and older adults. Findings did suggest that there are a number of dimensions (points of connectedness) to the peer identity – of which age is likely to be relevant – and that these might be more or less specific in particular service delivery settings.

Strengths and limitations of the study

We identified a number of strengths in the research process, both methodological and in our selection of cases (specific issues around our coproduction approach are considered in detail in the following section):

1. The use of structured questions in the interview schedule facilitated the pattern-matching approach that we employed in our comparative case design, enabling us to identify generic and context-specific issues, especially where making comparisons between settings and between our NHS, voluntary sector and partnership cases. This approach offered an efficacious means of 'testing' a largely international evidence base in the context of mental health services in England.
2. The mixture of structured and open questions in our interview schedule, and the flexible use of that schedule by our researchers, was effective in eliciting in-depth data about issues that participants thought were important.
3. Analysis of the structured data was a useful tool for focusing our analysis of the in-depth qualitative data. The qualitative data set was very large and a conventional, inductive analysis of the data would have been unwieldy.
4. As suggested in the section above, selection of cases using relevant comparative criteria increased the explanatory power of our analysis.

There were limitations to the study. We have gone into some detail in the preceding section on how the sample might limit the generalisability of our research findings. We have also been clear that our use of structured data is part of the qualitative analysis process and, because of the way in which our sample was selected, should not be subject to a statistical analysis. This approach did present a difficulty when

interpreting differences in mean 'importance' scores in answer to our Question B for each item. It was unclear *how much* difference in mean scores was likely to be indicative of a potential pattern in our data and therefore worthy of further exploration. Once those data were broken down into stakeholder or context-specific subgroups, very few differences in means of more than a few tenths of a point were observed. We had anticipated this and included the 'top 3' question as an alternative approach to identifying context-specific patterns in attitudes to importance. The latter approach proved to be a more reliable way of identifying in-depth qualitative data that supported the structured data.

On the whole, as we have suggested above, our selection of cases was a strength of the study. However, an important group of cases was missing. Our cases did not include voluntary sector services or projects that were professionally, rather than peer led. Although the voluntary sector organisations hosting our BME-specific cases were led by non-peers, the specific projects we included in the study were all essentially peer led (including the voluntary sector organisations in our partnership cases). This is a limitation of the study as some mental health NHS trusts may well develop partnership arrangements around peer working with voluntary sector organisations that are led by non-peer staff. With hindsight, at least one of our voluntary sector cases might usefully have been a service run by one of the major UK mental health service provider charities.

Coproduction and research

The coproduction approach that we employed was a strength of this study. The range of stakeholders on the team contributed in a number of areas to decision-making within the study:

1. Engagement with sites and site leads, developing a good understanding of role and context at each site, and recruitment of participants through site leads all seemed to be facilitated by the lead role that service user researchers played in that 'site building' process. We wondered if, in a study about peer workers (coproduced with mental health services), the role of service user researchers in this process gave the study enhanced credibility with case study sites.
2. The research team and steering group provided a further 'validity check' of the items in our structured interview, using their varied expertise in peer support and organisational change to ensure that the range of issues covered by the schedule was both sufficient and relevant.
3. Voluntary sector members of the team helped shape a flexible approach to interviewing that would be cognisant of the fact that the language we used – especially in the structured part of the schedule – would not be the same language used in some of our cases (particularly BME cases). This approach was productive of alternative understandings of the peer worker role.
4. Service user researchers on the team felt that their disclosure of their service user identity put many participants, across stakeholder groups, at ease. We wondered if this was because participants were able to gauge service user researchers' connection to the research; of their somehow having a meaningful interest as 'peers' themselves, rather than being 'disinterested researchers'. We felt that this facilitated the collection of candid and in-depth data. In addition, service user researchers' understandings of many of the issues we observed – derived in part from their own lived experience – further enabled them to elicit detailed data through the interview process. Our service user researchers were trained and experienced interviewers; we did not encounter any resistance on the part of participants to being interviewed by service user researchers.
5. Through the framework dimension to our analysis approach, the team used their range of expertise to refine the emerging analytical framework. For example, the peer worker and strategic manager from one of our NHS partners introduced to the analysis the concept of 'mutuality' within the staff team – around openness about mental health – and this enriched our understanding of supportive culture within the staff team. In addition, voluntary sector team members, working from the perspective of lived experience, ensured that we pursued questions around peer identity through the analysis.

6. Throughout the analysis the two service user researchers led the process of developing, refining and interpreting our analytical categories and themes. Though the other members of the team all inputted into the analysis, the understanding of peer worker roles that has emerged was fundamentally shaped by the two service user researchers' intimate knowledge of the data and their insight into the roles, services and people in each of our cases. However, we also felt that the inclusion of the wider team at key points in the analysis process ensured that this process, though shaped by, was not monopolised by the service user perspective.

Alongside this project, an experienced service user researcher, supervised by a member of the steering group, has undertaken a structured, ethnographic study of the impact of coproduction on our research process and findings, based on a framework we developed in a previous National Institute for Health Research-funded study.[28] The findings of this piece of work will report elsewhere.

Implications for health care

How are new peer worker roles currently being introduced in mental health services in England?

Aim 1 of this study sought to test what is currently known about new peer worker roles – largely an international evidence base – in a number of contrasting cases in mental health services in England. We organised existing evidence, experiential insight and organisational thinking into a conceptual framework, in six domains, and tested the framework by using a structured questionnaire. These data are presented in *Chapter 3* and indicate where there are common issues around developing and implementing new peer worker roles, and where those issues are context specific. The main findings are summarised here.

Common issues across organisations and settings

In a number of areas, our observations in mental health services in England reflected international evidence and organisational thinking on what works well in introducing new peer worker roles:

- Formal recruitment processes for peer workers were widely in place across the NHS and voluntary sector, as were flexible terms and conditions for peer workers.
- Peer workers were likely to be recruited from the range of different communities which they worked in.
- The importance of peer workers being able to manage boundaries in their work was widely recognised, although different stakeholders understood boundaries differently in different contexts.
- Peer workers were receiving training that was specifically designed for the role.
- Peer workers were generally supported by other members of the team.
- Line managers did support peer workers if they became unwell and this was valued by peer workers.
- There was widespread evidence of support for peer worker initiatives at the highest organisational level, good strategic fit between the introduction of peer worker roles and other strategic agendas, and peer worker roles were highly valued within organisations.

On the other hand, there were a number of issues where the developments we observed did not reflect existing evidence about best practice in introducing new peer worker roles:

- Although parity of pay for peer workers with others doing similar work was seen as important, it was not widely in place; neither was access to trade union membership nor opportunities for promotion.
- Although it was acknowledged that leadership for peer working should come from within the communities served, this was not always happening, and there was little agreement that the language used to describe the peer worker role was relevant to the full range of communities that peer workers worked in.

- The need for shared understanding of the peer worker role was widely seen as important, but there was mixed evidence of shared understandings, and of the distinctiveness of the peer worker role compared with other roles that peer workers worked alongside.
- Training for other members of the team in working alongside peer workers was patchy.
- Formal one-to-one line management for peer workers was not consistently in place, although it was valued by both peer workers and their managers.

There were some issues that we observed consistently across our cases that might be idiosyncratic to introducing peer worker roles in mental health services in England (that is, these findings were not reflected in the existing wider literature):

- It was not generally seen as important that training for peer workers was externally accredited and neither was access to external mentoring for peer workers.
- Locally developed training was widely seen as an important part of the role development process.
- Professionalism in the peer worker role was seen as important in all settings and by nearly all stakeholders, although many different understandings of professionalism applied.

Peer workers in the NHS

There were specific challenges to directly employing peer workers in mental health NHS trusts. Introducing this very new way of working into large organisations that, by necessity, were highly structured and had well-developed cultures of practice resulted in tensions that peer workers, their managers and coworkers in our cases were working hard to address:

- The Agenda for Change pay structure restricted opportunities for promotion for peer workers and constrained the level of role distinctiveness that could be written into job descriptions.
- Shared understandings of the peer worker role were lower in the NHS than elsewhere; clarity of job description did not always address shared expectation within teams.
- Coworkers in the NHS did not always think they should be supporting the peer workers they worked alongside, or thought that this placed an additional burden on their work.
- Peer workers were not always managed by line managers who were familiar with, or who had the skills to support them well.
- There were concerns about competition for jobs between peer and non-peer roles of the same grade that senior managers needed to address.
- Turnover of executive management in mental health NHS trusts could disrupt consistent strategic support for the introduction of peer worker roles.

Some distinctive features of peer worker role adoption in the NHS were observed in our cases that were not otherwise identified in the wider literature:

- Expectations that peer workers would disclose specific details about their lived experience of mental health problems in their work were higher in the NHS than elsewhere, with training given in some cases on how that was to be done.
- There was a view among some NHS staff that peer workers should receive standard NHS training for managing violence; other NHS staff thought responding to service users' experience of crises should not be part of peer workers' remit.
- Some NHS staff and managers thought they should have specific information about peer workers' mental health history so that they could support them better.
- Peer worker roles in the NHS were often similar in function to non-peer roles, with an additional dimension around working relationally with service users.
- Management champions for peer working had a role to play in addressing resistance to the introduction of peer worker roles in the organisation.

Peer workers in the voluntary sector

Peer worker roles were generally better established in voluntary sector cases than in the NHS and so demonstrated a number of the characteristics identified in the wider evidence base as supportive of role adoption. This was both because some organisations had introduced peer workers a number of years ago, and because organisational cultures were more flexible and had peer working or peer leadership at the core of their organisational values:

- Good shared understanding of the peer worker role among stakeholders was widespread in the voluntary sector.
- Peer worker roles in the voluntary sector were seen as distinctive, generally in comparison with non-peer roles in the NHS.
- The peer worker role was most likely to be defined by a clear set of skills and competencies in the voluntary sector; peer workers in the voluntary sector were more likely to have the skills to manage crisis.
- Boundaries were most likely to be clearly managed by peer workers in the voluntary sector.
- Training for the team in working alongside peer workers was most likely to be happening in the voluntary sector.
- Access to benefits advice was most likely in the voluntary sector, especially where the voluntary sector employer had a working relationship with a welfare organisation.

There were also issues around which peer working was challenging in the voluntary sector:

- Although good progression routes were identified from service user to peer worker, it was not clear how these led to promotion within the organisation.
- Peer workers themselves felt they sometimes had to champion the peer worker role, and this could place an additional burden on them.

Some distinctive features of peer worker role adoption in the voluntary sector were observed that were not otherwise identified in the literature:

- Peer workers were often directly recruited from the service they used, as a developmental or vocational opportunity; this could bring its own challenges as well as opportunities.
- There was some evidence that not knowing which employees in a voluntary sector organisation had lived experience of mental health problems, and which did not, was empowering for service users; similarly, functional difference between peer and non-peer roles was seen as less important in the voluntary sector.

Peer workers in organisational partnerships

A particular set of issues characterised the introduction of peer workers in the context of partnerships between mental health NHS trusts and voluntary sector and social care partners. There were important opportunities in partnership arrangements:

- Peer worker roles were most distinctive in partnership contexts and were highly valued as such by all stakeholders.
- Peer workers were most likely to have a different relationship with service users (than did non-peer staff) where they were employed in the voluntary sector and worked on a NHS inpatient ward.

The partnership context also brought its own set of challenges:

- There was a lack of parity of pay in partnership contexts where unpaid or low-paid peer workers were working alongside better-paid NHS colleagues doing similar work, or where employers had yet to develop the structures for properly paying peer workers.

- Boundaries were least likely to be clearly managed in partnership contexts; the challenges of working to competing value systems in partnership arrangements were acknowledged.
- Clear and consistent line management arrangements were least likely to be in place in partnership contexts.

Peer workers in inpatient settings

Particular implementation issues characterised peer working in inpatient settings. Positively:

- Shared understanding of the peer worker roles was higher among stakeholders in inpatient settings (compared with community or BME settings).
- Peer workers were most likely to have a different relationship with service users (than did non-peer staff) where they worked on an NHS inpatient ward and were employed in the voluntary sector.
- Training for the team in working alongside peer workers was most likely to be happening in inpatient settings.

Challenges in inpatient settings included:

- The distinctiveness of the peer worker role could be undermined where there were staffing shortages.

Other characteristics of the role specific to inpatient settings included:

- Professionalism was seen as most important in inpatient settings, where it was often associated with maintaining good boundaries.
- The skills to manage crisis were seen as most important in inpatient settings, as was receiving generic NHS training in managing violence.

Peer workers in community settings

There was little evidence of a particular set of issues unique to community settings. Parity of pay for peer workers was worse in community settings than elsewhere, at times because voluntary sector or partnership organisations had yet to develop appropriate pay structures, or because peer workers were compared with higher-paid colleagues in the NHS.

Peer workers in BME-specific services

There were a number of issues particular to peer worker roles in BME-specific settings:

- Peer workers in BME settings noted how appropriate use of language could act as a bridge in their work with service users – peer workers interpreted between English and mother tongues, but also translated mental health concepts so that they were culturally relevant – but language could also act as a barrier where assumptions about peer working were applied inappropriately.
- There were particular concerns in BME settings that professionalism might undermine the peer worker role if it imposed a sense of formality on the relationship between peer worker and service user.
- There was less role-specific training in BME settings, where hands-on experience was seen as more important.

Learning from the research: future development of new peer worker roles

In *Chapter 4* we discussed our data in more detail to identify and understand the opportunities and challenges faced in our cases, and how those challenges were overcome as peer worker initiatives evolved. That learning reflected and built further on what is shown in the wider literature. Our in-depth analysis enabled us to draw out organisational learning in the form of specific facilitators of, and barriers to, the adoption of peer worker roles in mental health services in England. The main facilitators and barriers are summarised below.

Facilitators of peer worker role adoption

Valuing what is distinctive about the peer worker role
Acknowledgement by staff, managers and commissioners of what is distinctive about the peer worker roles is essential to facilitate role adoption. In particular, the differential knowledge that peer workers bring to the role, and the different relationships that peer workers are able to build with service users (compared with staff working in non-peer roles) should be openly valued. It should be recognised that the bridging and engaging role played by peer workers is based on their ability to build relationships of trust with service users, to use language differently in building connections based on shared lived experience, and to give voice to service users' priorities and concerns. Peer workers are empowered to do their job well when these essential qualities of their work are valued throughout the organisation.

Maintaining peer identity
It is necessary to have a clear understanding of the level of shared lived experience and shared identity that it is important for peer workers to have with service users in each particular setting. Having peer workers with a range of different backgrounds on a team can facilitate shared identification for service users. At the same time, it is important to acknowledge the challenges peer workers face in being different from service users (by virtue of their role of work). Peer workers need to be enabled by staff to retain a peer identity in their working roles, and supported in managing that complex 'dual' identity. Language used to describe the peer worker role must be appropriate to the service delivery setting and cultural context.

Supporting the individual peer worker
It is important to recognise that peer workers might need support to stay well because the role requires them to make use of sometimes difficult lived experience to make personal connections. Skilled, dedicated and trusted one-to-one support that is accessible for peer workers should be provided, with a clear understanding of the distinction between task-related management and supervision for the peer-specific challenges of working in a peer worker role. Dedicated peer support from other peer workers should also be accessible, and role-specific training should encompass maintaining personal wellness.

Evolving organisational structures to support the peer worker role
Having enough peer workers (a critical mass) in an organisation or team to make a difference to the culture of the team is vitally important for empowering the role, as is clearly establishing the distinctiveness of the peer worker role compared with other roles on the team. Sufficient flexibility should be built into the role and into the way the team works to enable adjustments to be made that respond to individual peer workers' wellness and working needs. This can only be achieved with supportive, aware and enabling management, at all levels of the organisation. It is much easier to put supportive structures in place where a good fit can be articulated between the values underpinning peer working, and the quality and productivity agendas that commissioners and strategic managers are required to deliver, and where evidence can be produced of peer workers delivering strategically relevant outcomes. Flexibility and creativity around workforce and practice policies and procedures need to be applied to ensure role adoption; for example, recognising the alternative, non-traditional expertise that peer workers can bring to risk management.

Evolving organisational culture to empower peer workers
Introducing peer workers into an organisation has the potential to fundamentally change the way mental health services are delivered through changing the organisation's culture. Key to enabling the new way of working that peer workers bring is recognition of the value of alternative, personally (rather than professionally) defined boundaries in their practice. Peer workers need to be trained, supported and enabled to exercise individual control over how they manage their boundaries and how they share their lived experience. In addition, peer workers need explicit support to speak out and challenge habitual use of stigmatising language within mental health teams. Organisational culture must be allowed to change – cultural change should be supported strategically – or peer workers will not be empowered to

work in a peer capacity. The peer worker role is most empowered where there is a culture of reflective practice within the organisation or team, and where there is a pervasive culture of valuing and using lived experience throughout the organisation.

Barriers to peer worker role adoption

Lack of shared understanding of the peer worker role
Adoption of the peer worker role is severely inhibited where there is a lack of shared understanding and acknowledgement of the essential aspects of the peer worker's role within the organisation. There is a risk then that an appropriate balance will not be found between tasks that are distinctive to the role and generic tasks. Peer workers can become a repository for low-value, unwanted tasks.

Undermining of peer identity
Overformalisation of the role – sometimes referred to as professionalisation – can act as a barrier to forming peer-based relationships. Relationships of trust with service users can be hard to form when peer workers are overly identified with as staff. Uncritical and culturally insensitive use of language around the peer worker role – imposing formal language on the work – can put distance between peer workers and the people they are supporting.

Lack of role-specific support
An overly medical response – from managers or coworkers – to peer workers becoming unwell, and a general lack of acknowledgement of the support potentially needed to enact a peer role is disempowering and undermining of the role. Assigning peer workers to managers who have not been prepared to provide role-specific support is also disempowering. Where peer workers receive general training in working as a peer, but not training that enables them to apply their lived experience in specific service delivery environments, they can find it hard to work in a peer role.

Reshaping the role to fit existing organisational structures
Modifying the peer worker role to fit existing, inflexible organisational structures – rather than enabling structures to evolve to accommodate the role – will result in the peer worker role becoming diluted and losing its distinctive peer qualities. Where there is a lack of understanding and awareness of the peer worker role at all levels of organisational management, structural change is likely to be blocked. A lack of shared strategic vision across organisational partnerships is another potential block to necessary change.

Cultural inflexibility within the organisation
Rigid reinforcement of cultural norms within the organisations – for example, training peer workers to work to traditional clinical practice boundaries – questions what is valuable about sharing lived experience in the role. Assertion of clinical jurisdiction in the multidisciplinary team – not enabling the peer voice within the team – sends strong signals that peer expertise is not valued, as does a general lack of openness about mental health problems within the organisation as a whole. This cultural inflexibility sends a mixed message to peer workers, is disempowering for individual peer workers and will ultimately dilute the role.

Organisational learning tools

Alongside the main study we were funded to undertake knowledge mobilisation work to support the transfer of applied learning from the research into an additional group of mental health NHS trusts that were in the early stages of developing peer worker roles. We initiated this project because a number of trusts and other organisations had been interested in taking part in the main study but were not sufficiently progressed in their role development to be considered as case study sites at that time. That parallel piece of work is reported in detail in *Appendix 9* and further supported the second aim of our study, to inform the development of new peer worker roles in mental health services in England.

As part of the knowledge mobilisation project we sought to develop a set of organisational learning tools that aimed to assist mental health service provider organisations in decision-making about where, why and how to introduce new peer worker roles into their service delivery. The tools aim to provide a key to the learning in this study. In each local mental health care economy, decisions will be made about the most appropriate organisational arrangements for employing peer workers – in the NHS, voluntary sector or in partnership arrangements – and those decisions will relate to existing and historical organisational configurations. Different service delivery settings will be prioritised based on local need or opportunity. There will be specific learning from this study that will enable those options appraisals. Once those decisions have been made there will be further learning that points to the barriers to, and facilitators of, implementation.

We are in the process of developing three learning tools:

1. *Peer worker role mapping tool* This tool is designed to encourage mental health NHS trusts, their voluntary sector and social care partners, and commissioners to agree priorities for new peer worker role development, to identify existing local resources and opportunities (e.g. existing peer-led initiatives in the voluntary sector), and to make decisions about where to focus future role development.
2. *Peer worker role implementation inventory* This tool is based on the structured part of our interview schedule and will be refined through further data analysis to a reduced set of 20–25 items. The tool is designed to be used with a range of stakeholders – peer workers, service users, coworkers, managers and commissioners – to identify local priorities for role development.
3. *Peer worker role star* This is designed as both a role development tool and a training tool for teams introducing new peer worker roles. Again to be used by a range of stakeholders, the role star is designed to enable organisations and teams to reach consensus on expectations around core components of the peer worker role.

A structured set of good practice guidance will be prepared that is linked to completion of each tool, enabling site-specific reports to be generated. Much of the work of the knowledge mobilisation project has been around trialling tools and developing the accompanying guidance. This remains work in progress. It is the team's intention to make these learning tools freely available as interactive, web-based tools on the project website.

Recommendations for research

As we noted at the outset of this report, there is a lack of good quality, formal evaluation of interventions based on new peer worker roles, especially in the UK. Those studies that do exist internationally evaluate a number of very different interventions, explore a range of outcomes, and use a number of different observational, experimental and quasi-experimental study designs. As a result, the overall picture demonstrating the effectiveness of peer worker interventions remains less than convincing.[16]

Medical Research Council guidance for the evaluation of complex interventions[21] suggests that sufficient theoretical, modelling and piloting work needs to be done around complex, organisational or service-level interventions before properly informed decisions can be made about what to evaluate and how. The introduction of peer workers into existing teams alongside other mental health professionals within the NHS, or establishing innovative peer-led services in partnership with or outside of statutory mental health service provision, constitute complex approaches to mental health care. It is necessary to identify the active components of those service-level developments and to understand which outcomes peer workers have an impact on, and how, before appropriate evaluation can be designed.

There are a plethora of current approaches to introducing new peer worker roles in mental health services in England – this study was in large part an effort to understand some of those underlying processes – in a range of organisational and service delivery contexts. Furthermore, a recent Cochrane Review has indicated that the equivocal nature of findings in trials of peer worker intervention to date is at least in part due to poor definition of the intervention and associated mechanisms of change.[16] Coherent future evaluation that usefully informs service provision in England might therefore be prioritised as follows:

1. 'preclinical' theoretical work to develop a coherent theoretical framework describing how the mechanisms of 'what peer workers do' are linked to identifiable service- and individual-level outcomes
2. developmental work to model and then pilot peer worker-based interventions – in a range of organisational and service delivery contexts – to ensure that interventions are feasible, acceptable and can be delivered with sufficient fidelity to enable formal evaluation
3. development and testing of fidelity measures to support formal evaluation of peer worker interventions
4. experimental or quasi-experimental studies, appropriately designed to best evaluate complex, peer worker-based interventions.

Other research building on this study might include:

1. testing the organisational conditions for implementing new peer worker roles developed in this study – through role development and piloting – in a range of other service delivery settings (e.g. forensic mental health services; younger or older adults' services)
2. mixed-method studies to better understand the longer-term impacts, for peer workers, of working in a peer worker role (including health, well-being and employment outcomes)
3. developing better understanding of the commissioning, organisational, service, team and individual benefits and challenges of partnership working where organisations with very different cultures of practice work together to provide a complex intervention
4. evaluating the organisational learning tools in development as part of this research project.

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Philip Cohen undertook the knowledge mobilisation initiative that took place alongside the research project. Philip wrote *Appendix 9* of this report, describing that work.

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Contributions of authors

Steve Gillard (Senior Lecturer, Social and Community Mental Health) was principal investigator of the study, contributed to data analysis and report writing, and had editorial control over the final version of the report.

Christine Edwards (Professor, Human Resource Management) contributed to study design, analysis of organisational data, and to writing and editing the final report.

Sarah Gibson (Research Assistant, Service User Researcher) contributed to study design, data collection and analysis, and to writing and editing the final report.

Jess Holley (Research Assistant) contributed to data collection and analysis, and to writing and editing the final report.

Katherine Owen (Research Assistant, Service User Researcher) contributed to study design, data collection and analysis, and to writing and editing the final report.

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Appendix 1 Part 1 interview schedule

	A. Is this happening here?					B. How important do you think this is?					
	Yes	Partly	No	Don't know	Not relevant	Extremely important	Quite important	Not very important	Not at all important	Don't know	Not relevant
Section 1 – Recruitment, job description and career pathway											
1.1 Peer Workers are recruited through a formal recruitment process											
1.2 Peer Workers have lived experience of using the same or similar services as those they are working in											
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a Peer Worker											
1.4 Peer Workers have a job description that defines tasks and responsibilities that are specific to the Peer Worker role											
1.5 Terms and conditions for Peer Workers include 'reasonable adjustments' such as flexible working arrangements											
1.6 Peer Workers are paid the same as other workers in the organisation doing similar work											
1.7 Peer Workers have the same access to trade union representation as other workers in the organisation											
1.8 There are opportunities for promotion for Peer Workers in the organisation											
Section 2 – Expectations of the role											
2.1 There is a shared understanding of the role of Peer Workers in the organisation											
2.2 The Peer Worker role is clearly different to other roles in the organisation											
2.3 Peer Workers are expected to be as professional as any other worker in the organisation											
2.4 Peer Workers are expected to disclose their personal mental health history as part of their work											
2.5 Boundaries between Peer Workers and service users are clearly managed (e.g. confidentiality, contact, availability)											

	A. Is this happening here?					B. How important do you think this is?					
	Yes	Partly	No	Don't know	Not relevant	Extremely important	Quite important	Not very important	Not at all important	Don't know	Not relevant
2.6 The Peer Worker role is defined by a specific set of Peer Worker skills and 'competencies'											
2.7 Service users' relationships with peer workers are different to their relationships with other workers/ staff in the organisation											
2.8 Peer Workers have the necessary skills to provide support for service users who are experiencing a mental health crisis											
Section 3 – Peer Workers & diversity											
3.1 Peer Workers are recruited from the community or communities that the organisation provides a service to											
3.2 The Peer Worker role is about a wide range of issues including access to services, social inclusion and community rights											
3.3 Leadership for Peer Work comes from within the community or communities that the organisation provides a service to											
3.4 The language used to describe the Peer Workers role is relevant to the community or communities that the organisation provides a service to											
Section 4 – Training & support											
4.1 Peer Workers receive training which is specifically designed for this purpose											
4.2 Peer Worker training is externally accredited (i.e. they receive a qualification from a university or college)											
4.3 Peer Workers receive the same training in core competencies that all NHS mental health workers receive											
4.4 Other staff in the organisation receive training in working alongside Peer Workers											
4.5 Peer Workers are supported by the organisation to access advice about benefits and welfare rights											
4.6 Peer workers have access to independent mentoring from outside the organisation											

	A. Is this happening here?					B. How important do you think this is?					
	Yes	Partly	No	Don't know	Not relevant	Extremely important	Quite important	Not very important	Not at all important	Don't know	Not relevant
Section 5 – Team working and management											
5.2 Team managers provide formal one to one line management to Peer Workers											
5.3 Team managers provide support for Peer Workers who become unwell (including support with mental health issues)											
5.4 Team managers are required to have specific skills in order to lead teams which include Peer Workers											
5.5 Cover is provided by other members of the team if Peer Workers become unwell											
5.6 Colleagues are informed about the specific mental health history of Peer Workers they work alongside											
5.7 Risk management procedures are in place that refer specifically to issues relevant to Peer Working											
5.8 Peer Workers have a specific function that is different to that of other team members											
5.9 Peer Workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/ other support workers)											

Section 6 – Organisation

6.1 The employment of Peer Workers is supported at the highest level in the organisation					
6.2 A single or small number of individuals 'champion' the role of Peer Workers in the organisation					
6.3 The employment of Peer Workers fits in to the organisation's wider strategic objectives					
6.4 The organisation has policies and procedures that deal with issues such as Peer Workers and Risk Management					
6.5 The role played by Peer Workers is valued across the organisation					

Please look through the list of statements above and indicate what you think are the **three most important issues** around the introduction of the Peer Worker role in your organisation. These could be things that have worked well or things that were challenging (write the statement numbers below):

(1) _____   (2) _____   (3) _____

Finally, please briefly tell the interviewer why you think those three issues are the most important.

Appendix 2 First version of the analytical framework

Section 1: recruitment, JD & career
- Peer worker choice of role
- Recruitment process
- Personal experiences of Peer Workers
- Differing understandings of Peer Worker
- Treatment of Peer Workers
- Identity?

Section 2: expectations of the role
- Role description
- Peer Expertise (differential knowledge?)
- Relationship issues
- Benefits of the role
- Challenges of the role

Section 3: Peer Workers & diversity
- Understandings of diversity
- Representations of diversity
- Barriers to diversity
- Facilitators of diversity

Section 4: training & support
- Training
- Support
- Sharing
- Supportive culture

Section 5: teamworking & management
- Honesty about mental health
- Tasks & responsibilities
- Planning
- Treatment of Peer Workers
- Mutuality?
- Team preparedness?

Section 6: organisation
- Culture
- Interpersonal relationships
- Setting
- Contrasts between voluntary & statutory sector
- Policies & procedures
- Relationships between organisations

Success & essence
- Success: use of mental health services
- Success: personal outcomes
- Success: organisational outcomes
- Essence: support
- Essence: relationship
- Essence: role

Appendix 3 Theme content tables

Label	*1.1 Peer worker choice of role*
Content	Service user identity; transition to workplace
Notes	

Label	*1.2 Recruitment process*
Content	Quality of process (formal/informal); interview; knowing people; CV; personal/lived experience
Notes	

Label	*1.3 Personal experiences of peer workers*
Content	Practical experience; lived experience; shared experience; lived understanding; peer worker credibility; service user identity; disclosure
Notes	From whole team meeting, lived experience as 'dialectic' (advantage and disadvantage)

Label	*1.4 Differing understandings of peer worker roles*
Content	By peer worker; by service user; service user as peer worker; peer worker as staff
Notes	From whole team meeting, organisation where (nearly) everyone is a peer, who is a peer?

Label	*1.5/5.4 Treatment of peer workers*
Content	Equality; inclusion; othering; tokenism; patronising; lack of clarity; accounting for peer worker vulnerability; stigmatisation in peer worker roles
Notes	Refers to treatment of peer workers both during the recruitment process and in the context of teamworking/treatment by managers
	From whole team meeting, peer workers in a position of strength in peer-led organisations/informal understandings difficult in NHS context, acknowledging vulnerabilities

Label	*1.6/2.6/3.5 Identity?*
Content	
Notes	Suggested in whole team meeting as a theme likely to emerge during discussion about 'who is a peer worker?'; potentially would also apply to Section 2 of the schedule (Expectations) and Section 3 (Diversity)

Label	*2.1 Role description*
Content	Development; skills; tasks; attitudes
Notes	

Label	*2.2 Peer expertise*
Content	Lived experience; breaking down stigma; role model
Notes	The issue of 'differential knowledge' was introduced at whole team meeting (knowledge that is distinctive to peer experience – linked to peer identity – as opposed to 'technical' knowledge about mental health that might be shared with non-peers); that knowledge is therapeutically useful

Label	*2.3 Relationship issues*
Content	Boundaries; disclosure; length of relationships; difference with non-peer staff relationships
Notes	Whole team meeting, confidentiality

Label	*2.4 Benefits of the role*
Content	Benefits for service users; benefits of peer workers; benefits for non-peer staff
Notes	

Label	*2.5 Challenges of the role*
Content	Challenges for peer workers
Notes	

Label	*3.1 Understandings of diversity*
Content	Social; race; country of origins; area; education; age . . . and 'mental health communities'
Notes	

Label	*3.2 Representations of diversity*
Content	Within team; between service users; between team and service users; within organisation
Notes	

Label	*3.3 Barriers to diversity*
Content	Geographical area; staff; service users
Notes	

Label	*3.4 Facilitators of diversity*
Content	Practical; organisational culture; service promotion
Notes	

Label	*4.1 Training*
Content	Relevance; on the job; informal; reflection
Notes	

Label	*4.2 Support*
Content	Support in the office; mutual support in the team; peer worker to peer worker; supervision; management; debriefing; reflection; validation; understanding group dynamics
Notes	Includes both mechanisms of support and qualities of support; might separate later and/or incorporate qualities of support with 'sharing' theme below?

Label	*4.3 Sharing*
Content	Sharing the experience; sharing concerns; sharing information; sharing the load
Notes	

Label	*4.4 Supportive culture*
Content	Team openness regarding own mental health; acceptance; peer worker vulnerability; management
Notes	Links to 'honesty' theme below

Label	*5.1 Honesty about mental health*
Content	Team openness/disclosure regarding own mental health; confidentiality; acceptance; peer worker vulnerability; peer worker self-awareness
Notes	Core element of 'supportive culture' theme above

Label	*5.2 Tasks and responsibilities*
Content	Levels of responsibility/accountability; interchangeability of task; teams within teams; working together/as equals; hierarchies
Notes	

Label	*5.3 Planning*
Content	Planning through reflection
Notes	

Label	*5.5 Mutuality?*
Content	Peer worker–service user; within team; difficult for those who have come through system; sharing risk and responsibility
Notes	Suggested at whole team meeting

Label	*5.6 Team preparedness?*
Content	Done in NHS? Personal planning (for whole team); healthy environment
Notes	Suggested at whole team meeting

Label	*6.1 Culture*
Content	Voluntary sector ethos; voluntary sector practices; valuing staff support; service user involvement
Notes	

Label	*6.2 Interpersonal relationships*
Content	Relationships in the voluntary sector
Notes	

Label	*6.3 Setting*
Content	Voluntary sector setting; empowering; statutory sector setting
Notes	

Label	*6.4 Contrasts between voluntary and statutory sectors*
Content	Power; attitudes; structures; advantages; disadvantages
Notes	

Label	*6.5 Policies and procedures*
Content	Style; risk management; sickness; strategic objectives
Notes	

Label	*6.6 Relationships between organisations*
Content	Quality of relationships; communication
Notes	

Label	*7.1 Success: use of mental health services*
Content	No use of statutory services; reduced use of statutory services; different use of statutory services; use of other services
Notes	

Label	*7.2 Success: personal outcomes*
Content	Intrapersonal; interpersonal; general
Notes	

Label	*7.3 Success: organisational outcomes*
Content	Development of services, roles, partnerships; recognition; funding; evaluations
Notes	

Label	*7.4 Essence: support*
Content	Peer worker skills; peer worker attitudes; peer worker experience
Notes	

Label	*7.5 Essence: relationship*
Content	Peer worker–service user relationship; peer worker–peer worker relationship
Notes	

Label	*7.6 Essence: role*
Content	Fulfil service user potential; use difficulties in a positive way; be of value to others
Notes	

Appendix 4 Part 1 analysis output

Responses to question A for each item: proportions compared by employer

For each pair of bars in *Figures 6–11*, the first bar relates to cases where peer workers were employed in the voluntary sector, and the second to cases where peer workers were employed in the statutory sector.

1.1 Peer workers are recruited through a formal recruitment process

1.2 Peer workers have lived experience of using the same or similar services as those they are working in

1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker

1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role

1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements

1.6 Peer workers are paid the same as other workers in the organisation doing similar work

1.7 Peer workers have the same access to trade union representation as other workers in the organisation

1.8 There are opportunities for promotion for peer workers in the organisation

FIGURE 6 Recruitment, job description and career progression: comparison by employer.

2.1 There is a shared understanding of the role of peer workers in the organisation

2.2 The peer worker role is clearly different to other roles in the organisation

2.3 Peer workers are expected to be as professional as any other worker in the organisation

2.4 Peer workers are expected to disclose their personal mental health history as part of their work

2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)

2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'

2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation

2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis

FIGURE 7 Expectations of the role: comparison by employer.

3.1 Peer workers are recruited from the community or communities that the organisation provides a service to

3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights

3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to

3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to

FIGURE 8 Peer workers and diversity: comparison by employer.
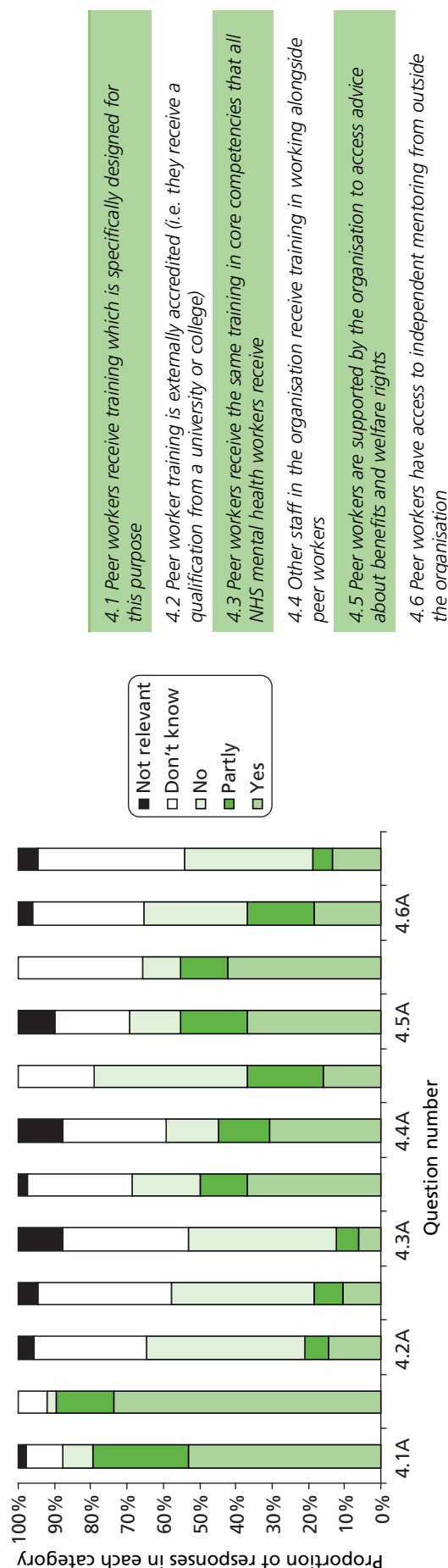
FIGURE 9 Training and support: comparison by employer.

4.1 Peer workers receive training which is specifically designed for this purpose

4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)

4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive

4.4 Other staff in the organisation receive training in working alongside peer workers

4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights

4.6 Peer workers have access to independent mentoring from outside the organisation

5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)

5.2 Team managers provide formal one-to-one line management to peer workers

5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)

5.4 Team managers are required to have specific skills in order to lead teams which include peer workers

5.5 Cover is provided by other members of the team if peer workers become unwell

5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside

5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working

5.8 Peer workers have a specific function that is different to that of other team members

5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)

FIGURE 10 Teamworking and management: comparison by employer.

6.1 The employment of peer workers is supported at the highest level in the organisation

6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation

6.3 The employment of peer workers fits into the organisation's wider strategic objectives

6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management

6.5 The role played by peer workers is valued across the organisation

FIGURE 11 Organisation: comparison by employer.

Responses to question A for each item: proportions compared by organisational context

For each set of three bars in *Figures 12–17*, the first bar relates to NHS cases, the second to partnership cases and the third to voluntary sector cases.

FIGURE 12 Recruitment, job description and career progression: comparison by organisational context.

2.1 There is a shared understanding of the role of peer workers in the organisation

2.2 The peer worker role is clearly different to other roles in the organisation

2.3 Peer workers are expected to be as professional as any other worker in the organisation

2.4 Peer workers are expected to disclose their personal mental health history as part of their work

2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)

2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'

2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation

2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis

FIGURE 13 Expectations of the role: comparison by organisational context.

3.1 *Peer workers are recruited from the community or communities that the organisation provides a service to*

3.2 *The peer worker role is about a wide range of issues including access to services, social inclusion and community rights*

3.3 *Leadership for peer work comes from within the community or communities that the organisation provides a service to*

3.4 *The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to*

FIGURE 14 Peer workers and diversity: comparison by organisational context.

4.1 Peer workers receive training which is specifically designed for this purpose

4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)

4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive

4.4 Other staff in the organisation receive training in working alongside peer workers

4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights

4.6 Peer workers have access to independent mentoring from outside the organisation
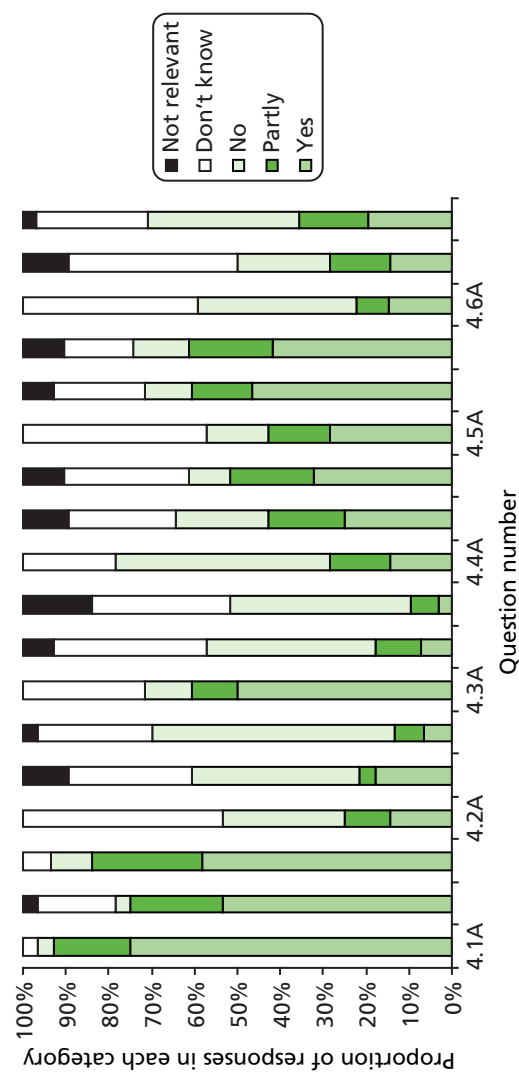
FIGURE 15 Training and support: comparison by organisational context.

5.1 Peer workers are supported by other other members of the staff team (other peer workers and/or non-peer colleagues)

5.2 Team managers provide formal one-to-one line management to peer workers

5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)

5.4 Team managers are required to have specific skills in order to lead teams which include peer workers

5.5 Cover is provided by other members of the team if peer workers become unwell

5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside

5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working

5.8 Peer workers have a specific function that is different to that of other team members

5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)

FIGURE 16 Teamworking and management: comparison by organisational context.

6.1 The employment of peer workers is supported at the highest level in the organisation

6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation

6.3 The employment of peer workers fits into the organisation's wider strategic objectives

6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management

6.5 The role played by peer workers is valued across the organisation

FIGURE 17 Organisation: comparison by organisational context.

Responses to question A for each item: proportions compared by service setting

For each set of three bars in *Figures 18–23*, the first bar relates to inpatient cases, the second to community cases and the third to BME-specific cases.

1.1 Peer workers are recruited through a formal recruitment process

1.2 Peer workers have lived experience of using the same or similar services as those they are working in

1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker

1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role

1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements

1.6 Peer workers are paid the same as other workers in the organisation doing similar work

1.7 Peer workers have the same access to trade union representation as other workers in the organisation

1.8 There are opportunities for promotion for peer workers in the organisation

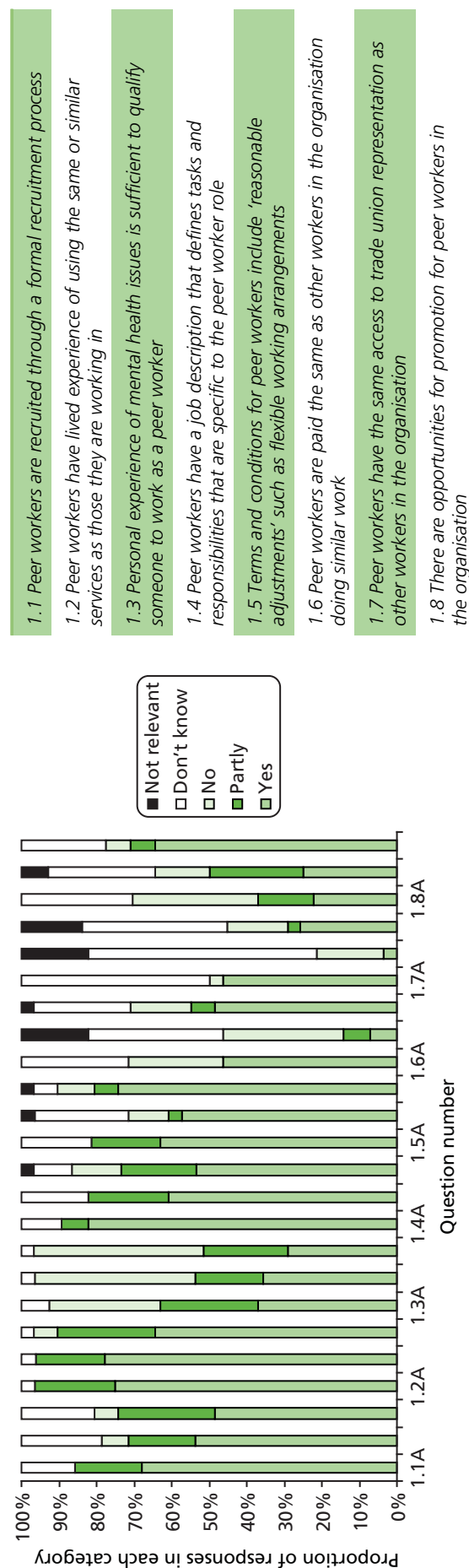**FIGURE 18** Recruitment, job description and career progression: comparison by service setting.

2.1 There is a shared understanding of the role of peer workers in the organisation

2.2 The peer worker role is clearly different to other roles in the organisation

2.3 Peer workers are expected to be as professional as any other worker in the organisation

2.4 Peer workers are expected to disclose their personal mental health history as part of their work

2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)

2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'

2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation

2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis
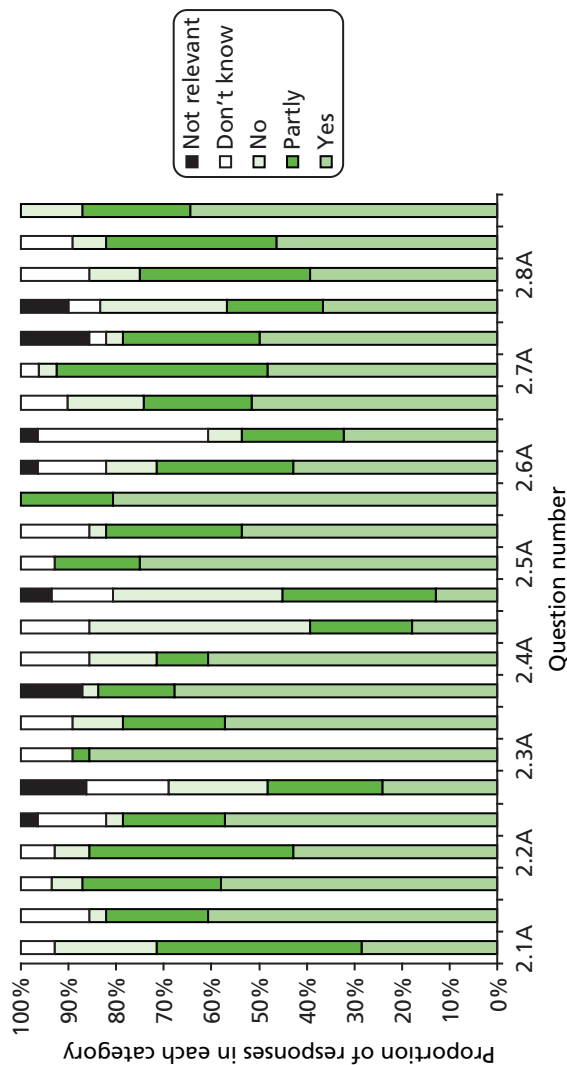
FIGURE 19 Expectations of the role: comparison by service setting.
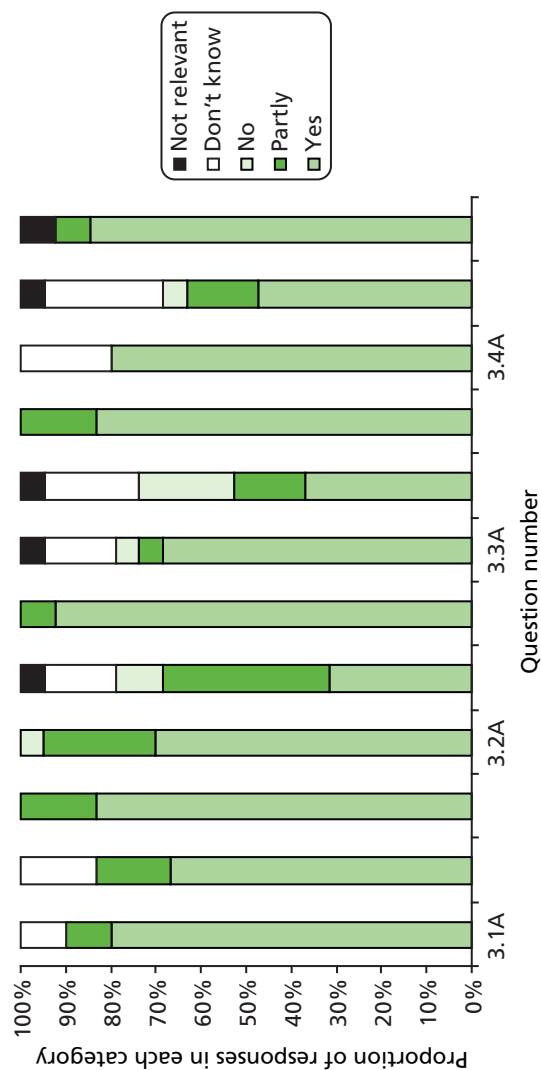
FIGURE 20 Peer workers and diversity: comparison by service setting.

3.1 Peer workers are recruited from the community or communities that the organisation provides a service to

3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights

3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to

3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to

4.1 Peer workers receive training which is specifically designed for this purpose

4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)

4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive

4.4 Other staff in the organisation receive training in working alongside peer workers

4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights

4.6 Peer workers have access to independent mentoring from outside the organisation

FIGURE 21 Training and support: comparison by service setting.

5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)

5.2 Team managers provide formal one-to-one line management to peer workers

5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)

5.4 Team managers are required to have specific skills in order to lead teams which include peer workers

5.5 Cover is provided by other members of the team if peer workers become unwell

5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside

5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working

5.8 Peer workers have a specific function that is different to that of other team members

5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)

FIGURE 22 Teamworking and management: comparison by service setting.
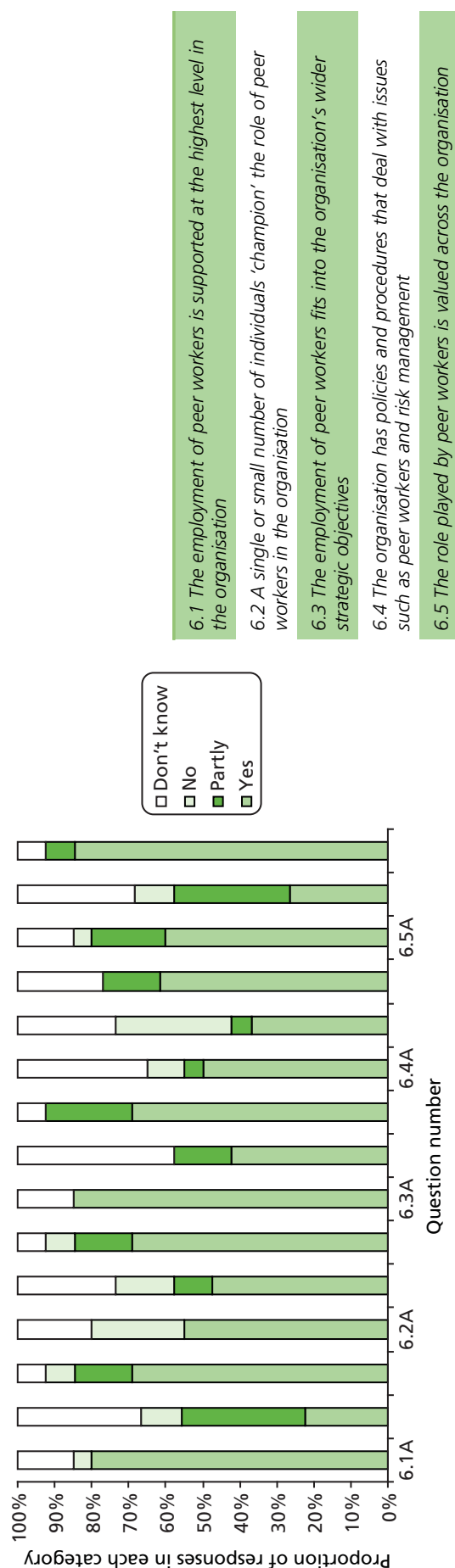
FIGURE 23 Organisation: comparison by service setting.

6.1 The employment of peer workers is supported at the highest level in the organisation

6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation

6.3 The employment of peer workers fits into the organisation's wider strategic objectives

6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management

6.5 The role played by peer workers is valued across the organisation

Responses to question B for each item: mean scores compared by employer

TABLE 8 Recruitment, job description and career progression: comparison by employer

Interview item	Employer	
	Voluntary	Statutory
1.1 Peer workers are recruited through a formal recruitment process	3.5	3.5
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	3.5	3.5
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	3.1	3.2
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	3.6	3.8
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	3.7	3.7
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	3.4	3.3
1.7 Peer workers have the same access to trade union representation as other workers in the organisation	3.5	3.3
1.8 There are opportunities for promotion for peer workers in the organisation	3.6	3.4

TABLE 9 Expectations of the role: comparison by employer

Interview item	Employer	
	Voluntary	Statutory
2.1 There is a shared understanding of the role of peer workers in the organisation	3.5	3.9
2.2 The peer worker role is clearly different to other roles in the organisation	3.0	3.4
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.5	3.8
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	2.9	3.1
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.8	3.7
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.3	3.4
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.0	3.4
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.6	3.4

TABLE 10 Peer workers and diversity: comparison by employer

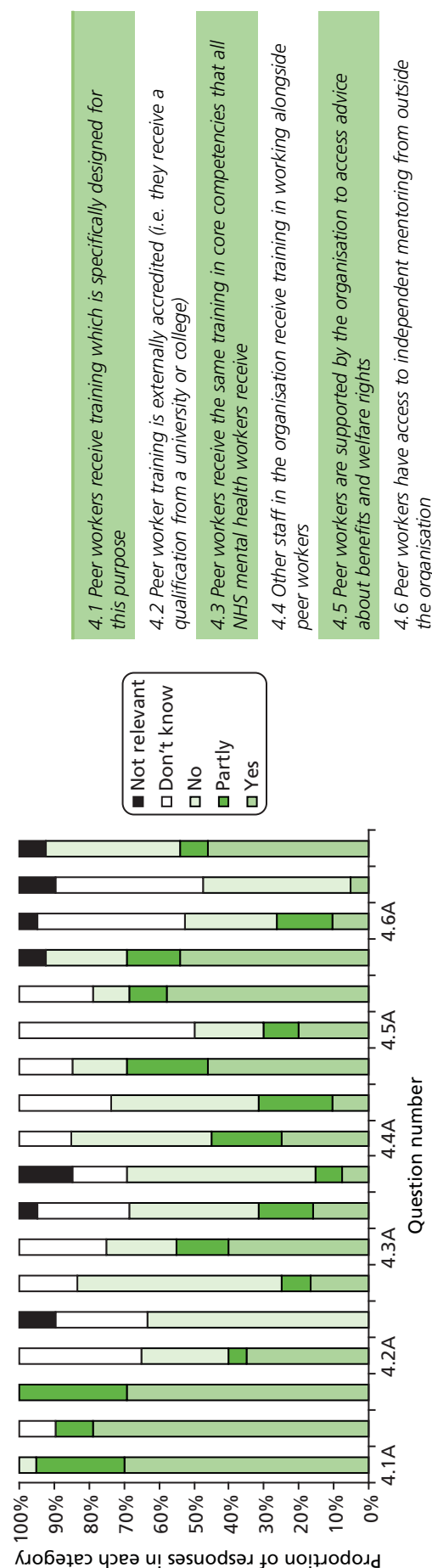| Interview item	Employer	
	Voluntary	**Statutory**
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	3.3	3.3
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	3.6	3.4
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	3.5	3.1
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	3.7	3.6

TABLE 11 Training and support: comparison by employer

Interview item	Employer	
	Voluntary	**Statutory**
4.1 Peer workers receive training which is specifically designed for this purpose	3.6	3.8
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	2.8	3.0
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	2.6	3.3
4.4 Other staff in the organisation receive training in working alongside peer workers	3.3	3.3
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	3.3	3.4
4.6 Peer workers have access to independent mentoring from outside the organisation	3.1	3.3

TABLE 12 Teamworking and management: comparison by employer

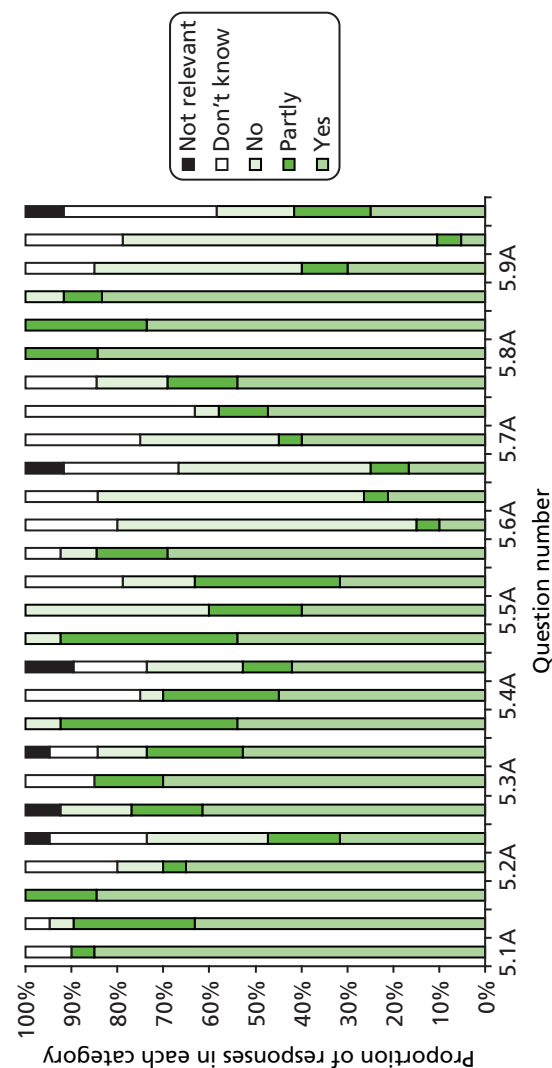| Interview item	Employer	
	Voluntary	Statutory
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	3.8	3.9
5.2 Team managers provide formal one-to-one line management to peer workers	3.6	3.4
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	3.7	3.7
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	3.5	3.5
5.5 Cover is provided by other members of the team if peer workers become unwell	3.6	3.4
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	2.2	2.4
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	3.3	3.4
5.8 Peer workers have a specific function that is different to that of other team members	3.1	3.4
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	2.5	2.8

TABLE 13 Organisation: comparison by employer

Interview item	Employer	
	Voluntary	Statutory
6.1 The employment of peer workers is supported at the highest level in the organisation	3.8	3.7
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	3.1	3.4
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	3.7	3.7
6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management	3.6	3.4
6.5 The role played by peer workers is valued across the organisation	3.9	3.8

Responses to question B for each item: mean scores compared by organisational context

TABLE 14 Recruitment, job description and career progression: comparison by organisational context

Interview item	Context		
	NHS	Partnership	Voluntary
1.1 Peer workers are recruited through a formal recruitment process	3.7	3.5	3.4
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	3.4	3.6	3.5
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	3.2	3.3	3.0
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	3.9	3.5	3.6
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	3.9	3.6	3.7
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	3.6	2.9	3.5
1.7 Peer workers have the same access to trade union representation as other workers in the organisation	3.6	3.1	3.4
1.8 There are opportunities for promotion for peer workers in the organisation	3.6	3.3	3.6

TABLE 15 Expectations of the role: comparison by organisational context

Interview item	Context		
	NHS	Partnership	Voluntary
2.1 There is a shared understanding of the role of peer workers in the organisation	3.8	3.6	3.5
2.2 The peer worker role is clearly different to other roles in the organisation	3.4	3.3	2.9
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.9	3.5	3.4
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	3.2	3.1	2.7
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.9	3.6	3.8
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.5	3.2	3.3
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.5	3.0	3.0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.4	3.4	3.6

TABLE 16 Peer workers and diversity: comparison by organisational context

Interview item	Context		
	NHS	Partnership	Voluntary
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	3.2	3.4	3.4
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	3.5	3.4	3.5
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	3.1	3.3	3.6
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	3.6	3.6	3.7

TABLE 17 Training and support: comparison by organisational context

Interview item	Context		
	NHS	Partnership	Voluntary
4.1 Peer workers receive training which is specifically designed for this purpose	3.8	3.6	3.6
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	3.2	2.7	2.7
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	3.6	2.8	2.5
4.4 Other staff in the organisation receive training in working alongside peer workers	3.4	3.4	3.2
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	3.2	3.5	3.3
4.6 Peer workers have access to independent mentoring from outside the organisation	3.4	3.2	2.9

TABLE 18 Teamworking and management: comparison by organisational context

	Context		
Interview item	**NHS**	**Partnership**	**Voluntary**
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	3.9	3.8	3.8
5.2 Team managers provide formal one-to-one line management to peer workers	3.7	3.3	3.6
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	3.7	3.7	3.7
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	3.4	3.6	3.5
5.5 Cover is provided by other members of the team if peer workers become unwell	3.4	3.4	3.8
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	2.1	2.5	2.3
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	3.4	3.2	3.4
5.8 Peer workers have a specific function that is different to that of other team members	3.5	3.3	3.0
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	2.8	2.5	2.7

TABLE 19 Organisation: comparison by organisational context

	Context		
Interview item	**NHS**	**Partnership**	**Voluntary**
6.1 The employment of peer workers is supported at the highest level in the organisation	3.8	3.6	3.8
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	3.4	3.2	3.1
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	3.9	3.6	3.7
6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management	3.3	3.5	3.6
6.5 The role played by peer workers is valued across the organisation	3.8	3.9	3.9

Responses to question B for each item: mean scores compared by service setting

TABLE 20 Recruitment, job description and career progression: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
1.1 Peer workers are recruited through a formal recruitment process	3.8	3.2	3.3
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	3.6	3.6	3.3
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	3.3	3.2	2.8
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	3.8	3.6	3.4
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	3.9	3.5	3.5
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	3.7	2.7	3.1
1.7 Peer workers have the same access to trade union representation as other workers in the organisation	3.6	2.9	3.1
1.8 There are opportunities for promotion for peer workers in the organisation	3.5	3.3	3.6

TABLE 21 Expectations of the role: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
2.1 There is a shared understanding of the role of peer workers in the organisation	3.8	3.8	3.1
2.2 The peer worker role is clearly different to other roles in the organisation	3.6	3.4	2.9
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.7	3.6	3.1
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	3.2	3.1	2.8
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.9	3.6	3.7
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.6	3.2	3.1
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.4	3.0	3.0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.7	2.9	3.2

TABLE 22 Peer workers and diversity: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	3.2	3.2	3.3
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	3.7	3.1	3.6
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	3.6	2.6	3.7
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	3.9	3.3	3.7

TABLE 23 Training and support: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
4.1 Peer workers receive training which is specifically designed for this purpose	3.9	3.8	3.5
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	3.2	2.6	2.9
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	3.2	2.9	2.3
4.4 Other staff in the organisation receive training in working alongside peer workers	3.6	3.1	3.1
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	3.4	3.4	3.3
4.6 Peer workers have access to independent mentoring from outside the organisation	3.5	2.9	2.9

TABLE 24 Teamworking and management: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	3.9	3.9	3.8
5.2 Team managers provide formal one-to-one line management to peer workers	3.8	2.9	3.3
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	3.9	3.7	3.4
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	3.8	3.4	3.2
5.5 Cover is provided by other members of the team if peer workers become unwell	3.2	3.4	3.6
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	1.8	2.5	3.0
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	3.2	3.4	3.4
5.8 Peer workers have a specific function that is different to that of other team members	3.6	3.4	3.3
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	2.2	2.7	2.7

TABLE 25 Organisation: comparison by service setting

Interview item	Setting		
	Inpatient	Community	BME
6.1 The employment of peer workers is supported at the highest level in the organisation	3.8	3.6	3.6
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	3.3	3.5	3.6
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	3.9	3.6	3.5
6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management	3.4	3.4	3.3
6.5 The role played by peer workers is valued across the organisation	3.9	3.8	3.7

Responses to question B for each item: mean scores compared by stakeholder group

TABLE 26 Recruitment, job description and career progression: comparison by stakeholder group

Interview item	Stakeholder group					
	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
1.1 Peer workers are recruited through a formal recruitment process	3.3	3.3	3.5	3.8	3.7	3.9
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	3.5	3.5	3.4	3.5	3.3	3.6
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	3.0	3.2	3.2	2.9	3.8	3.0
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	3.5	3.4	3.8	3.7	3.9	4.0
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	3.5	3.7	3.6	3.8	3.9	4.0
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	3.2	3.0	3.2	3.7	3.5	4.0
1.7 Peer workers have the same access to trade union representation as other workers in the organisation	3.1	3.2	3.2	3.9	3.7	3.7
1.8 There are opportunities for promotion for peer workers in the organisation	3.7	3.3	3.5	3.4	3.4	3.9

TABLE 27 Expectations of the role: comparison by stakeholder group

	Stakeholder group					
Interview item	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
2.1 There is a shared understanding of the role of peer workers in the organisation	3.5	3.3	3.9	3.8	3.8	4.0
2.2 The peer worker role is clearly different to other roles in the organisation	3.0	3.2	3.2	3.2	3.2	3.9
2.3 Peer workers are expected to be as professional as any other worker in the organisation	3.6	3.1	3.7	3.9	3.8	3.7
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	3.0	3.1	2.9	2.8	3.3	3.0
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3.5	3.7	3.8	3.9	3.9	4.0
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3.3	3.1	3.3	3.4	3.6	3.6
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	3.0	3.2	3.1	3.4	3.3	3.2
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3.5	3.5	3.6	3.5	3.4	3.2

TABLE 28 Recruitment, peer workers and diversity: comparison by stakeholder group

	Stakeholder group					
Interview item	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	3.5	2.9	3.2	3.5	3.3	3.6
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	3.4	3.4	3.6	3.4	3.7	3.3
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	3.2	3.2	3.5	3.3	3.6	3.8
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	3.6	3.4	3.8	3.5	4.0	3.8

TABLE 29 Training and support: comparison by stakeholder group

Interview item	Stakeholder group					
	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
4.1 Peer workers receive training which is specifically designed for this purpose	3.8	3.4	3.8	3.7	3.7	3.7
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	3.0	2.6	2.6	3.2	2.6	3.4
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	2.9	2.7	3.2	3.2	2.3	3.6
4.4 Other staff in the organisation receive training in working alongside peer workers	3.4	3.1	3.5	3.2	3.3	3.8
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	3.3	3.2	3.5	3.3	3.5	3.4
4.6 Peer workers have access to independent mentoring from outside the organisation	3.2	3.0	3.2	3.2	2.9	3.6

TABLE 30 Teamworking and management: comparison by stakeholder group

Interview item	Stakeholder group					
	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	3.8	3.8	3.9	3.9	4.0	3.8
5.2 Team managers provide formal one-to-one line management to peer workers	3.7	3.5	3.3	3.5	3.4	3.7
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	3.7	3.9	3.8	3.7	3.4	3.9
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	3.6	3.5	3.5	3.5	3.5	3.3
5.5 Cover is provided by other members of the team if peer workers become unwell	3.7	3.3	3.4	3.6	3.6	3.8
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	2.4	2.7	2.5	1.8	2.4	1.9
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	3.6	3.8	3.4	2.9	3.0	3.0
5.8 Peer workers have a specific function that is different to that of other team members	3.2	3.1	3.3	3.2	3.5	3.7
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	2.6	2.7	2.9	2.5	2.8	2.1

TABLE 31 Organisation: comparison by stakeholder group

Interview item	Stakeholder group					
	Peer worker	Service user	Coworker	Line manager	Strategic manager	Commissioner
6.1 The employment of peer workers is supported at the highest level in the organisation	3.8	3.7	3.6	3.7	3.9	3.9
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	2.8	3.6	3.6	3.1	3.3	3.6
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	3.7	3.4	3.8	3.9	3.9	3.9
6.4 The organisation has policies and procedures that deal with issues such as peer workers and risk management	3.5	3.7	3.6	3.3	2.9	3.7
6.5 The role played by peer workers is valued across the organisation	3.8	3.9	3.9	3.8	4.0	3.9

Responses to the 'top 3' issues question

TABLE 32 'Top 3' issues: frequency compared by employer

Interview item	Voluntary (*n*)	Statutory (*n*)
1.1 Peer workers are recruited through a formal recruitment process	2	0
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	14	9
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	9	2
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	4	3
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	5	0
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	5	4
1.8 There are opportunities for promotion for peer workers in the organisation	1	1
2.1 There is a shared understanding of the role of peer workers in the organisation	9	7
2.2 The peer worker role is clearly different to other roles in the organisation	2	4
2.3 Peer workers are expected to be as professional as any other worker in the organisation	5	5
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	3	1
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	9	5
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	3	1
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	1	2

TABLE 32 'Top 3' issues: frequency compared by employer (*continued*)

Interview item	Voluntary (*n*)	Statutory (*n*)
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	5	3
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	4	3
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	3	0
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	5	2
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	2	0
4.1 Peer workers receive training which is specifically designed for this purpose	12	12
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	1	1
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	1	2
4.4 Other staff in the organisation receive training in working alongside peer workers	1	2
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	0	1
4.6 Peer workers have access to independent mentoring from outside the organisation	1	0
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	10	5
5.2 Team managers provide formal one-to-one line management to peer workers	2	2
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	1	2
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	1	2
5.5 Cover is provided by other members of the team if peer workers become unwell	2	0
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	1	1
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	2	2
5.8 Peer workers have a specific function that is different to that of other team members	2	6
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	0	1
6.1 The employment of peer workers is supported at the highest level in the organisation	6	6
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	1	2
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	1	2
6.5 The role played by peer workers is valued across the organisation	8	10

TABLE 33 'Top 3' issues: frequency compared by organisational context

Interview item	NHS (*n*)	Partnership (*n*)	Voluntary (*n*)
1.1 Peer workers are recruited through a formal recruitment process	0	1	1
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	5	10	8
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	1	5	5
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	2	2	3
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	0	3	2
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	4	2	3
1.8 There are opportunities for promotion for peer workers in the organisation	1	0	1
2.1 There is a shared understanding of the role of peer workers in the organisation	7	4	5
2.2 The peer worker role is clearly different to other roles in the organisation	2	4	0
2.3 Peer workers are expected to be as professional as any other worker in the organisation	4	2	4
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	1	2	1
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3	3	8
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	1	1	2
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	1	2	0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	3	1	4
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	2	2	3
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	0	0	3
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	1	2	4
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	0	1	1
4.1 Peer workers receive training which is specifically designed for this purpose	8	8	8
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	1	0	1
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	2	1	0
4.4 Other staff in the organisation receive training in working alongside peer workers	1	2	0
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	1	0	0
4.6 Peer workers have access to independent mentoring from outside the organisation	0	1	0
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	2	6	7

TABLE 33 'Top 3' issues: frequency compared by organisational context (*continued*)

Interview item	NHS (*n*)	Partnership (*n*)	Voluntary (*n*)
5.2 Team managers provide formal one-to-one line management to peer workers	2	1	1
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	0	2	1
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	2	0	1
5.5 Cover is provided by other members of the team if peer workers become unwell	0	1	1
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	1	0	1
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	1	2	1
5.8 Peer workers have a specific function that is different to that of other team members	5	3	0
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	1	0	0
6.1 The employment of peer workers is supported at the highest level in the organisation	4	4	4
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	2	0	1
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	1	2	0
6.5 The role played by peer workers is valued across the organisation	9	3	6

TABLE 34 'Top 3' issues: frequency compared by service setting

Interview item	Inpatient (*n*)	Community (*n*)	BME (*n*)
1.1 Peer workers are recruited through a formal recruitment process	0	0	1
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	4	6	1
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	2	2	1
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	2	2	3
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	1	0	1
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	2	0	2
1.8 There are opportunities for promotion for peer workers in the organisation	1	0	1
2.1 There is a shared understanding of the role of peer workers in the organisation	2	3	2
2.2 The peer worker role is clearly different to other roles in the organisation	4	2	0
2.3 Peer workers are expected to be as professional as any other worker in the organisation	2	3	2
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	1	1	0
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	3	2	3
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	0	0	1
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	1	2	0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	1	0	1
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	1	1	0
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	0	0	2
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	1	1	0

TABLE 34 'Top 3' issues: frequency compared by service setting (*continued*)

Interview item	Inpatient (*n*)	Community (*n*)	BME (*n*)
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	1	0	1
4.1 Peer workers receive training which is specifically designed for this purpose	5	8	3
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	0	0	0
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	2	1	0
4.4 Other staff in the organisation receive training in working alongside peer workers	1	1	0
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	0	0	0
4.6 Peer workers have access to independent mentoring from outside the organisation	0	0	0
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	5	3	4
5.2 Team managers provide formal one-to-one line management to peer workers	2	0	0
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	0	2	0
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	1	1	1
5.5 Cover is provided by other members of the team if peer workers become unwell	0	0	1
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	0	0	0
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	1	1	1
5.8 Peer workers have a specific function that is different to that of other team members	3	5	0
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	0	1	0
6.1 The employment of peer workers is supported at the highest level in the organisation	2	3	1
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	1	1	0
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	2	1	0
6.5 The role played by peer workers is valued across the organisation	5	4	4

TABLE 35 'Top 3' issues: frequency compared by stakeholder group

Question	Stakeholder					
	Peer worker (*n*)	Service user (*n*)	Coworker (*n*)	Line manager (*n*)	Strategic manager (*n*)	Commissioner (*n*)
1.1 Peer workers are recruited through a formal recruitment process	1	0	0	1	0	0
1.2 Peer workers have lived experience of using the same or similar services as those they are working in	6	9	1	3	3	1
1.3 Personal experience of mental health issues is sufficient to qualify someone to work as a peer worker	4	3	3	1	0	0
1.4 Peer workers have a job description that defines tasks and responsibilities that are specific to the peer worker role	0	1	3	1	1	1
1.5 Terms and conditions for peer workers include 'reasonable adjustments' such as flexible working arrangements	0	3	1	1	0	0
1.6 Peer workers are paid the same as other workers in the organisation doing similar work	3	0	1	2	1	2
1.8 There are opportunities for promotion for peer workers in the organisation	2	0	0	0	0	0
2.1 There is a shared understanding of the role of peer workers in the organisation	5	0	2	5	1	3
2.2 The peer worker role is clearly different to other roles in the organisation	0	0	3	1	2	0
2.3 Peer workers are expected to be as professional as any other worker in the organisation	4	2	1	3	0	0
2.4 Peer workers are expected to disclose their personal mental health history as part of their work	2	0	0	2	0	0
2.5 Boundaries between peer workers and service users are clearly managed (e.g. confidentiality, contact, availability)	2	1	7	1	2	1
2.6 The peer worker role is defined by a specific set of peer worker skills and 'competencies'	1	1	2	0	0	0
2.7 Service users' relationships with peer workers are different to their relationships with other workers/staff in the organisation	1	2	0	0	0	0
2.8 Peer workers have the necessary skills to provide support for service users who are experiencing a mental health crisis	2	2	2	1	0	1
3.1 Peer workers are recruited from the community or communities that the organisation provides a service to	0	1	3	2	1	0

TABLE 35 'Top 3' issues: frequency compared by stakeholder group (*continued*)

Question	Stakeholder					
	Peer worker (*n*)	Service user (*n*)	Coworker (*n*)	Line manager (*n*)	Strategic manager (*n*)	Commissioner (*n*)
3.2 The peer worker role is about a wide range of issues including access to services, social inclusion and community rights	1	0	1	0	1	0
3.3 Leadership for peer work comes from within the community or communities that the organisation provides a service to	3	0	1	2	0	1
3.4 The language used to describe the peer worker role is relevant to the community or communities that the organisation provides a service to	0	1	0	1	0	0
4.1 Peer workers receive training which is specifically designed for this purpose	8	4	1	4	5	2
4.2 Peer worker training is externally accredited (i.e. they receive a qualification from a university or college)	0	1	0	1	0	0
4.3 Peer workers receive the same training in core competencies that all NHS mental health workers receive	0	1	1	1	0	0
4.4 Other staff in the organisation receive training in working alongside peer workers	2	0	0	1	0	0
4.5 Peer workers are supported by the organisation to access advice about benefits and welfare rights	0	0	1	0	0	0
4.6 Peer workers have access to independent mentoring from outside the organisation	0	0	0	0	1	0
5.1 Peer workers are supported by other members of the staff team (other peer workers and/or non-peer colleagues)	4	2	4	2	3	0
5.2 Team managers provide formal one-to-one line management to peer workers	0	0	1	0	2	1
5.3 Team managers provide support for peer workers who become unwell (including support with mental health issues)	1	2	0	0	0	0
5.4 Team managers are required to have specific skills in order to lead teams which include peer workers	1	1	0	1	0	0
5.5 Cover is provided by other members of the team if peer workers become unwell	1	1	0	0	0	0
5.6 Colleagues are informed about the specific mental health history of peer workers they work alongside	0	1	0	1	0	0

TABLE 35 'Top 3' issues: frequency compared by stakeholder group (*continued*)

	Stakeholder					
Question	Peer worker (*n*)	Service user (*n*)	Coworker (*n*)	Line manager (*n*)	Strategic manager (*n*)	Commissioner (*n*)
5.7 Risk management procedures are in place that refer specifically to issues relevant to peer working	1	2	0	0	1	0
5.8 Peer workers have a specific function that is different to that of other team members	4	1	2	1	0	0
5.9 Peer workers are being employed in jobs that were previously occupied by non-peers (e.g. mental health professionals/other support workers)	0	0	0	1	0	0
6.1 The employment of peer workers is supported at the highest level in the organisation	1	1	1	3	3	3
6.2 A single or small number of individuals 'champion' the role of peer workers in the organisation	0	0	0	1	1	1
6.3 The employment of peer workers fits into the organisation's wider strategic objectives	0	0	0	0	0	3
6.5 The role played by peer workers is valued across the organisation	4	4	6	1	2	1

Appendix 5 *Chapter 3* analysis protocol

1. Open word document with section heading (section document).
2. Use question A part 1 analysis of whole data set to write brief preface about general fit of data with the conceptual framework (i.e. high and low agreement).
3. Use question A part 1 analysis by *employer*, *organisational context* and *service setting*, question B analysis by *employer*, *organisational context*, *service setting* and *stakeholder* and 'top 3' data to identify up to six subheadings (part 1 items or groups of items).
4. Identify categories using analytical framework document (including category definitions) relevant to each subheading.
5. Generate queries for each subheading specifying categories and factor (e.g. *employer*, *stakeholder*) for each query.
6. Run query to produce NVivo output file for each query.
7. Insert subheadings into section document and estimate word budget for each (total of approximately 3000 words for whole document).
8. Write brief preface for each subsection based on relevant part 1 data analysis (e.g. high agreement/ disagreement by *setting/stakeholder*).
9. Cut and paste exemplar quotes from NVivo query output into each subsection.
10. Write commentary around quotes as necessary.
11. Check memos, team analysis notes and feedback workshop output for additional content.
12. Edit to length and send to next team member for review.

Appendix 6 Part 2 interview schedules

PEER WORKER'S INTERVIEW SCHEDULE

1) Human Resources Management

    a) Can you tell me about how you became a Peer Worker?

- What **motivated** you to become a Peer Worker?
- What was the **process** of getting the job? What **helped**? What **hindered**?

    b) What does it mean to you to be called a 'Peer Worker' in your organisation?

    c) In Part 1 we had a few questions about Peer Workers and issues about Diversity. What does this mean to you?

2) Role

Can you tell me about your role as a Peer Worker?

    a) What **do you do** as a Peer Worker? (tasks)
    How is this different to what other workers do?
    How do you use your **personal experience** of mental health issues when working with Service Users?
    How is the way you work **different** to the way other staff (non-peers) in the team work?

    b) How would you describe the **relationship** between you and the Service Users? (What works well in this relationship?/ What are the challenges of this relationship?)
    How is this **different** to the relationship between Service Users and other staff/team members?

    c) What are the **benefits** of the role for you?
    What are the **challenges** of the role for you?

3) Training

Can you tell me about any training you have had in your role as a Peer Worker?

- What was **useful** about this training/ how has training supported you in carrying out the Peer Worker role?
- What could have been **improved**?
- What **other training** would support you in your role?

4) Support

c) What do you think **the essence** of the Peer Worker role is in mental health services? What makes it unique?

8) End

Is there **anything else** that you would like to addabout the introduction of Peer Worker roles in mental health services?

STRATEGIC MANAGER'S INTERVIEW SCHEDULE

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1)   Human Resource Management

a) Can you tell me **how the Peer Worker role was introduced** into the organisation?

- Where did the initiative to introduce Peer Workers come from?
- How and by whom was the decision made to introduce Peer Workers?

b) What is the process of **recruiting Peer Workers** to the organisation?

- What have been the learning's and the challenges from the process?
- Were there any adaptions to the HR procedures to employ Peer Workers? What were they?
- What terms and conditions do Peer Workers work under? Are they different to those of other workers? How have they been adapted?

---

2)   Role/ Relationship

a) **How would you describe the role of a Peer Worker(s) in this organisation?**

- What does a peer worker do? (please give examples)
- How is that different to what other staff members do here?
- Can you describe any differences **in the way** in which Peer Workers and other staff members work?

b) **How would you describe the relationship between Peer Workers and Service Users?**

- How is this different to the relationship between service users and other staff members? (For example, are there different boundaries, issues of disclosure?)

---

3)   Training

a) **Can you tell me about any training the organisation provides for the Peer Workers?**

- How does this support Peer Workers in their role?

- How much of that training is purposely designed for Peer Workers and how much is generic training offered to all your staff? How did you develop your purposely designed Peer Worker training?

b) Can you tell me about **any training or information staff and mangers have received around the introduction of Peer Workers here**? (For example, briefings, preparation, discussions, courses and formal training)

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4)   Support

Can you tell me how Peer Worker are supported by the organisation?

e)   What **line management and supervision** arrangements are in place for Peer Workers? Is this/how is this different to the support other staff receive?
f)   Are/ how are **colleagues and other team members expected to support** Peer Workers?
g)   What support are managers/ other team members given around working with Peer Workers?

---

5)   Team working

a) Can you describe how **Peer Workers fit into the organisation**?

- What are the **benefits** of having Peer Workers in the team/ working alongside other staff? What are the **challenges**?
- What **influence** do Peer Workers have in the team they work in/ with those they work alongside?
- Can you describe what the Peer Workers **bring to the team**/ to other staff who they work alongside? (that isn't already there)

b) How would you describe the **relationships**between the Peer Workers and other team members? How are differences in **power, perspective or status** that arise dealt with?

c) What is the role of the Manager/Team Leader in relation to the Peer workers and the other team members?

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6)   Leadership and Management/ Strategic

a)How does the Peer Worker **role fit with the organisation's aims and objectives?**

b) Can you tell me about any **strategic documents** that have been developed or updated around the introduction of Peer Workers? In what way?

c) Can you tell me about any **policies and procedures** that have been developed or updated around the introduction of Peer Workers? (e.g. risk management, HR)

h)   Who led the introduction of the Peer Worker role in your organisation? How was this achieved?

e) How do Peer Worker roles fit with **other mental health provision locally**?

f) What would you say is the **biggest challenge** that you are facing now around Peer Worker roles? What do you think is **likely to be your biggest challenge**?

7)   Expectations

a) What does the **successful introduction** of Peer Worker roles in this organisation/ service mean to you?

- How would this impact at individual service user and Peer Worker level?
- How would this impact at the level of team and organisation?

b) How would this service make **the best use** of the Peer Worker role?

c) What do you think **the essence** of the Peer Worker role is in mental health services? What makes it unique?

8)   End

Is there **anything else** that you would like to add about the introduction of Peer Worker roles in mental health services?

COMMISSIONER'S INTERVIEW SCHEDULE

1) PARTICIPANT'S ROLE

a) What is your **role**?

b) What does your **job entail**?

2) DEFINITONS AND INTEREST

a) What does it mean to you if someone is **called a 'Peer Worker'**? What makes someone a Peer Worker?

b) Can you tell me why are you **interested in commissioning Service User Led organisations/ services with Peer Workers in**?

c) Can you tell me **where your interest in Peer Worker's comes from**? (Is it a response to NHS Trust strategy, Government Strategy or more bottom up?)

d) In Part 1 we had a few questions about **Peer Workers and Diversity**. What does this mean to you?

3)　LSLCS

a) What is your **involvement with the LSLCS**? How much contact do you have with them?

b) Why were LSLCS **successful** in being commissioned?

c) What makes it **unique** as a service?

d) How does what this service offer **differ to what other mental health services offer locally**?

4)　PEER WORKER ROLE

a) How would you describe **the relationship between the Peer Workers in this service and the Service Users**?

b) How is this **relationship different** to that between staff members and service users in other organisations you work with?

c) What do you think are the **benefits of the Peer Worker role**? What do you think are the **challenges** of the Peer Worker role?

5)　TRAINING

a) What do you **look for in terms of training** in organisations you commission?

b) What strikes you as important about the training for Peer Workers at the LSLCS?

c) How is this different to other organisations you work with?

6)　SUPPORT

a) What do you **look for in terms of support for workers** in the organisations you commission?

b) What strikes you as important about the support the Peer Workers in the LSLCS get?

c) How is this different to other organisations you work with?

7)　WORKING RELATIONSHIPS

a) What are the **advantages and disadvantages** of working with a service user led organisation/ an organisation run by Peers?

b) How is your working relationship with LSLCS **the same or different** to other organisations that you work with?

8)　STRATEGIC MANAGEMENT

a) How do the aims and objectives of the LSLCS fit with your **wider strategic aims**?

b) What struck you as important about LSLCS's **policies and procedures** when you are assessing their tender?

c) What would you say are the **biggest challenges** you are facing now around Peer Worker roles?

9) EXPECTATIONS

a) What is **the measure of the successful introduction of Peer Worker Roles** in organisations, or in LSLCS? How would you measure success in the Peer Support Worker's role?

b) What do you think is **the essence** of the Peer Worker Role in mental health services?

10) END

Is there **anything else** you would like to add about the introduction of Peer Worker roles in mental health services?

Can you tell me about any support you receive to undertake your role?

- What **supervision** and/or **mentoring** do you receive?
  (What is useful about supervision/mentoring? / What is challenging about supervision/mentoring? Can you describe an issue that you've taken to supervision/your mentor?)
- Do you have **Peer Support** from other Peer Worker's?
- What support is available if you become **unwell**?

5)	Team working

Can you tell me about the team you work in?

- How would you describe the **place** of Peer Worker's in the team you work in?
- What are the **benefits** of being a Peer Worker in a team?
- What are the **challenges** of being a Peer Worker in a team?
- Can you describe what Peer Worker's **uniquely** bring to the team?
- Can you describe what **influence** you have on any decisions made in the team?
- What is the **relationship** between Peer Worker's and other team members?

6)	Leadership and Management/Strategic Support

a) Can you tell me about **how you are managed**?

- In what ways do you feel **supported** in your role by your manager/team leader?
- In what ways do you feel **unsupported** in your role by your manager/team leader?
- What **other support** from your manager/team leader would help you in your role?

b) Can you tell me about **how the Peer Worker role fits in with the wider organisation**?

- In what ways do you feel **supported** in your role by your organisation? (For example, by the structures and policies of the place, by senior managers)
- In what ways do you feel **unsupported** in your role by your organisation?
- What **influence** do you have in the organisation/or in the work you do?
- What **other support** from your organisation would help you in your role?

7)	Expectations

a) What does the **successful** introduction of Peer Worker roles in your organisation mean to you? How would you measure success in your role? How do you know you are doing your job well?

b) What is the **essence** of the Peer Worker role in your organisation? What makes the Peer Worker role **unique**?

8)	End

Is there **anything else** that you would like to add about the introduction of Peer Worker roles in mental health services?

SERVICE USER'S INTERVIEW SCHEDULE

1) Human Resources Management

a) Can you tell me how you first **came to know** your Peer Worker?

- How were you introduced to your Peer Worker?
- Did you receive any information about the Peer Worker before they started to work with you?
- What helped you get to know your Peer Worker? What hindered you in getting to know your Peer worker?
- What could have been done differently in the early days of getting to know your Peer Worker?

b) What does it **mean to you** if someone is called a '**Peer** Worker' in your organisation?

c) In Part 1 we had a few questions about Peer Workers and **issues about Diversity**. What does this mean to you?

2) Role

a) How would you **describe the role** of a Peer Worker here?

- What does your Peer Worker do? (tasks)
- How is this different to what other workers do?
- How does your Peer Worker support you? What does the Peer Worker support you with?
- How is that different to the way other staff members/professionals do their work? How is that different to how other staff members/professionals support you?

b) How would you **describe the relationship** between you and the Peer Worker?

- What are the good things about your relationship? What are the difficult things about your relationship?
- How different is your relationship with them to that with other staff members/ professionals here? (Is it like that with other staff here?)

c) What so you think are the **benefits** of the Peer Worker role? What do you think are the **challenges** of the Peer Worker role?

- Would you be interested in becoming a Peer Worker in the future?

3)	Training

a) Can you tell me about **any training** you are aware of your Peer Worker having?

b) What do you think your Peer Worker **should know** to carry out their role?

4) Support

    a) Can you tell me about **any support** you are aware of your Peer Worker getting?

    b) What **other support** would it be good for your Peer Worker to have?

5) Team working

    a) What does your Peer Worker **bring to the team** they work in/ who look after you?

    b) How do the people involved in your care **seem to get along**?

    c) Have you got any examples of how your Peer Worker **influences the team** they work in?

6) Leadership and Management/ Strategic Support

    a) How do you think your Peer Worker is **supported by senior managers** and the structures and policies of the place?

    b) What **influence** does your Peer Worker have in the organisation/ on the ward/ in the project?

    c) What **influence** does your Peer Worker have on the structure of your care plan, early discharge or in your review?

7) Expectations

    a) What would be your **measure of success** for having a Peer Worker to work with? How do you know it is **working well** for you?

    b) What is the **essence** of the Peer Worker role in your organisation? What makes the Peer Worker role unique?

    c) Would you **recommend** a worker like this to other Service Users? For what reasons?

    d) What would you **miss the most** if your Peer Worker had not been here?

8) End

Is there **anything else** that you would like to add about the introduction of Peer Worker roles in mental health services?

STAFF TEAM MEMBER'S INTERVIEW SCHEDULE

1) Human Resource Management

Can you tell me **how the Peer Worker role was introduced** here?

- Where did the initiative to introduce Peer Workers come from?
- Were you part of the process of recruiting Peer Workers?
- Were you given any information about the Peer Workers before they started here? (about their role, their history)
- What helped/hindered you in getting to know the Peer Workers?

2) Role/ Relationship

a) How would you describe the role of a Peer Worker(s) here?

- What does a Peer Worker do? (tasks)
- How is that different to what other staff members/you do here?
- Can you describe any differences in the way in which Peer Workers and other staff members work?

b) How would you describe the relationship between Peer Workers and Service Users?

- How is this different to the relationship between service users and other staff members? (For example, are there different boundaries, issues of disclosure?)

3) Training

a) Can you tell me about **any training you are aware of the Peer Workers having?**
- How has this supported Peer Workers to carry out their roles?
- What other training would support Peer Workers in their roles?

b) Can you tell me about **any training or information you have had around the introduction of Peer Workers here?** (including team briefing, preparation, discussions)
- What training or information would have supported you in working with the Peer Workers?

4) Support

Can you tell me about **any support the Peer Worker receives** to undertake their role?

- Has any additional support been available to you since the Peer Worker roles have been introduced? Where does this support come from?
- Can you tell me about any support you give to the Peer Workers?

5)	Team working

a) Can you describe **how Peer Workers fit into the team** you work in/alongside other staff?

- What are the **benefits** of having Peer Workers in the team/ working alongside other staff? What are the **challenges**?
- What **influence** do Peer Workers have in the team they work in/ with those they work alongside?
- Can you describe what the Peer Workers **bring to the team**/ to other staff who they work alongside? (that isn't already there)

b) How would you describe the **relationship** between the Peer Workers and other team members?

c) What is the **role of the team leader** in relation to the Peer Workers and the other team members?

6)	Leadership and Management/ Strategic

a) How does the Peer Worker **role fit in with the organisation's aims and objectives**?

b) Can you tell me about any **policies and procedures** that have been developed or updated around the introduction of Peer Workers? (e.g. risk management) Has this led to **any changes in the ways that you work** since Peer Workers were introduced?

c) How does the Peer Worker **role fit with other provision for mental health locally**?

7)	Expectations

a) What does the **successful introduction** of Peer Worker roles in this organisation/service mean to you?

b) How could this **service make the best use of the Peer Worker role**?

c) What do you think **the essence** of the Peer Worker role is in mental health services? What makes it unique?

8)	End

Is there **anything else** that you would like to addabout the introduction of Peer Worker roles in mental health services**?**

LINE MANAGER/TEAM LEADER'S INTERVIEW SCHEDULE

1)　Human Resource Management

a) Can you tell me **how the Peer Worker role was introduced** into the organisation?

- Where did the initiative to introduce Peer Workers come from?
- How and by whom was the decision made to introduce Peer Workers?

b) What is the process of **recruiting Peer Workers** to the organisation?

- What have been the learning's and the challenges from the process?
- Were there any adaptions to the HR procedures to employ Peer Workers? What were they?
- What terms and conditions do Peer Workers work under? Are they different to those of other workers? How have they been adapted?

2)　Role/ Relationship

a) How would you describe the role of a Peer Worker(s) here?

- What does a peer worker do? (please give examples)
- How is that different to what other staff members do here?
- Can you describe any differences **in the way** in which Peer Workers and other staff members work?

b) How would you describe the relationship between Peer Workers and Service Users?

- How is this different to the relationship between service users and other staff members? (For example, are there different boundaries, issues of disclosure?)

3)　Training

a) Can you tell me about any training the Peer Workers have had to carry out their role?

- How has this supported Peer Workers in their role?
- How much of that training is purposely designed for Peer Workers and how much is generic training offered to all your staff? How did you develop your purposely designed Peer Worker training?

b) Can you tell me about **any training or information you, or your team, have received around the introduction of Peer Workers here?** (For example, briefings, preparation, discussions, courses and formal training)

4)　Support

Can you tell me about any support the Peer Worker receives to undertake their role?

a) What **line management and supervision** arrangements are in place for Peer Workers? Is this/how is this different to the support other staff receive?
b) Are/ how are **colleagues and other team members expected to support** Peer Workers?
c) What support are managers/ other team members given around working with Peer Workers?

5)	Team working

a) Can you describe how **Peer Workers fit into your team/alongside other staff**?

- What are the **benefits** of having Peer Workers in the team/ working alongside other staff? What are the **challenges**?
- What **influence** do Peer Workers have in the team they work in/ with those they work alongside?
- Can you describe what the Peer Workers **bring to the team**/ to other staff who they work alongside? (that isn't already there)

b) How would you describe the **relationships**between the Peer Workers and other team members? How do you deal with any **power, perspective or status** differences that arise?

c) What is**your role/ responsibility**in relation to the Peer workers and the other team members? How do you deal with 'dual role' issues?

6)	Leadership and Management/ Strategic

a) How does the Peer Worker **role fit with the organisation's aims and objectives?**

b) Can you tell me about any **policies and procedures** that have been developed or updated around the introduction of Peer Workers? (e.g. risk management) Has this led to any changes in the way you work?

d) How do Peer Worker roles fit with **other provision for mental health locally**?

d) What would you say is the **biggest challenge** that you are facing now around Peer Worker roles? What do you think is **likely to be your biggest challenge**?

7)	Expectations

a) What does the **successful introduction** of Peer Worker roles in this organisation/service mean to you?

b) How could this service make **the best use** of the Peer Worker role?

Appendix 7 Feedback workshop materials

Slide title	Exemplar data
Sameness and difference (1)	. . . one of the original peer workers . . . struggled to work here and it was because she had never been an inpatient . . . and some of the reasons were it was so culturally different to what she was used to, she had only had her service in primary care . . . those guys that had been inpatients, they weren't shocked, they weren't surprised by what they were coming across and in a sense she almost had some of the same fears and anxieties that a member of the public that doesn't understand a unit like this would have . . . the two that really flourished are the two that have been inpatients . . . so they knew what a ward environment was like. They knew that it can be slow paced. They knew that it can be sitting around. They were both quite happy to just hang out, wait for someone to speak to, recognise sometimes people didn't want to speak . . . the individual that didn't last just felt like a spare part and just wondered what to do with herself and I think that probably was difficult . . . so she started to almost like want to make beds and help with the domestics and stuff which wasn't really the peer support job. *PST* . . . they would have a greater understanding of the needs of those communities. They would have an understanding of, you know, cultural issues, spirituality issues, even people's backgrounds, family issues, things that are important to people . . . *VPW*
Sameness and difference (2)	'Is personal experience of mental health issues sufficient?' And my answer to that would be kind of 'no' . . . and actually is having African Caribbean background, is that sufficient? And my answer again would be 'no'. Actually it's about the everything that somebody brings . . . It's those challenges and adversity that happens to people . . . a loss of identity, loss of finances, stigma. It tends to be those things where people, there is that almost thing in common, though the situations, their culture can be different, you know, you don't have to match a peer to somebody the same because there seems to be a common thread, that pulls through, of understanding. *NSM* I don't think people individually do need to know who is and who isn't. I think it models something far stronger just the fact that some of us are and some of us aren't. Actually, it doesn't really matter and we are both equally capable. And that's kind of the ethos that we're hoping people will then subliminally when they're thinking about the expectations themselves. *VPW*
Language	I personally don't feel very comfortable with the term 'peer worker' . . . the reason being because, for me, it started off as peer support, which is something I think I've been engaged, involved in, been part of ever since I was diagnosed with a mental illness. And peer support, for me, is about people with similar experiences of mental health sharing, supporting each other in various ways . . . on a very informal level . . . It's not a contract. There's no written rules about how it should be done. There's no dos and don'ts . . . I was quite comfortable being a development worker, a project worker, because within that there was more to it than just the peer element of it. *VPW* We all discuss it because in English or in Chinese they different meaning, yes, sometime the same word? . . . So maybe they don't happy when they start, if they have problem they don't like to see this word. When we translation, yeah, how to translate the mental health? In mental health you translate strict in Chinese word like 'crazy' or something . . . The project is using the very simple words to make them understand what is mental health . . . after the training they say, 'Oh, this more easier to understand what is mental health, how to help people, yeah, how you help a friend'. *VPW*

Slide title	Exemplar data
The essence of the role (1): differential knowledge	*It's that bit about peers potentially having a sense of the different priorities that service users might have than staff. And actually in terms of service users' experience of being on a ward, some of those things are the things that really matter . . . I'm not sure that you necessarily grasp how much they matter unless, perhaps, you've experienced that same sense of disempowerment, really, by entering a service.* *NSM* *I think potentially peers are less afraid of engaging service users around risk and around those issues, perhaps than staff do. Yeah, there's a whole kind of mystique around risk . . . potentially peers can start to just unravel some of that mystique.* *NSM* *The difference is, I know what schizophrenia is. I don't understand it. They do. That's basically it in a nutshell. You know, I don't know what depression is. I know what the word is. I don't know what it feels like. They do.* *NST*
The essence of the role (2): different relationships (enabling openness)	*I was sitting with a client in one of my rooms and we were having a discussion and then her care co-ordinator walked in and she just completely shut down . . . I just kind of looked at her and I thought, 'What's wrong with her?' . . . and then when the care co-ordinator left she had become kind of another different person . . . She was very open with me, very comfortable. You could see it in her body language, everything . . . I've kind of seen that now with a lot of my clients . . . they tell me a lot more things that they don't tell their care co-ordinator. I mean, I'm sure some of them know that we all communicate anyway and we have to write our notes on the computer but it might just be that actually they feel more comfortable telling me certain things . . . they know that I've had these personal experiences. They know that I know what they're going through . . .* *NPW* *. . . the advantages we've got now is the fact that they're not nursing staff, seen as nursing staff . . . the individual can just be completely themselves because they're talking to someone that has been there, that has been through the services and I think they become like sort of really quite good friends and confidants . . . that's a more human, natural relationship . . . I think people will disclose . . . they give people an outlet. There's someone to speak to that they're not going to be suspicious of; that they're not going to feel judged.* *PST*
The essence of the role (3): role modelling	*. . . if I'd seen someone in this kind of level seven years ago, when I was in a really bad place, would have given me hope. It's sort of modelling normality and that it's possible and that people doing that are people who's had varying degrees of severity. And some of them, you know, people that ten years ago you would have gone, 'They are never going to get anywhere useful' . . . it gives a bit of hope and can be a little bit inspiring without having to really go, 'Look at me I'm an inspiration. Look at what you could be . . .'* *VPW* *You act as a role model for them in the future . . . so breaking down the stigma, it's a slow and cautious process . . . but by being open and when people see that when you're well you just act normally, they can see that when someone has a mental illness it's only when they're unwell that their behaviour might seem strange but the rest of the time they're just normal people and it can happen to anyone. So that's what I mean about breaking down stigma.* *VPW*
The essence of the role (4): engaging and bridging	*Some people, probably especially our generation, tend to have a real problem with authority of any kind . . . and find it easier with the peer relationship. So it very much depends on the individual but people have said to me that it's important to them that I've gone through something similar.* *NPW* *. . . it helps me because I can help them open their eyes. If there's a problem I'll say, 'Well, look, so-and-so said this, that you don't understand. Well I can understand where they're coming from because you haven't looked in a certain way upon the problem. You're looking at it from one way of thinking and you're not approaching it at the right angle' . . . I explain it in a way that they can understand . . . maybe because of the years of experience I can explain things better than a service user who's unwell on the ward . . . so I can put it in their language, because I've learnt a bit of their jargon.* *NPW*

Slide title	Exemplar data
	I want somebody to speak to somebody. If they don't feel like they can speak to a member of staff, sometimes they'll speak to [peer] workers . . . who will feed it back to us . . . So it is important that they are different just to get that little bit of extra information that can sort of help . . . it's just another way in for us to sort of give us more things to work with . . . it feeds down so that trust develops a little bit quicker for us . . . They've got a chance for working more closely with somebody . . . they trust it's going to happen because [the peer worker has] developed a closer relationship than I can do. *NST*
The essence of the role (5): being a team player – how much generic task?	*Some peer workers get treated like another staff member where they're like, 'can you go into the office and get me something from my box.' Or, 'can you open up this room for me?' And that's like a basic help, you know, practical help and that's fine . . . That's what the patient might ask the staff to do.* *PPW* *. . . in the beginning people were just telling me, 'Could you do this? Could you do that?' And I'd just be doing it . . . and I felt, 'This is not what I came here to do.' This is not what I wanted to do and what my purpose was to come here . . . things like, 'Oh, can you fill out this application form.' 'My client needs to go and buy some curtains, can you go with them?' Yes, okay, I'm willing to go with somebody to buy some curtains, helping them, but that's not my sole purpose of what I came here to do.* *NPW* *I still do things because I am part of the team and if we are short staffed and things like that, if we have four patients on observations and we've got one staff member off sick . . . ward round, medication, we go around with a bed board every hour to make sure everybody's safe, that's all manpower that you need. If they're short staffed . . . I'm happy to do it because it's all part of the team . . . but sometimes it can have an impact on my role . . . if there are patients that really wanted one to one with me and I've not been able to do it because I've spent three hours up at the hospital escorting just the one person . . . that is frustrating.* *NPW*
The essence of the role (6): professionalism in the role?	*. . . [professionalism means] adhering to your job description and carrying out our role and responsibility and duties according to that and in line with the organisation's mission statements and aims and objectives and not breaching protocol . . . I think that's very important. I wouldn't like someone to come and work here who didn't believe in the organisation and what they were doing . . .* *VPW* *You have to be good at recording, writing, because that's a crucial part of the job. It's all very well doing the work but you do have to do notes in the medical notes.* *NPW* *. . . when you start saying 'peer worker', for me, has a whole different meaning to 'peer supporter' . . . because a peer worker then almost becomes a professional person. It's almost as if you are now a professional peer. You've had training on how to be a peer . . . you even have to get a CRB check before you can work as a peer worker . . . for me, it's creating a barrier between myself and my peers because what does it make the peer I'm working with? . . . I don't see myself as a peer being a professional or being separate because peer is about being the same, being equal.* *VPW*
Cultural change (1): the challenge	*. . . it seemed like the team knew nothing about me as a [peer worker]. They knew nothing about what it is that I do . . . we had a manager then who didn't quite understand . . . also a support worker left at that point so they thought I replaced her . . . I was trying to tell them, 'No. I'm a peer support, which is completely different.' And I explained to them I had mental health issues myself and that I'll be explaining that to my clients . . . the manager at the time, when I actually spoke to him and said 'look, this is what a [peer worker] is' . . . he said, 'well I wouldn't tell the team that you have mental health issues.' So I said 'well, actually I can't really do my job unless they know, because that is the whole concept of my role.'* *NPW*

Slide title	Exemplar data
	. . . because the manager didn't get what my post was about, I was being used more as an OT assistant and HCA and I found that very frustrating, very demoralising . . . it is a lottery, definitely, as to who your manager is . . . if the manager is not open, supportive, is visionary enough, to actually see what we can do . . . that was one of the obstacles we got because it was, like, 'Oh, well, if you hadn't have been employed we could have had another HCA' . . . in other words, 'Well, you might be employed as that but actually we wanted one of those and that's what we're going to use you for.' *NPW*
	I'm not very good at kind of going, 'actually I can't really cope with this.' I find that quite difficult. So it's almost like I'm expected to cope as well as everybody else but also you want my experience . . . that's the risk. *VPW*
Cultural change (2): the opportunity	*Staff can only treat others with kindness and compassion and warmth if that's what they're receiving. So as the manager of this service, the staff are very important to me . . . it's my role to look after them so they can look after the [service users]. 'Look after' sounds a bit parental and paternalistic. I don't quite mean it like that, but the staff can only give the conditions they're receiving. So the therapeutic approach that the whole organisation uses is the person-centred approach . . . our belief is it won't be a person-centred service if we don't manage our staff in a person-centred way . . . I think one of the things that's probably quite defining about being a [peer]-led service is that because people are employed here because of their own experiences we're all very personally invested in working here.* *VSM*
	I can just imagine someone coming in and wanting to make things more robust and put in lots of procedures and, you know, bring in the risk management coach and it would just be such a disastrous waste of everyone's time and really boring and no-one would benefit from it really apart from the organisation feeling that little bit safer, which doesn't really do any good to anyone . . . what would be lost is [peer workers] feeling that they can be trusted to run this system . . . I'm not saying we can't improve it but usually the best way of improving things like that is listening to the [peer] workers, not to some guy or woman from outside who says, 'Oh, you need to have these structures in place and da-de-da-de-da.' *NSM*
Challenging boundaries	*One of the things . . . we're taught to do . . . when we first engage with a patient what we say is, 'Okay, I'm the peer support worker, I've lived experience, blah, blah, blah. However, if you at any time tell me anything that I have concerns about I do report it . . . and every time I have a meeting with you I do write up notes about it . . . so that you're not seeing me as somebody that you can tell a confidence to.' And we are all encouraged and I do it and it's very crucial . . . You have to do that.* *NPW*
	. . . staff don't reveal personal things about themselves. That's the difference . . . they shouldn't say about themselves because the poor old little service user can't take the burden of it. Well that's rubbish, actually. People want to know. We're all curious about each other, aren't we? . . . maybe a professional would steer it back and say, 'Let's talk about you rather than me.' Well I would answer the question. I'd get into a social conversation with them . . . I would protect myself in a certain way. I wouldn't give them very intimate details but, you know, I think that is one of the different ways of working. *PPW*
	One of the most important things people get from our service because it is actually only through being truly connected to another person that people will heal from distress . . . that is quite a taboo, risky thing to say. Because actually all mental health services should be about love and compassion and they're not, they're about treating people. I think even most voluntary sector organisations would not talk about love. They think it sounds dodgy or fluffy. *VSM*
Changing conversations	*. . . if they're talking about something, sometimes the conversations are dehumanised. They seem to forget that they're talking about a human being . . . but by me being part of the team . . . by me occasionally saying, 'Well, actually when I was really unwell and I tried to take my own life I felt like that . . .' it brings them out of it . . . I've had some very interesting conversations afterwards with staff, where they've actually said, 'Oh, you know, you've really made me think' . . . so I think it's a very powerful thing used in the right way.* *NPW*

Slide title	Exemplar data
	. . . actually what it means is people have just kind of had their conscience pricked almost and while ideally we'd like them never to need to have, because they're always impeccably behaved at all the time, there is something about, well, actually that is a function of having somebody with lived experience in the room and in the dialogue that actually people, perhaps, are a bit more thoughtful.
	NSM
	On a ward round I would go in with the patient and sit with them and the person leading the ward round would just carry, you know, start saying, 'Blah-blah, blah-blah, blab, blah, blah.' And when it first happened, I was like, 'Oh, okay.' But then after the third or fourth time I actually said, 'I'm ever so sorry, but would you mind introducing yourselves?' Because I knew. Of course I speak to the peers afterwards and I'd say to them, 'Did you know that . . .?' 'No.' 'Did you not know anybody at the . . .' 'No, I didn't know who that was.'
	NPW

CRB, Criminal Records Bureau; HCA, health-care assistant; NPW, peer worker (NHS case); NSM, strategic manager (NHS case); NST, (non-peer) staff member or coworker (NHS case); OT, occupational therapy; PPW, peer worker (partnership case); PST, (non-peer) staff member or coworker (partnership case); VPW, peer worker (voluntary sector case); VSM, strategic manager (voluntary sector case).

Appendix 8 Feedback workshop output

Examples of hierarchies of statements from feedback workshops

Group A	Group B
Support for the peer worker	Challenging boundaries
Supportive culture	Changing conversations
Changing conversations	Support for the peer workers
The language of peer support	Supportive culture
The essence of the peer worker role	
Challenging boundaries	

Examples of constellations of statements (including new statements nominated by workshop groups) from feedback workshops

Group C

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                    ┌─────────────────────────┐
                    │   The essence of the peer│
                    │        worker role      │
                    └─────────────────────────┘
              ┌─────────────────────────┐
              │   Changing conversations │
              └─────────────────────────┘
    ┌──────────────────────┐   ┌───────────────────────────┐
    │   Confidentiality     │   │ The language of peer support│
    └──────────────────────┘   └───────────────────────────┘
              ┌──────────────────────┐
              │   Finance (resources) │
              └──────────────────────┘
                                  ┌──────────────────────────┐
                                  │  Challenging boundaries  │
                                  └──────────────────────────┘
                 ┌──────────────────────────┐
                 │   Organisational structure │
                 └──────────────────────────┘
                    ┌──────────────────────┐
                    │   Supportive culture  │
                    └──────────────────────┘
                       ┌───────────────────────────┐
                       │  Support for the peer worker│
                       └───────────────────────────┘
                          ┌──────────────────────┐
                          │  Peer worker well-being│
                          └──────────────────────┘
                             ┌──────────────────────┐
                             │  'Peerness' and diversity│
                             └──────────────────────┘
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Group D

> **Supportive culture**

> **Organisational structure**

> **Support for the peer worker**

> Finance/funding/resources

> The essence of the peer worker role

Appendix 9 Final report: knowledge mobilisation project

Report authored by Philip Cohen.

Knowledge mobilisation project: supporting cross-sector organisational learning in the NHS

Structure

- Section 1: project rationale
- Section 2: literature review on knowledge mobilisation
- Section 3: the process of the knowledge mobilisation initiative
- Site visits
- Impacts
- Strengths and limitations

Section 1: rationale for the knowledge mobilisation initiative

While recruiting case study sites for the main study there was a good deal of interest from both mental health NHS trusts and voluntary sector organisations who were in the early stages of planning or developing peer worker initiatives and whose expressed interest in participation in the main study was largely motivated by a need to learn from the ongoing research in order to improve implementation locally. This offered an opportunity to mobilise knowledge from the main study to a relevant end user audience, to study how organisations learn from each others' innovative practice (including learning across statutory and voluntary sector boundaries) and to build capacity in the NHS to facilitate knowledge mobilisation. The aims of the project were to:

1. facilitate mobilisation of knowledge from the main study into organisations at an early stage in the innovation pathway, through improved linkage between change leaders and managers in those organisations and the research project
2. assess the impact of that knowledge mobilisation process
3. make use of the organisational learning loop to optimise knowledge mobilisation from the main study to the NHS and to mental health health service providers nationally by improving the quality and relevance of the research findings to NHS managers
4. build capacity for knowledge mobilisation in the NHS through enhancing the ability of managers to access, appraise and use research evidence.

More detail

Facilitating knowledge mobilisation
Initially it was intended to use action learning sets for change leaders from eight organisations, to enable participants to share their own learning experiences as well as inputting findings and learning from the main study. It did not prove practicable to co-ordinate the service development activities in participating organisations with the time frame of the study and so a series of knowledge mobilisation events were held (see *Section 3: process of the knowledge mobilisation initiative*) rather than a formal learning set series.

Assessing the impact of knowledge mobilisation

It was planned to use two approaches to assess the impact of mobilising knowledge into participating organisations: (i) learning cases to assess how knowledge from the action learning sets is mobilised into host organisations; and (ii) a survey to assess the extent to which learning from the main study is reflected in implementation of peer worker initiatives in host organisations.

Optimising knowledge mobilisation

The NHS co-applicant was to work with the research team to ensure that learning from this project – in particular the assessment of how findings from the main study were or were not transferred through the action learning sets into host organisations – would be used to optimise the quality, relevance and dissemination of main study findings. It was intended that the focus would be on ensuring that learning materials are presented and delivered in a way that is relevant and accessible to change leaders in mental health service organisations in both the NHS and voluntary sector. The NHS co-applicant was to ensure that the input of stakeholders in those organisations shaped research outputs, and was expected to contribute to the development of outputs that were relevant to research end users (including NHS managers), including the main end of project conference and online learning materials.

Building learning capacity

It was intended that the NHS co-applicant would acquire considerable expertise in both facilitating (through action learning sets) and assessing (through research) the process whereby research knowledge is transferred into organisations, including mental health NHS trusts. Organisational learning capacity – capacity to access, use and appraise research – was to be acquired by the organisations participating in this learning project, which they would then be able to model and share as they develop further innovative strategy and practice. Mental health NHS trusts are continuing to develop and implement a diversity of models of employing peer workers in the delivery of mental health services, either directly or through partnership with voluntary sector organisations, and in the absence of an organisational evidence base supporting that complex workforce and delivery change process. Although the rationale for the main study was to provide that evidence, it remained important to understand how that research-based knowledge could be best mobilised in an environment where innovation is proliferating but where there is little systematic transfer of learning from successful change-leading organisations to later-adopting organisations.

Section 2: literature review on knowledge mobilisation

Knowledge mobilisation as a concept was introduced in Canada in 2001–2 by the Social Sciences and Humanities Research Council of Canada. The definition of mobilisation was taken in large part from the French conceptualisation – *mobilisation* – making ready for service or action.

It is a broad term that includes the products, processes and relationships among knowledge creators, users and mediators. Knowledge mobilisation has been defined as the direct application of research knowledge in order to benefit as many people as possible.[100] Knowledge mobilisation is not only a matter of producing more knowledge but also of improving both the desire and capacity for its use as well as the mediating processes.[101]

Ward *et al.*[102] describe the transfer of knowledge into action as a messy process involving a complex series of interactions between the producers and users of research. From a review of 28 published models which explained all or part of the knowledge transfer process (another term for the sharing of research facts and findings) they identified the individual elements which appeared to be crucial in transferring knowledge into action.

These were:

- identifying and communicating about the problem which the knowledge needs to address
- analysing the context surrounding the producers and users of knowledge
- developing and selecting the knowledge to be transferred
- selecting specific knowledge transfer activities
- considering how the knowledge will be used in practice.

Based on their research they have proposed a framework which helps producers and users of research to think about the key issues and questions related to knowledge transfer, focusing on the process rather than a set of activities. They have produced two versions of the framework, one for research users and the other for research producers, which they say can be used as a template to assess the success of a knowledge transfer initiative.
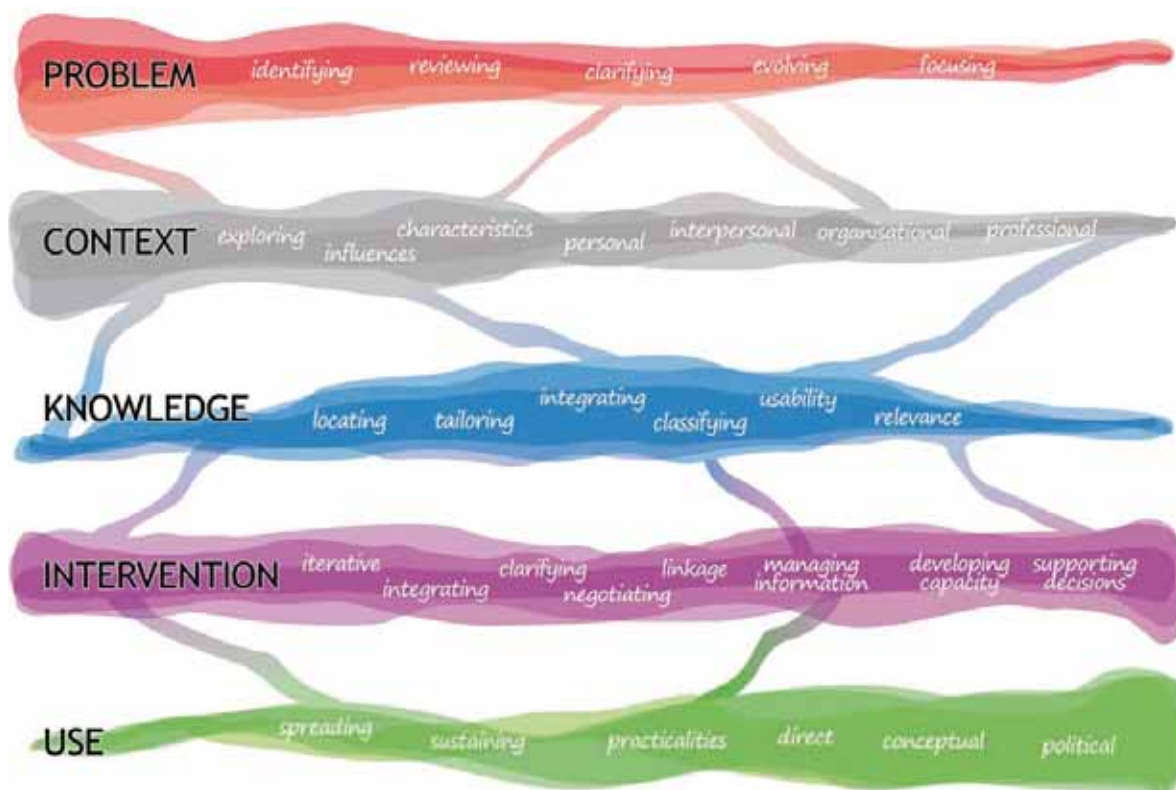
Revised model of knowledge transfer
The caveat to this model is that it was based on a piece of work using a knowledge broker. This model is quite detailed; however, the five main elements provide a useful structure, based on a comprehensive review of the literature, within which to consider the knowledge mobilisation initiative (KMI) and why it did not develop as was originally anticipated.

Problem
This involves asking questions such as: to what extent is the problem being addressed by researcher users (in this case managers and workers within the organisations); and to what extent does that mesh with the needs and concerns of case managers and workers within the organisations?

Context

This suggests that researchers have a good understanding from the users of the research of the kind of issues that would be relevant.

These might include the users' present/prior work and what they have done to address the problem under consideration; discussion of the attitudes, prior experiences and motivation of individuals involved in the project; and information about the situation within which the team is working, including discussions of resources, external or internal pressures, administrative details and team dynamics.

Knowledge

What is considered here is selecting the knowledge from the research in ways that are most useful and relevant to the needs of the users.

Intervention

This would focus on suggestions for activities to facilitate access to, and use of, information (including carrying out reviews, research users providing/discussing feedback or reflections on the activities, and activities which point to links between KB and the team, including attendance at meetings and communication about the progress of projects).

Use

This involves identifying how the knowledge relating to the problem is likely to be used. Users of the research may make decisions about whether or not to use specific pieces of knowledge. Users explicitly relate the identification of knowledge to changing their practice, thoughts or circumstances.

Section 3: process of the knowledge mobilisation initiative

A manager from the local mental health trust was seconded to lead on the knowledge mobilisation project 2.5 days per week. His background was that of social work and he additionally had experience of working with people in peer worker roles through a parallel secondment to a recovery college within the mental health trust.

The KMI began in November 2010. At that point the objective was to become acquainted with the project and make contact with those organisations that had expressed interest in being part of action learning sets. This proved more challenging than anticipated. In some cases the contact people had moved on or changed their responsibilities and it was not always clear who had taken over, or else the organisation felt that it no longer had the capacity to be involved in the project.

One trust that had initially been interested wrote back to say:

> Sorry due to current service demands I have been advised by the managers that we simply cannot be involved in the project.

In an effort to recruit other sites that might have been interested, contact was made with sites with whom others working on the peer worker project had contact, and a flyer was issued via the NHS Confederation inviting organisations to take part in the action learning sets.

As a result of this, interest was expressed by a peer worker in post within a trust who was clearly interested in the further development of such roles. However, this agreement to be involved was subsequently withdrawn by a manager from the same organisation writing to say that:

> Unfortunately, [the trust] is not able to be involved at this point. Due to the level of commitments currently we are unable to engage with the project as fully as we first hoped . . .

This suggested that as with a number of organisations there was a willingness to participate in the KMI.

In order to appreciate the extent of the impact of knowledge mobilisation, fact-finding interviews, using the fact-finding interview questionnaire from the main peer worker study, were undertaken with the sites that initially agreed to participate in the KMI. These were:

Berkshire Healthcare Foundation Trust The contact here was the team lead for Transitional Care and Social Inclusion in Compass Opportunities, a project which is part of Reading Mental Health team and funded by Reading and Berkshire Healthcare Foundation Trust. The service users receiving a service from the team are people who are moving on from CMHT services. In this service the term 'volunteer' or 'service user volunteer' is used. When the project was set up it initially comprised a service user and a psychology graduate. The term 'peer worker' was not used.

The kinds of activities undertaken by service users are very variable and depend very much on the skills of the volunteer group at the time. They include a badminton group, a long-term group providing support to service users with poor social networks who are very isolated, a group for living skills and work done with service users on WRAP plans. There is a healthy walking group, a mother and baby support group and an allotment group. The service also provides a computer room which service users maintain while volunteers run groups on the wards.

In terms of training, everybody completes training on safeguarding adults and children and some people have done National Vocational Qualification (NVQ) 2 training using government funding. Some have undertaken specific training related to the groups they are running, for example food hygiene.

There are some paid staff in the team. The volunteers work with service users. There is no self-referral and generally there is no one-to-one work, as in the past this has created a capacity issue.

Tyne and Wear Valley Foundation Trust The contact here was the Clinical Director for Research and Development in the Trust who said that there was willingness to expand the development of peer roles generated by the Chief Executive, who had come from Nottingham, where much work had been done. At the time of speaking there was a planned masterclass with senior leaders in the Trust, being led by Julie Repper, Recovery Consultant from Nottingham. The responsibility for peer worker roles was about to be allocated to the Allied Professionals Lead. At the time of my interview the first peer worker had been established in the early intervention service; the role holder had only just started in post and was working alongside the care co-ordinators within the team.

Hoot Creative Arts Ltd This was originally a charity and is now set up as a charitable company. The contact was the Operations Manager. This organisation had not used the term 'peer worker' and the role of members is much vaguer than that term suggests. The aim of the organisation was said to be to encourage a sense of ownership of the project, giving members a sense of having an active role; for example, members might get chairs out or welcome others to the project. In contrast, volunteers have a more structured role. There are several artists on the staff. The organisation uses arts, dance and singing as a way of enhancing well-being.

Kent and Medway Partnership Mental Health Trust The contact was the project manager for the recovery service line. This trust was very interested in further developing peer support roles in the Trust, with a Trust-wide conference being planned.

Two further sites then joined the initiative: Glyndwr/Betsi Cadwaladr University Health Board (the Welsh equivalent of a mental health NHS trust), who participated with a voluntary sector partner, Hafal Mental Health Charity; and Northumberland Tyne and Wear NHS Foundation Trust.

Hoot was subsequently unable to attend any of the initiatives and so the project focused on the six mental health NHS trusts listed above.

All the sites agreed to participate in action learning set meetings. However, in practice the reality was somewhat different. The intention had been to have a number of the sets in London with the rest being undertaken via Skype™. Unfortunately, this strategy became impossible because of time constraints placed on the participants (which did not allow enough of them time to come to London), plus the real difficulties for the NHS participants of getting agreement from their information technology (IT) departments to use Skype, as well as the lack of any other common system used by all to do this.

As a result of these difficulties, a revised knowledge mobilisation package was created, comprising:

- a 1-day seminar in London in the autumn of 2012, where all participating sites were able to meet and share experiences of developing peer support roles
- attendance at a workshop which was run on two occasions, taking place first at St George's, University of London and subsequently at Huddersfield University in February 2013, where feedback from the research was shared and discussed with organisations participating in the research project
- a site visit – this was only taken up by Glyndwr/Betsi Cadwaladr University Health Board and was undertaken by video conference (see below)
- priority booking with reduced prices for peer workers at the conference at the end of the peer worker research project.

The knowledge mobilisation seminar

This was called *Peer Worker Knowledge Mobilisation Project – Learning from the Research*, and took place at St George's, University of London on 10 December 2012. The aim was both to impart knowledge and stimulate thinking, and to engage participants through good hospitality. To this end, a hot lunch was provided and we offered to pay travel expenses.

Ten people attended and included the following roles.

Role	Organisation
Senior Nurse Manager	West London Mental Health Trust
Local Services Recovery and Involvement Lead/Professional Lead Occupational Therapy	West London Mental Health NHS Trust
Specialist Practitioner	Kent and Medway NHS and Social Care Partnership Trust
Project manager – Recovery	Kent and Medway NHS and Social Care Partnership Trust
Patient and Public Involvement Officer	Tyne, Esk and Wear Valleys Foundation Trust
Advanced Specialist in Vocational Rehabilitation	Tyne, Esk and Wear Valleys Foundation Trust
Senior Lecturer in Mental Health Nursing	Glyndwr/Betsi Cadwaladr University Health Board
Regional Manager	Hafal Mental Health Charity
Transitional Care and Social Inclusion Manager	Reading Borough Council – Berkshire Healthcare NHS Foundation Trust
Head of Patient and Carer Engagement	Northumberland Tyne and Wear NHS Foundation Trust

Content of the day
The agenda for the day was planned to begin by introducing participants to the aims of the KMI and the background to the main peer worker research project. Participants were introduced to the peer worker implementation inventory and asked to complete it for their own organisation and reflect on the

responses. Participants found this an interesting exercise which allowed them to realise how far they had come, or how far they needed to travel, in implementing peer support roles. The day was designed to introduce participants to learning and decision-making tools to enable them to think about elements in relation to introducing peer roles, with the intention that they would take these back into their organisations and bring together a group of stakeholders. These tools had been developed initially by the research team and steering group meetings. These included a peer worker roles mapping tool, an implementation inventory and a role star, developed first in research team and steering group meetings. The mapping tool had previously been tested in two groups at the Royal College of Psychiatry Rehabilitation Psychiatry Faculty conference in November 2012. It is important to note that participants made it clear that they were very keen to learn via the main study about what went well and what challenges had to be overcome in implementing peer support roles. The data in the main study were not sufficiently analysed at the time of the KMI seminar to be able to provide this in optimal usable form. As knowledge mobilisation from the main study will be an ongoing process, these will continue to be tested and refined. Additionally, it was clear from some participants that although they themselves were committed to introducing peer worker roles, they were also looking for evidence to convince others of the need to pursue this route with vigour in their organisations.

Participants were asked to take back to their organisations both the peer worker implementation inventory and the peer worker roles mapping tool, and introduce them to a range of stakeholders for further discussion. It was planned that the KMI project lead would then arrange site visits for January 2013. However, participants felt this to be too early and wanted deferment until March. In reality even that did not prove to be long enough.

Feedback from the knowledge mobilisation initiative event
In order to gauge satisfaction with the day, participants were asked to fill out an evaluation form which asked about what they got from the day and what changes they would like to have seen made to the day. Responses to the question, 'What are three most useful things that you got from today?' are shown in the box below.

Opportunity to network and learn from each other

Meeting people from other areas and hearing what is happening there

Hearing and discussing with other services around the country

Finding out more about peer support workers

In depth discussion regarding introduction of PSW

Gaining deeper understanding of the complexity and different components of peer support

Opportunity to think about the future/reflect on progress made

Time out to reflect/consider current trust position

Going through the questionnaire realising how far or not we are down the road

Having a range of services at different stages

Understanding the research

Information on research was useful will work that up

Peer working being valued

I think I am the only voluntary sector attendee. It is good to hear that health trusts are keen on developing peer support workers

Seeing that Peer involvement is on the agenda

The question, 'How could this event have been improved?' provided some indication of what participants would have wanted and would want for a future event.

More detail of successful peer support worker models, what they look like, how successful they've been

Hearing more about the research detail

More information regarding the models of peer worker role deployment and development

More information about sites in the study . . . what was going well . . . what doesn't work . . . service structures

Probably one or two real stories to demonstrate an impact of Peer Worker Role on individual recovery

In order to find out how satisfied participants were with the event itself participants were asked, 'Was an appropriate amount of material covered during the day? If not was it too much or too little?' Generally participants were positive, with a few qualifications.

Appropriate – again would have valued hearing about the research and spending time on the various models

More detail of successful peer support worker models, what they look like, how successful they've been

Yes but could have done with slides on the day

Quite a short period on future but on the whole would not have been able to put any more in. It was facilitation which was good rather than 'front load'

The comments also alluded to something that came up several times in the day: a feeling that some participants were at the day to gather ideas and information to persuade more senior people in their organisation about the need for PSWs.

Regarding, 'Was the day pitched at the right level for you?' most participants felt that the day was at the right level, with some qualifications.

Yes fine – I found the mapping hard – may have been better to have used a little more time on services in the project and using these as examples on mapping sheets

Felt a bit frustrated at times as I have lived this concept for a long time

In response to 'Was the material relevant to your work in introducing peer roles in your organisation?' there was generally a positive response.

> *Very relevant – helpful to think and clarify thinking*
>
> *Yes – more actual examples would have helped*
>
> *The material was all relevant*

Participants were also asked, 'If another event like this was to be organised is there anything that you would like to be different?'

> *More discussion/time on the deployment and organisational forms*
>
> *Possibly – perhaps inviting some of the implementers*
>
> *No other than perhaps a bit pre read but not too much info*
>
> *I expected to go away with a jd [job description] but now think that was unrealistic*
>
> *Case studies and some structures to aid implementation*

The following were given in response to the question, 'What suggestions do you have for the Knowledge Mobilisation Initiative to further support your work in introducing peer support roles?'

> *More information on current services. What they look like. Positives/negatives*
>
> *Blog on the website*
>
> *Case studies on websites*
>
> *More information and contacts of different organisations*
>
> *Improve website materials*
>
> *Develop forum online/website to continue sharing ideas and support*
>
> *Use social media to spread the word*
>
> *To provide evidence that this is an initiative worth pursuing*
>
> *Support with training/preparing teams to be effective and supportive when employing PSWs*

Following the day seminar all participants received an e-mail thanking them for their participation, along with a set of slides from the day. Additionally, we talked about the next two stages of the knowledge mobilisation process: firstly reminding them of the takeaway task and, secondly, asking them to find a date for a site visit. Unfortunately, for a range of reasons including sickness at the sites and difficulties that contacts had in arranging a suitable date to involve strategic decision-makers, these visits did not happen.

Feedback workshops

Additional feedback on the tools and the impact of the project was gained from feedback workshops. These are described in *Chapter 2*, *Developing organisational learning*. Several KMI sites were represented at these feedback workshops. At the end of the workshops participants were asked for feedback.

In response to the question, 'What are three most useful things that you got from today?' some different themes emerged.

Detail about the peer support project

Feedback from interviews

Presentation re project

Qualitative information

Academic aspects of research project

Preliminary feedback on research

Comparison with other organisations

Understanding of where other organisations are

A sense that our organisation is ground breaking re peer support

Learning from other organisations/people

Understanding how differently organisations 'do' peer work

Discussing the potential future of peer support in UK and generating ideas for further development

Meeting other peer support workers . . . Meeting people from other Trusts/organisation

The range of ideas around what was at the start a smaller strand but opened out lots of possibilities and opportunities

Understanding of Peer Support priorities

The challenges that must be faced before putting into place the peer worker eg organisational structures, supportive culture, the language of peer support

Networking

Meeting others

Networking with users and professionals

Format of the session

Group task and seeing 'funding' come up in each group

Miscellaneous

Validation of my role as PSW

Info to do the PSW role more effectively

Discussion about definitions

The responses to the questions, 'How could this event have been improved?' and 'If another event like this was to be organised is there anything that you would like to be different?' were generally positive with some suggestions for improvement.

General

More than superb event

More time. It was all great

Nicely done – was interactive

Excellent

Earlier start and finish to allow travel to and from event

Workshop organisation

I found one organiser quite pushy in the group task – less unnecessary anxiety please

Handouts

Maybe a presentation from an organisation where Peer Working working well

More time to network with more experienced peer organisations

Copies of slides if possible – very interested in the final report

More patient experiences – Perhaps to give us a talk

If Powerpoint presentation should be readable and handouts

Yes – top tips please what works best

More group time

Possible examples of obstacles and barriers that people have experienced

Travel arrangements/administration

Earlier start and finish times!!! To miss the main commuter congestion as travelled from Cambridge

Earlier confirmation/map/directions only arrived on Friday

The question, 'Was an appropriate amount of material covered during the session? If not was it too much or too little?' again elicited general satisfaction, with a few exceptions.

Perfect – couldn't take any more on

You covered a lot in an appropriate way

Really good amount just right

Yes but I would have liked a hand out of the power point presentation so that I could read and digest in my own time

Yes . . . However a little longer for group work/discussions

I think more material could have been covered, maybe in a more general manner – themes that have been found and examples of these themes

The session prioritising statements was very good – needed more time

A little too much

Regarding the level of the workshop, participants were asked, 'Was the day pitched at the right level for you?' There was a unanimous vote of confidence.

Really good amount just right

It was indeed!

Absolutely, plenty of time for delegates to speak

Nearly – just setting out

Excellent

Further, participants generally felt that the material was relevant to their work in developing peer roles in their organisations.

> *It was reassuring*
>
> *Yes, gave a wider perspective*
>
> *Not much NHS focus, but still relevant for my work*
>
> *Very much so*
>
> *Yes very relevant to developing peer worker roles in developing services*
>
> *Yes – it was interesting to hear the views of others and the data itself*
>
> *Yes – have taken away new ideas*
>
> *Yes – particularly regarding opinions of job descriptions*

The following were responses to a question asking, 'How will you use what you have learnt today in your work on peer support?'

> *Setting up roles/referral processes for peer support roles*
>
> *Planning on pinching quote from presentation*
>
> *Being more aware of different avenues etc*
>
> *Share with rest of team, discuss further with colleagues put learning into practice*
>
> *Yes thinking more widely round the subject*
>
> *Straight back to my team to share everything*
>
> *Will pass on to others in my trust and keep fingers crossed that final report has a positive impact on our role*
>
> *Take it back to various forensic groups*
>
> *Through developing organisation, framework to support setting up and developing posts in range of services*
>
> *More understanding. Aim to be more supportive*
>
> *Take back to peer forum*
>
> *Think about some of the issues in relation to my peer support service and how to support peers*
>
> *Yes – need to press on quickly with staff training to challenge all time*

North Wales Recovery Network presentation

Dr Steve Gillard gave a presentation at a recovery meeting of the North Wales health board, demonstrated the mapping tool and role star and gave examples of learning output from the research that would be linked to completing these. The tools are to be sent to that team for them to complete, and we will generate a learning report for them based on their responses to include feedback from North Wales. Once we get the feedback from North Wales on the usefulness of the report, the plan is to develop an interactive online version of the three tools linked to learning output, plus the team will continue to work with main study and KMI sites around developing a new project evaluating peer workers supporting discharge from inpatient psychiatric wards.

Attendees

Role	Organisation
Regional Manager+one other	Hafal (Welsh equivalent of Rethink)
Senior Lecturer in Nursing	Glyndwr University, Wrexham
Chair	North Wales and North Powys Recovery Network
Representative	Flintshire Mind
CPN	Powys (BCUHB)
Primary Care Services Manager	BCUHB
Manager	Assertive Outreach Services Manager, BCUHB
Service Manager	Flintshire Social Services
Manager Recovery Services	BCUHB

BCUHB, Betsi Cadwaladr University Health Board.

All attendees were asked via e-mail for feedback on the presentation. They reported that they liked the open-minded approach to peer support, and the thing that they remembered and valued most about the presentation was what was said about peer support working needs; i.e. flexibility, training and education, and being valued; the usefulness of making peer worker training localised, and the reduced importance of this being accredited; the need for absolute clarity of the peer worker role for it to be able to work; and the need for education within teams as an important step prior to the peer workers being introduced.

Another person sent the following e-mail:

> I enjoyed you presentation to the Recovery Network yesterday and think we could learn a lot from your research.
>
> Clinical Programme Manager, Primary Care & Psychological Therapies.
>
> BetsiCadwalder University Health Board.

Strengths and limitations of the knowledge mobilisation project

It is useful to think about the strengths and limitations of the aforementioned framework by Ward *et al*.[102]

Problem

Clearly, the KMI sites did feel that the research had relevance for them, and even now there are e-mails being received wanting to hear more, even though they were unable to find time for the site visits.

There needs to be further consideration of the extent to which there was commonality between the issues investigated by the research team and those faced by the KMI sites. Given that the uptake from the KMI sites was more limited than had been hoped for, it may be that the KMI lead should have spent more time getting a fuller appreciation of the problems and issues that faced the KMI sites and what they felt they needed.

Context

One of the main limitations of the KMI was timing. The project was required to deliver its final report at the same time as the main project. Many of the sites that we initially recruited seemed to be operating on a very different timescale from the research project and wanted findings that only now can be made available. It is clear that many of the sites would want to be further involved but there is a greater need to understand the pressures each is under to tailor what is offered. It may be that to have offered the KMI out to a number of national sites should have been a longer-term aspiration and that much could be learnt by working with one or two local sites.

Additionally, there is the question of whether or not we had the right people involved – people with decision-making ability. This links to whether the organisations taking part had taken a strategic decision at the top to introduce peer support roles into the organisation, or whether this commitment was only located among particular lower-level managers and practitioners. Our experience suggests that the lack of whole-hearted commitment and competing demands in organisations may have had significance.

Knowledge

Sites are clearly seeking help with implementing peer support roles and valued what was offered. However, it is likely that the knowledge delivered to different organisations may need to be selected and tailored to fit with what organisations are saying they want, and this is likely to be different for different organisations. A future KMI may need to tailor knowledge according to the organisations' needs.

Intervention

The action learning approach, although valuable in principle, proved logistically difficult. It was possible for sites to benefit from the KMI seminar, and now that the peer worker project has concluded there is still a need to take this to sites. However, any future interventions need to be aware of the competing time pressures that sites may be under and have the ability to mirror the sites' time frames.

Use

There would be value, as mentioned earlier, in the research project being more aware of the very specific purposes for which sites are wanting to use the research findings.

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