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

Steve Gillard,[1]* Christine Edwards,[2] Sarah Gibson,[1] Jess Holley[3] and Katherine Owen[1]

[1]Division of Population Health Sciences and Education, St George's, University of London, London, UK
[2]Kingston Business School, Kingston University, Kingston upon Thames, UK
[3]Joint Faculty of Health, Social Care and Education, St George's, University of London, London, UK, and Kingston University, Kingston upon Thames, UK

*Corresponding author

Declared competing interests of authors: none

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

Published July 2014
DOI: 10.3310/hsdr02190

Scientific summary

New ways of working in mental health services
Health Services and Delivery Research 2014; Vol. 2: No. 19
DOI: 10.3310/hsdr02190

NIHR Journals Library www.journalslibrary.nihr.ac.uk

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

Funding for this study was provided by the Health Services and Delivery Research programme of the National Institute for Health Research.

Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: nihredit@southampton.ac.uk

The full HS&DR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr. Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: www.journalslibrary.nihr.ac.uk

Criteria for inclusion in the *Health Services and Delivery Research* journal
Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: www.netscc.ac.uk/hsdr/

This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its proceeding programmes as project number 10/1008/15. The contractual start date was in September 2010. The final report began editorial review in June 2013 and was accepted for publication in November 2013. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

Published by the NIHR Journals Library (www.journalslibrary.nihr.ac.uk), produced by Prepress Projects Ltd, Perth, Scotland www.prepress-projects.co.uk).