

New Ways of Working in mental health services: assessing and informing the emergence of Peer Worker roles in mental health service delivery

Aims

Research undertaken by this team exploring support for self care in mental health described service users, current and former, employed to provide support to their peers by both Mental Health NHS Trusts and third sector organisations (Gillard et al 2010). A growing empirical literature on use of peer support as a component of mental health service delivery has also indicated that 'peer workers' are increasingly playing an important role in service delivery, alongside mental health professionals and other mental health workers. In response to a range of health and social care policy drivers, a number of Peer Worker models are emerging, ranging from Peer Support Workers who have a formal case management role as part of multi-disciplinary teams within NHS Mental Health Trusts, to less formal support roles within third sector and user-led mental health services. However an established role change literature indicates that the emergence of new roles is by no means assured (see Conceptual Framework below), and that a range of factors impact on successful widespread adoption of new roles. As both statutory and third sector providers turn to Peer Workers to make up an increasing proportion of their workforce it becomes vital to understand what expectations are of the role of Peer Workers in mental health service delivery, to identify the extent to which a distinctive body of practice is being developed in fulfilling that role, and to investigate how Peer Worker roles are being supported and implemented by service provider organisations. This project will seek to test and provide transferable learning that supports the emergence of Peer Worker roles that offer service users and mental health service providers the benefits of a meaningful new body of peer practice. The specific aims of this project are:

To test the existing, provisional evidence base indicating facilitators and barriers to the successful introduction of Peer Worker roles in a range of UK mental health service settings in the statutory and voluntary sectors;

To provide mental health service organisations and managers with guidance on recruiting, training and supporting Peer Workers in the delivery of mental health services.

Background

The introduction of Peer Workers, alongside or as members of teams providing mental health services offers health service organisations – including Mental Health NHS Trusts – the opportunity to meet current productivity and quality challenges required by the QIPP agenda (DH 2009a). Replacing earlier strategies to meet these challenges through a reorganisation of services away from secondary care and into primary care polysystems (Darzi 2008), the publication of a new health white paper – Equity & Excellence: Liberating the NHS (DH 2010a) – envisages GP Consortia commissioning as the mechanism for bringing down costs, responsible for pursuing QIPP 'with a greater urgency'. Patients are indicated as the driving force for improvement through increased access to quality data and choice, with payment for NHS services linked to a standardised set of effectiveness, patient experience and safety outcomes (DH 2010b), rather than service activity. The McKinsey Report (DH 2009b), published by the new Health Secretary, indicated where major cost efficiencies can be made through increased service provider productivity and workforce reorganisation; adjusting the skill mix of frontline staff. Involving people more closely in directing their own care has been shown to contribute to significantly lower demands on health services over the longer term (Wanless 2002). While it remains to be seen how 'Liberating the NHS' impacts on mental health policy, New Horizons (DH 2009c) had offered a vision for personalised, service user directed mental health care. Peer support has been identified as a key facilitator across a range of health and social care strategic agendas, including mental health recovery (SCIE 2008), self care (DH 2006) and personalisation (DH 2008). The teams' own research has shown that peer mentoring interventions were highly valued components of individual service users' recovery strategies, with credibility attached to learning about coping and management strategies that have worked for others with similar problems (Turton, Wright, Gillard et al 2009). There is a strong rationale for employing Peer Workers as an innovative response to the quality and productivity challenges of the new White Paper.

Other DH policy advocates peer recruitment as part of the New Ways of Working (NWW) agenda (DH 2007), noting that failure to involve service users will defeat the object of the Creating Capable Teams Approach (CCTA), with Peer Workers seen as helping Mental Health Service teams to reflect on their current and future capabilities and skill mix. The important role of peers in 'Wellness Recovery Action Planning' (Copeland 1997) and in-house training has been recognised for some years (NIMH, 2004).

Skills for Health (2009) identified new roles and new sets of competencies that would be required in order to implement the Personalisation agenda. Competencies that service users would need to employ these new workers were also noted, although the potential for service users to work in roles supporting Personalisation is not fully explored.

A range of different Peer Worker models has been identified (Sells et al 2006), with studies providing some empirical support for the feasibility of Peer Worker based interventions and for beneficial outcomes, including: longer periods of living in the community without rehospitalisation and lower rehospitalisation rates (Min, 2007); increased general well-being and decreased neurotic distress (Galanter, 1988); increased self-confidence and social skills, improved maintenance of employment, and decreased drugs and alcohol use (New York State Office MH, 1993); higher scores on measures of recovery orientation, confidence, and empowerment (Resnick, 2008). Lawn et al (2008) conclude that peer support has benefit to service users and peers, offers substantial savings to systems, and has the potential for encouraging mental health service culture and practice towards a greater recovery focus.

However, while the policy case for further development of the Peer Worker role is well made, and there is some evidence to suggest the potential benefits of peer support in mental health service provision, use of Peer Workers in delivering mental health services constitutes a novel and complex intervention for which feasibility and piloting work in both development and evaluation is lacking (MRC, 2000). In completed SDO funded research undertaken by the research team (Gillard, Edwards et al 2010) exploring support for self care provided by mental health services, peer support was 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.

Contribution to the collective research effort and research utilisation

There is some evidence indicating how peer support facilitates the implementation of mental health recovery, self care and personalisation strategies, and some evidence indicating that use of peer support offers service providers and commissioners cost efficiencies. However the current evidence base supporting the effectiveness of using peer workers to provide mental health services is limited. Despite the limitations of this evidence base mental health services nationally are in the early stages of introducing a range of peer worker models, either directly provided by Mental Health NHS Trusts themselves, or delivered in partnership with social care and third sector providers, in response to a strong policy rationale to do so. The Peer Worker is emerging, by default and in various guises, as a new role within, or in addition to existing mental health teams. An empirical and theoretical literature exists that indicates that the meaningful emergence of new roles is by no means assured. However there is a lack of empirical research describing the emergence of Peer Workers as a new role, or identifying factors that might facilitate or hinder the successful introduction of Peer Worker roles either as part of, or in addition to existing mental health teams, within statutory or third sector health and social care organisations. And because the expectations of various stakeholders of the Peer Worker role are not clear, neither do we know what the impacts of Peer Workers would be that constitute successful introduction of the role.

Using the UKCRN study portfolio and the Social Care Institute for Excellence database of ongoing (as yet unpublished) UK based research we identified some studies in the broad area of peer support. The Support at Home – Interventions to Enhance Life in Dementia study (Orell, University College London) is a programme of research that will tailor, pilot and test through randomised controlled trial a peer support programme for family carers of people with dementia. Mums4mums (Barlow, University of Warwick) will adapt and pilot a Canadian telephone peer support intervention for women experiencing postnatal depression. RAPSID (Simmons, Addenbrookes Hospital) comprises developmental research and a trial of one to one, group and combined peer support for people with Type 2 Diabetes. The Peer Support Project (Forbes, Cheshire Centre for Independent Living) is a mixed method observational study that aims to map and understand how peer support networks and activities can be used by people with disabilities in receipt of Direct Payments. A new review of Peer Support in mental health published by Together for Mental Wellbeing since the submission of our original proposal (Repper 2010) offers some empirical insight, based on a small, largely US evidence base, into organisational factors that might impact on the implementation of Peer Worker roles in mental health.

The study described here is highly distinctive from that other work in that it explicitly sets out to:

- a) test the provisional evidence base on the emergence of Peer Worker roles in a range of settings (statutory, third sector and partnership);
- b) identify the extent to which findings about factors that facilitate or hinder the successful emergence of Peer Worker roles are generalisable across UK mental health service settings or are specific to particular contexts (e.g. statutory services or voluntary services);
- c) develop and make available a range of knowledge and practical tools that can be used by organisations across sectors in order to support the successful introduction of Peer Workers roles.

Our study is also distinctive in that it will consider and contrast models of Peer Worker roles taking place in the voluntary sector with models located within Mental Health NHS Trusts. This is particularly timely given the emphasis placed in the new health white paper on NHS commissioning from the third sector (DH 2010).

This study is predicated on research findings having practical utilisation by service providers. Organisational learning loops are built into the study design (Davis & Nuttley 2000) enabling host provider organisations to transfer knowledge from the study into the refinement and further implementation of Peer Worker initiatives. The end users of this research – NHS clinicians, statutory and third sector managers, peer workers and service users – are key members of the research team. Coproduction of research knowledge of this sort has been shown to close the ‘relevance gap’ between research and practice (Starkey & Madden 2001) and improve the sustainability of innovative developments in service delivery (Hall 2006). We will exploit these processes in developing research outputs that can be readily transferred to service providers across sectors. St George’s, University of London and Together For Mental Wellbeing will jointly host a National Peer Support Conference towards the end of the study, presenting and promoting learning and tools supporting the development of Peer Worker roles within and across different sectors produced in this study as well as the work of other organisations undertaking similar development and evaluation work. Alongside this Together For Mental Wellbeing will host dedicated Peer Support webpages on its website which will provide a virtual learning environment from which mental health provider organisations can access a range of information and practical tools supporting training and implementation of Peer Worker initiatives. Service user involvement throughout the research process underpins all these knowledge transfer strategies. Service users are co applicants and project advisors to the bid, the researcher employed to undertake the research will be an experienced service user researcher and the involvement of Together For Mental Wellbeing will ensure that the findings of the research and the dissemination strategy are relevant to a wide service user and third sector audience. Further dissemination will take place through the SWAN Institute of Leadership & Management (CE, SG) and our links with the NHS Confederation (CE, AB), applications to establish Knowledge Transfer Partnerships with service provider organisations, as well as conventional dissemination through academic, professional and service user conferences and publications.

Need

Health and Wealth Need - Only 13% of people with mental health problems are in long term employment (Sayce & Morris 1999). The total cost to the economy of treating mental health problems is greater than that for Ischaemic heart disease, breast cancer and diabetes combined (Dawson & Tylee 2001). In 2008/9 the cost of providing adult mental health services was indicated as £5.892 billion, an increase of 6.6% on the year before, reflecting recurrent year on year rises (Mental Health Strategies 2009). The total cost to employers of mental ill health has been indicated as over £25 billion, with 40% of sickness absence due to mental health problems (SCMH 2007). An association between high rates of physical ill health and mental illness have long been indicated (Phelan et al 2001) including health issues associated with poor general self care (Brown et al 1999). Evidence cited above indicates the potential role of Peer Workers in returning and maintaining people in healthy living in the community, including improved maintenance of employment.

Expressed need - Existing policies on healthy communities and personalized health and social care (Darzi 2008; New Horizons DH 2009; Personalisation DH 2008) had all emphasized the role that intentional peer support can play in fulfilling core policy objectives of developing new ways of working and of delivering services that: improve quality at the point of care; offer cost efficiencies; enable greater patient choice and engagement in directing their own care. The publication of the new Health White Paper (2010) has added urgency to pursuing QIPP programmes and indicated the increased

importance of finding integrated approaches to supporting self directed care, ensuring a sustained interest in using Peer Workers to deliver mental health services over the next decade and beyond. *Capacity to generate new knowledge* – While new knowledge is emerging about the effectiveness of peer support interventions in mental health there is a gap in knowledge about the implementation of new Peer Worker roles. This study will generate new knowledge about factors which enable or hinder the successful development and adoption of Peer Worker roles, in statutory, third sector and partnership service delivery settings. In so doing it will also identify the measures of successful implementation – impacts and outcomes on both service user and organisational levels – from a range of stakeholder perspectives. This knowledge will better inform future studies that seek to measure the effectiveness and cost effectiveness of Peer Worker interventions.

Organisational focus consistent with SDO mission - The SDO seeks to provide research evidence that improves practice, organisationally and in service delivery. This study will identify and describe a range of organisational factors that provide an evidence base for strategic development of new mental health workforce and innovative ways of providing services. This evidence will also inform protocol design and help ensure model fidelity when Peer Worker interventions are subsequently evaluated.

Generalisable findings – The comparative case study approach we are taking will enable us to identify factors in the development of Peer Worker roles that are both generic across statutory and third sector health and social care organisations, and that are specific to particular sectors and settings. Our national peer worker mapping exercise will give some indication of the current spread of Peer Worker initiatives within, and referred to by Mental Health NHS Trusts. This will complement the ongoing mapping exercise of Peer Worker initiatives in the third sector currently being undertaken by Together For Mental Wellbeing. The findings from these mapping exercises will enable us to reflect on the extent to which our findings have relevant across statutory and third sector mental health provision nationally.

Building on existing work – This project builds on the existing SDO programme of research exploring support for self care for chronic conditions (08/1715/161, 162 & 165). The SDO has previously commissioned several projects researching change management in the NHS (SDO/38/2002; SDO/91/2005; SDO/94/2005). There have been projects evaluating models of service development in mental health care (SDO/154/2006; SDO/75/2003) including service user involvement in change management in mental health care (SDO/18/2002). Specifically, this project will build on a small but growing body of research investigating peer support initiatives across health service areas (see background above) as well as projects in development by members of the team that seek to evaluate the effectiveness and productivity of Peer Worker initiatives in mental health services.

Actionable findings and prospects for change – This study will identify a number of factors that facilitate or inhibit the development and implementation of Peer Worker roles in a range of mental health service settings, statutory and third sector. These will include the tools developed by case study provider organisations for recruiting and training Peer Workers and for implementing new practice within or alongside existing mental health teams. The study design incorporates feedback of findings into the service delivery environment, enabling us to explore transfer of knowledge generated by the research. We will make that actionable knowledge, including access to tools and case studies in different provider settings, available through a virtual learning environment jointly hosted by SGUL and Together For Mental Wellbeing, as well as through a National Peer Support Conference.

Methods

Conceptual framework

This study is underpinned by a conceptual framework informed by:

- a) The existing evidence base, comprising provisional findings of completed SDO funded research undertaken by the team (Gillard, Edwards et al 2010) offering insight into the role of peer workers supporting self care in mental health, as well as Together For Mental Wellbeing's Peer Support in Mental Health review (Repper 2010);
- b) Theoretical understandings of how new roles emerge, communities of practice and professional jurisdiction, derived from a wider empirically based Organisational Research literature;
- c) Experiential insight into the introduction of peer worker roles, derived from a series of meetings held with members of the PEER (Peer Expertise in Education & Research) group at SGUL.

Each of these bodies of knowledge identifies a provisional range of factors impacting on the successful introduction of Peer Worker roles in mental health services. As such these factors

constitute a conceptual framework that proposes the organisational conditions under which Peer Worker roles are successfully introduced into mental health services, and that can be tested empirically in a UK mental health services context. That existing knowledge is summarised below:

a) The existing evidence base – the introduction of Peer Worker roles in mental health

The research undertaken by the team (Gillard, Edwards et al 2010) indicated a number of possible factors that impacted on the development of the peer worker role, as articulated by a range of stakeholders in supported mental health self care:

- 1) Peer workers (PWs) raised issues about their role identity (was theirs a professional role or not?), boundary issues (how much should they disclose about their own mental health issues?) and concerns about becoming unwell because of the job;
- 2) Mental health professionals (MHPs) working directly with PWs were also concerned about boundary issues, risk management and, for some, that a need to look after PWs placed a drain on the team's resources. They wondered what and how much responsibility to share with peer workers but also felt that PWs brought valuable insight to the team, especially when making judgements in grey areas such as managing and facilitating positive risk taking by service users;
- 3) Service users (SUs) identified with PWs and felt that when PWs disclosed their mental health issues this gave their advice and guidance credibility. However SUs were not always sure what the PW's role was and were anxious whether they would have the clinical competence necessary if the SU was in crisis;
- 4) Line and service managers were concerned about the level and type of support and supervision PWs needed over and above what MHPs required and were not sure what responsibilities they could give to PWs;
- 5) Senior and strategic managers were positive about innovative practice fitting with their organisations' wider strategic objectives but were concerned that the culture change this implied would be met by resistance further down the organisation, that innovation might not spread to different parts of the organisation and that this raised risk issues for the Mental Health Trust. Additionally there were bureaucratic issues for HR departments on how to recruit PWs and the lack of fit between PW roles and existing job profiles.

The new review of Peer Support in mental health published by Together For Mental Wellbeing (Repper & Carter 2010) offers some empirical insight, largely from the US, into organisational factors that might impact on the implementation of Peer Worker roles in mental health:

1. Role confusion (by Peer Workers and by others);
2. Lack of confidentiality about PW's history;
3. Clear job structure (including opportunities for promotion and a clear career pathway);
4. Supervision and team support (including support for issues arising from the 'dual role');
5. HR policies allowing experience in lieu of formal qualification;
6. Level of remuneration and award evaluated by the same performance criteria as other staff;
7. Properly accredited training;
8. Specific training for trainers and training for non-peer staff;
9. Benefits and welfare rights advice;
10. Clarification of relationship with service users.

b) The theoretical role change literature

There is a 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 (Lipman-Blumen 1973). The current productivity and quality challenges facing the NHS, which would see payments to the NHS aligned with the quality of care that patients received (DH 2010), 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 (SCIE 2008), self care (DH 2006) and personalisation (DH 2008) agendas, and improving health and social care outcomes for those people accessing mental health services. A diffusion model of role change (Bernard 1976) 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 (1990) 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 to date indicate that development of peer support roles in mental health services nationally is probably currently somewhere around the innovation/ early acceptors stage, and as such at critical point in terms of widespread implementation. Turner (1990) 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, Turner (1990) 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 1988) 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 (Currie et al 2007, 2009), with a number of studies documenting the power of clinicians to block innovative practice (McNulty & Ferlie 2002; Pettigrew et al 2005). Role change – especially the introduction of new roles – brings about challenges over task and expertise boundaries, Turner (1990) 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 (2007) 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 is 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 task, enabling a consensus of expectation across roles (existing and new) and avoiding jurisdictional challenge to (and encountering 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 become embedded (Reay et al 2006), while 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 healthcare, social care and third sectors, and a lack of clarity and awareness over role; who is doing what and in which sector/ organisation (Dickinson et al 2008). Other organisational change literature has shown how organisational learning is more easily sustained within, rather than across communities of practice (Brown & Duguid 2001), how power relations between communities of practice mediate organisational learning (Fox 2002), and that the implementation of new ways of working can 'stick' at the interfaces between professional groups (Ferlie et al 2005a).

c) Experiential insight into the introduction of 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:

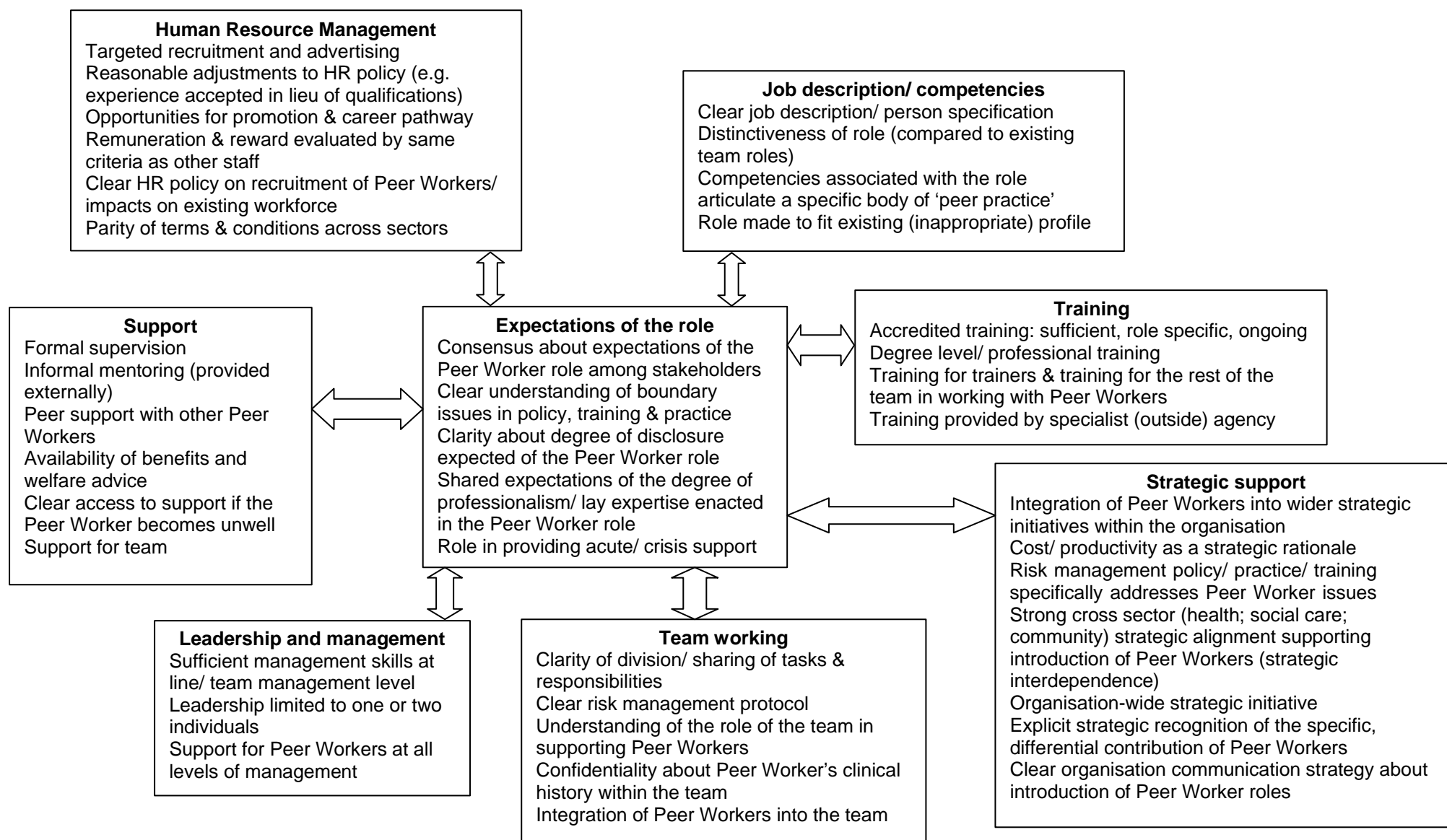
- i. Role that PWs should play: act as 'guides' through mental health services, especially for new service users; interface between service users & professionals; prevent people falling through the net between services; 'seeing the whole person'; empathy + experience + training;
- ii. Clarity needed about degree of professionalism of the role: PWs should have a professional manner but should not be over professionalised/ medicalised or benefits will be lost; what skills should PWs 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, to 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.

Summary

It has been noted that professionals, particularly in healthcare, are currently under increasing challenge to conform and support reform (Gleeson & Knights 2006) and as such the widespread introduction of peer support roles in mental health services seems likely to happen in the context of a strong, to a large part economically driven policy rationale for doing so (New Horizons 2009, Equity & Excellence: Liberating the NHS DH 2010). However, the evidence base and theoretical literature described above suggests that, in a context of early adoption and incremental role development, the successful introduction of Peer Worker roles cannot be assumed just because there is top down policy imperative to create these roles. As such a null hypothesis exists that Peer Worker roles will be: (i) indistinctive; (ii) fail to enact a specific body of peer practice; (iii) fail to deliver on the productivity and quality challenges that service providers hope to deliver. The various factors indicated above as potentially impacting on the introduction of Peer Worker roles – both facilitators and barriers – fall into a number of related domains that organise the conceptual framework. This conceptual framework, to be tested empirically in this study, is summarised in figure 1 below:

Figure 1: conceptual framework for investigating the introduction of Peer Worker roles in mental health services (facilitators and barriers)



Study design

This study will employ a comparative case study design in order to test the existing provisional evidence base about facilitators and barriers to the successful introduction of Peer Workers in a number of contrasting UK mental health service models in the statutory and voluntary sectors. A 'pattern matching' approach to analysis (Yin 1994) will be used to test the evidence base in each setting. Triangulation of documentary and interview data, as well as triangulation of perspective (Patton 1990) between different stakeholders will be used to explore issues of model fidelity (e.g. was the project implemented as described in the service specification) and tensions in the implementation process (e.g. the extent to which both peer workers and managers think that training provided was appropriate/ sufficient). A comparative case study approach (Ferlie et al 2005b) will enable us to assess the extent to which findings are generalisable across settings or are specific to particular settings (e.g. directly provided by Mental Health Trusts or by voluntary organisations). Feedback workshops will be used to check emerging analysis and inform study outputs.

Setting

Ten cases studies will be undertaken. Five case studies will be statutory sector models (provided or commissioned by mental health Trusts, including initiatives delivered in partnership with other providers) and five will be in the voluntary sector, including service user led initiatives (these initiatives might also be delivered in partnership with other providers). We will ensure that case studies are sufficiently contrasting on relevant dimensions of comparison informed by the conceptual framework. For example, statutory sector cases include models where:

- (i) Peer Workers are employed by the Trust to replace Mental Health Professionals on mainstream inpatient and community clinical teams (London);
- (ii) Peer Workers are employed by the Trust to specific roles with limited and defined tasks (Wellness Recovery & Action Planning (WRAP) trainers, Copeland 1997) (Hampshire);
- (iii) Peer Workers employed (on a paid or voluntary basis) by social services or third sector in partnership with MH Trust (community arts projects)

Voluntary sector cases include service user-led models of service delivery that take place wholly outside of the statutory sector but are routinely accessed by people who are also users of Mental Health NHS Trust services. These cases increase the relevance of our study in the context of the emphasis in the new Health White Paper (DH 2010) on commissioning of services on behalf of the NHS from the third sector. Voluntary sector cases have so far been identified in the following settings:

- (i) Leeds Survivor Led Crisis Service;
- (ii) CAPITAL (Clients & Professionals in Training and Learning), a user led and user run organisation that delivers peer support and confidence building/ leadership training in West Sussex;
- (iii) Enfield Mental Health Service Users Group (EMU) providing peer support on acute wards, in rehabilitation services and in the community.

In addition at least two case studies will be specific BME community based initiatives. This is part of the study's strategy to consider Peer Worker roles and BME mental health (see also *Sampling and recruitment strategy* and *Analysis strategy* below).

Data collection

Case studies will collect both documentary and interview data at each site. A structured data extraction tool will be used to collect relevant documentary data from documents including organisational business plans and strategies, service specifications, job descriptions and person specifications, and training materials. 8-10 semi structured interviews will be conducted with a range of stakeholders at each site (2 Peer Workers, 2 other team members (e.g. mental health professionals), 2 service users, 1-2 team/ service managers and 1-2 senior/ strategic managers, including commissioners). The range of roles selected will be relevant to each site/ organisation. For example, where the case study is a voluntary sector project 1 or 2 referring professionals from the local mental health Trust may be recruited instead of other team members. Where appropriate a mental health commissioner will be interviewed at each site, from either health or social services as relevant. The interview schedule will be largely structured in order to test the conceptual framework empirically. Structured questions will enable a 'pattern matching' approach to analysis (Yin 1994) to be adopted, testing the extent to which the range of factors proposed in the conceptual framework - as organisational conditions under which Peer Worker roles are successfully introduced into mental health services - have been found in each setting (or where alternative patterns are found proposing alternative conditions). Interviewees will also be asked to rate the importance of each factor (as either a facilitator or barrier to introducing Peer Workers) from their personal perspectives on a simple five

SDO 10/1008 New Ways of Working in mental health services: assessing and informing the emergence of Peer Worker roles in mental health service delivery

point adjectival scale. This will enable us to triangulate data by perspective (Patton 1990), testing tensions in the implementation process (e.g. the extent to which both peer workers and managers think that training provided was appropriate/ sufficient). Interviewees will be asked to identify the three most important facilitators or barriers to introducing Peer Workers and qualitative space will be given at the end of the interview schedule for interviewees to describe the specific impact of those factors, from their personal experience. Qualitative questions will also explore the culturally specific experiences of service users and staff from BME communities. Qualitative data will be important in order to provide handbook guidance for managers in the statutory and voluntary sectors on introducing peer workers (see below). Triangulation of documentary and interview data will be used to explore issues of model fidelity (e.g. was the project implemented as described in the service specification). Interviewees will also complete a small number of structured questions about socio-demographics and their role in relation to peer support. Each interview will take about 40 minutes to complete. Answers to structured questions will be recorded on a data sheet for each interviewee. Interviews will also be digitally recorded in order that qualitative data can be transcribed and entered into an NVivo database for analysis. All interviewees will be invited to a feedback workshop at each site, along with other stakeholders (service users, workers and managers) to the service or project.

Sampling and recruitment strategy

Participants will be recruited from one or more teams or projects at each site. All participants will be involved in the work of Peer Workers in the team or project: Peer Workers will be working in the team or project; Mental Health Professionals will be working in teams alongside Peer Workers; managers will either be leading teams employing Peer Workers or have senior or strategic management responsibility for the employment of Peer Workers in the organisation; service users will have had regular contact with Peer Workers, as appropriate to the role of Peer Workers in that project. As the level of enquiry in this study is the service or project employing Peer Workers, rather than individual stakeholders to peer support, it is neither pragmatic nor necessary to recruit a cross section of potential participants in each case study. However we will select participants that are different on some relevant criteria – e.g. Peer Workers with different previous work/ service use experiences; other team members with different professional backgrounds – in order that we can more fully test our conceptual framework. Given the size of case studies it will not be possible to ensure that the socio-demographic profile of the local population is represented in each case study. However, we will ensure that we have good representation of people from BME communities across the study as a whole. At least two case studies will be of peer support projects provided specifically for specific BME communities.

Peer Workers, Mental Health Professionals and service users will be recruited through the service manager of case study services who will work with the research team to identify potential participants and then to give them information about the study. Preferred contact details of individuals who are interested in participating will be passed to members of the research team who will make direct contact with potential participants to ask for their informed consent to participate and arrange interviews. Peer Workers and Mental Health Professionals may or may not have worked directly with service users recruited to the study. Participant information will make it clear to participants that research data will be anonymised and participation in the study will be kept confidential. The research team has experience of managing participant confidentiality in multi stakeholder research in the original *Self Care in Mental Health* study. Managers will be identified by the member of the research team who is facilitating access at each case study site through discussion with colleagues involved in Peer Workers locally. Members of the research team will work with Clinical Studies Officers (CSOs) employed in host Trusts or R&D Consortia on the recruitment strategy in order that CSOs can liaise between service managers and the research team. This makes the research project more cost efficient, especially in remote sites.

Analysis strategy

Analysis of the main, structured part of the interview will take the form of a content analysis of pattern matching questions. This will enable us to determine the extent to which the proposed conditions of successfully introducing Peer Worker roles were in place at each site, and where alternative patterns were found. Replication of proposed patterns across sites will demonstrate the wider external validity of the conceptual framework across UK mental health service settings (Yin 1994). However, where

alternative patterns are found – in individual sites or across a group of case studies (e.g. service user-led projects) – findings will demonstrate an internal validity within those cases and settings. We will be able to report on where barriers and facilitators of successful introduction of Peer Worker roles are generic across UK mental health service settings, and where these are specific to particular settings (e.g. voluntary sector initiatives). In addition, mean scores will be calculated for ratings of importance of each barrier and facilitator. Mean scores will be reported for the whole study, for each case study site, and for each stakeholder group (e.g. Peer Worker, service user, mental health professional). The frequency of 'top three' factors will also be reported across the study, by case study and by stakeholder group. These findings will enable us to consider different priorities in the implementation process between settings and between stakeholder groups.

The data extraction tool used for documentary evidence will also allow us to determine the extent to which the proposed conditions of successfully introducing Peer Worker roles were in place at each site, and where alternative patterns were found. We will be able to triangulate documentary findings and interview findings in order to reflect on issues of model fidelity and challenges in the implementation process. Illustrative examples of documentation used at case study sites in support of introducing Peer Worker roles (e.g. job descriptions, training materials, protocols and so on) will be used as appropriate – and with the permission of the owner organisations – in study outputs, both in the handbook and posted online as free to use resources.

Preliminary findings from the pattern matching analysis, importance ratings and model fidelity findings will be presented to feedback workshops at each site. Workshop participants will be invited to discuss these findings and notes made of the discussion. These discussions will be used to check our preliminary findings and to provide further content for study outputs, including guidance on introducing Peer Worker roles to be included in the handbook.

Qualitative data exploring interviewees' personal experiences of the factors they identify as the most important facilitators and barriers of introducing Peer Worker roles, as well as the culturally specific experiences of participants from BME communities, will first be analysed using the basic coding tools of inductive, qualitative enquiry (Ritchie & Lewis 2003) and coded using NVivo qualitative analysis software to aid data management. We will then undertake a complementary process of matrix analysis (Averill 2002), the whole research team discussing the preliminary analysis in order to integrate the range of expertise and experience in the team in the interpretation of data. Use of the matrix approach will allow us to compare qualitative data across sites and stakeholder groups. The analysis of this data – detailed qualitative accounts of key aspects of the introduction Peer Worker roles - will be used to further inform study outputs, including the development of specific guidelines to be included in the handbook and online materials.

Approval by Ethics Committees

It will be necessary to seek the approval of an NHS Research Ethics Committee for this research because data will be collected about the personal experiences of NHS patients and staff. While interviews are unlikely to raise difficult issues it is possible that service users will recall incidents that were personally distressing and staff may raise sensitive employment issues. All interviews will be risk assessed and a protocol will describe appropriate handover should interviewees or interviewers become distressed during an interview. Appropriate research training, including training for taking informed consent, and mentoring for the service user researcher will be described in the ethics application. An application for ethical approval for the study has been prepared and will be submitted as soon as we receive approval for changes to the proposal from the SDO Board.

Project management

The project will be managed using Prince2 methodology modified for research. The lead applicant (SG) will be the Project Manager. SG successfully managed the *Self Care in Mental Health* project – a considerably larger project – on a lower allocation of time through effective management processes and clear allocation of responsibilities and lines of reporting. This represents a cost efficiency for the research. A comprehensive Project Initiation Plan will be used, including a reporting and monitoring schedule with risks and contingencies planned in the areas of human, material and financial resources, and the delivery of research outputs. Exceptional Plans will be developed around the specific research issue of recruitment of participants. The Project Manager will receive monthly budget reports from SGUL Research Office indicative of variance against project spend on all cost

lines. Agreed variances will trigger contingency & exceptional planning. The site leads for Hants, Yorks and Together For Mental Wellbeing (SR, ML & ES) will report monthly to the project manager to ensure that data collection and analysis targets are being met as agreed. Research Team meetings will be approximately quarterly, timed to coincide with key stages in the research process. The location of the meetings will rotate so that meetings are held at least once at each case study site. In months one, nine and 18 there will be a Project Board meeting, comprising the Project Advisory Group as well as the Research Team. This will be independently chaired by Dr John Larsen, Head of Research & Evaluation at Rethink and will include two service user representatives of the group PEER, supported by SGUL, and two service user representatives from the Peer2Peer network supported by Together For Mental Wellbeing, as well as representatives of other mental health service providers with an interest in peer support. The Project Manager (SG) will report to the Project Board the management of project deliverables and dependencies; the Research Team will provide specialist methodological project assurance; the service user researcher coapplicants (KT, JMCK) and research assistant, as well as the Director of Service User Involvement at Together For Mental Wellbeing (AB) will ensure that progress of the study reflects the interests of the service user community; representatives of management and professionals at host Mental Health NHS Trusts (MR, ML, KC, KG) will report on the continued relevance of the study to their organisations as end users of the research. The Project Board will report to NIHR-NETSCC as customer through formal 6 month interim reporting and final report plus any highlight reporting as agreed.

Service users/ public involvement

This project embodies a collaborative approach to research. It is the continuation of an earlier study by members of the team (SG, CE, KT, ML) exploring self care and mental health which was characterised by a high level of service user involvement in designing the study, collecting and analysing data, and writing up findings. As such there was a high level of service user involvement in developing the research questions behind this study, complemented in the role played by PEER (Peer Involvement in Education & Research) – a service user group supported by the Section of Mental Health at SGUL – in developing the conceptual framework and research questions for this study. An experienced service user researcher (KT), service user trainer (JMCK) and the Director of Service User Involvement at Together For Mental Wellbeing (AB) have all been involved in the research design process and, as coapplicants on the study, will ensure that the conduct of the study, the development of interview schedules, the interpretation of data and dissemination of findings respond to the concerns and interests of the wider service user community. Service user members of PEER group at SGUL and the Peer2Peer network supported by Together For Mental Wellbeing will be appropriately supported to attend the Project Advisory Group and to report back to their constituencies, ensuring that a wider range of service user voices are represented in the governance of the study. The Research Assistant post will be specifically advertised as a service user researcher post, and will be advertised through service user research networks as well as usual HR approaches. The post has been costed at a sufficient point on the pay scale to enable an experienced service user researcher to apply for the post. Alternatively we would welcome a job share that balanced the preferred working arrangements of two or more service user researchers with the demands of the project (see justification of support below). The project PI (SG) has extensive experience of supporting service user involvement in research, and the Division of Mental Health has developed comprehensive guidelines, together with the SGUL HR and Occ Health departments, for supporting the employment and training of service user researchers. The service user researcher will be mentored throughout the study by KT, an experienced service user researcher.

Expertise and justification of support required

Coapplicants

The final report of the recently completed SDO funded *Supporting Self Care in Mental Health NHS Trusts* project received excellent peer reviews, indicating SG's ability to lead a team comprising NHS managers, and health service, organisational, service user and clinical researchers in the successful coproduction of research. SG will undertake project and financial management, lead on the qualitative analysis and data synthesis and will line manage researchers. SG has extensive experience supporting service user involvement in research, first of all in the voluntary sector where he also managed mental health services and more recently within a university setting. CE is an established research leader in Human Resource Management in the public sector, Director of the Institute for Leadership and Management in Health and will (as in the Self Care project) lead on organisational and HRM aspects of the research, complemented by EO's specific academic expertise in examining

collaboration and organisational analysis related to healthcare restructuring, organisational change and the challenges of multidisciplinary working. Whilst working with Lord Darzi during the London Review EO examined the process of staff and service user engagement and has published work in this area. KT is an experienced service user researcher and, now as chair of the voluntary sector organisation Emergence, has been closely involved with the development of national policy as part of the DH's Personality Disorder Programme. KT will mentor service user researchers in this project. JMck is an experienced service user trainer and research and will bring a first hand Peer Worker perspective to the team, having worked as a WRAP trainer in the Hants case study site. AB is Director of Service User Involvement at Together For Mental Wellbeing and has extensive experience of developing service user led services. Her ongoing work of ensuring that the views and experiences of service users are integrated into the development of mental health services and policies nationally has earned her an MBE for services to healthcare. With KT and JMck, AB will ensure that this research project and the dissemination of findings will be relevant and speak to a wide service user audience. ES is an experienced service and programme development manager leading on Peer Support Development at Together For Mental Wellbeing and will facilitate access to the service user led projects in the fourth case study. KC is Project Manager at the National Mental Health Development Unit (NMH DU) supporting the Mental Health Personalisation Programme, seconded from her substantive role as Head of Service Development at Hampshire Partnership NHS Foundation Trust. KC will be able to provide insight into policy implementation at both a national level and at a strategic level in Mental Health Trusts and will ensure that findings from this project are disseminated as part of the legacy of NMH DU's Personalisation work. KC's involvement has not been costed as it is within remit of her NMH DU brief. CW is a core member of the SGUL/ SWLSTG research group working on recovery orientated service delivery, and as lead clinician will facilitate access to the London case study site. CW has a strong track record evaluating implementation of major mental health service developments (e.g. Home Treatment and Assertive Outreach) and as a policy advisor at the DH. ML is in a joint NHS/University post which puts him in a good position to lead the West Yorkshire case study and has had positive preliminary discussions with leads for various project which may be included in the research. He has extensive experience of working with statutory and community services in various mental health research projects, using both qualitative and quantitative research methods and as a consultant clinical psychologist will be able to add that perspective to the research team. MR leads on developing and implementing the Peer Support Worker initiative in the London case study site, including development of training for Peer Support Workers. MR is Recovery and Social Inclusion lead for the London site, implementing Recovery focused practice across the organisation including implementation of peer support workers. ML has worked on Social Inclusion policy implementation at the National Institute for Mental Health England. SR is project coordinator for implementing WRAP training, including training of service users as WRAP trainers and will lead and facilitate access in the Hampshire case study site.

Research assistant (service user researcher)

The project has been designed so that it can be completed by one FTE research assistant with previous experience of conducting research with mental health service users and staff. During data collection this means that the researcher would need to conduct an average of 2 interviews a week alongside undertaking some transcription of data and ongoing data analysis. We would expect this study to be adopted by the Mental Health Research Network and therefore have access to Clinical Studies Officers who will help recruit participants and arrange interviews, making it possible to collect data efficiently through return visits to case study sites. This is considerably more cost effective than employing researchers at each site. Running groups of case studies in parallel is also more cost effective than running all four case studies in series. Additional resources are included for transcribing the majority of interviews although it is good practice for the research assistant to transcribe a subsample of interviews. The research assistant will be responsible, along with site leads, for planning and coordinating local feedback workshops and, with Together For Mental Wellbeing, the final National Peer Support Conference.

Research costs

Research costs will include payments for service user, carer and staff (who are not participating during paid NHS time) research participants to reflect the value of their time (@ £10 per interview plus any travel expenses), travel and subsistence for the researcher to undertake interviews, travel for team meetings and site visits by team members, and travel and refreshments for Project Advisory Groups plus honoraria for service user advisory group members. Costs are included to run case study site feedback workshops. The costing given for the jointly hosted SGUL/ Together For Mental

Wellbeing National Peer Support Conference is based on costings for Together For Mental Wellbeing's successful 2009 Personalisation Conference. It will be a one day conference for approximately 150 delegates of whom 50% will be from the statutory and private sectors paying a full rate, 25% from the charity sector paying a reduced rate and 25% free places for service users and carers. Costs of reproducing feedback conference material and final reports are included here, but other associated research costs, including IT and setting up, operating and producing descriptive analysis of the online survey, will be met through HEI indirect costs. Support for transcribing qualitative interviews will reduce demands on the service user researcher, improving project feasibility.

Key references

- Abbott, A (1988) *The system of professions: an essay on the division of expert labour* Chicago: UCP
- Averill, J. (2002) Matrix Analysis as a Complementary Analytic Strategy in Qualitative Inquiry. *Qualitative Health Research*. 12 (6): 855-866
- Balogun, J. et al (2004). *Exploring strategic change*, London: Prentice Hall
- Bernard, J (1976) Change & stability in sex-role norms & behaviour *J. of Social Issues* 32: 207-223
- Brown S, Birtwistle J, Roe L, Thompson C. The unhealthy lifestyle of people with schizophrenia. *Psychol Med* 1999; 29: 697-701
- Brown, J., & Duguid, P. (2001) Knowledge and organization: A social-practice perspective. *Organization Science*, 12 (2) 198-213.
- Buchanan, D & Badham, R (2008). *Power, politics and organisational change* (2nd ed.). London: Sage.
- Copeland, M.E. (1997) Wellness recovery action plan. Peach Press, West Dummerston, VT
- Currie, G., Finn, R. & Martin, G. (2007). Spanning boundaries in pursuit of effective knowledge sharing within healthcare networks in the NHS. *Journal of Health Organization and Management*, 21(4/5), 406-17.
- Currie, G., Finn, R., & Martin, G. (2009). Professional competition and modernizing the clinical workforce in the NHS. *Work Employment Society*, 23(2), 267-284.
- Curtis L (2008) Unit costs of health and social care. Canterbury: PSSRU
- Darzi (Lord) (2008) High quality care for all. NHS next stage review. TSO, London.
- Davis, H. & Nutley S (2000) Developing learning organisations in the new NHS *BMJ* 320 998-1001
- Dawson, A & Tylee, A. (2001) (Eds) Depression: social and economic time bomb. London BMJ books
- DH (2006) Supporting people with long term conditions to self care: A guide to developing local strategies and good practice
- DH (2008) <http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm>
- DH (2009a) NHS 2010–2015: from good to great. Preventative, people-centred, productive
- DH (2009b) Achieving World Class Productivity in the NHS 2009/10 – 2013/14
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116521.pdf
- DH (2009c) New Horizons: towards a shared vision for mental health
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103175
- DH (2010a) Equity & Excellence: Liberating the NHS
- DH (2010b) Transparency in outcomes: a framework for the NHS
- Dickinson C et al (2008) Mapping new roles in mental health services: the development of four new mental health roles 2004-2006 *Journal of Mental Health Training, Education & Practice* 3(1) 4-11
- Dierdorff E & Morgeson F (2007) Consensus in Work Role Requirements: The Influence of Discrete Occupational Context on Role Expectations *Journal of Applied Psychology* 92(5) 1228–1241
- Edwards, C., & Robinson, O. (2001). Better quality part-time jobs? A study of part-time working in nursing and the police. *Employee Relations*, 23 (5), 438-453.
- Edwards, C., & Robinson, O. (2004). An evaluation of the business case for flexible Working among qualified nurses in the UK NHS. *British Journal of Industrial Relations*, 42 (1), 167-183
- Ferlie, E. et al (2005a) 'The (non) spread of innovations: the mediating role of professional groups' *Academic Review of Management* 48(1) 117-134
- Ferlie E, et al (2005b) Enacting Evidence Informed Health Care: Some Policy and Practice Implications. In: From Knowledge to Action. Dopson S & FitzGerald L (eds). OUP
- Fox, S. (2002) Communities Of Practice, Foucault And Actor-Network Theory. *Journal of Management Studies*, 37 (6) 853-868.
- Frost, P., & Egri, C. (1991). The political process of innovation. *Research in Organisational Behavior*, 13, 229–295
- Gillard, S., Edwards, C., White, S. et al (2010) *The barriers and facilitators of supporting self care in Mental Health NHS Trusts* Report to NIHR Service Delivery & Organisation R&D Programme
<http://www.sdo.nihr.ac.uk/files/project/165-final-report.pdf>

- Gleeson & Knights (2006) Challenging Dualism: public professionalism in troubled times *Sociology* 40 (2) 277-295
- Hall, J. E. (2006). Professionalizing action research -- a meaningful strategy for modernizing services? *Journal of Nursing Management*, 14(3), 195-200
- Iliffe et al (2004) *The development of a short instrument to identify common unmet needs in older people in general practice* British Journal of General Practice 54(509) 914-918
- Lawn, S., Smith, A., & Hunter, K. (2008) Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*, 17, 5, 498-508
- Lipman-Blumen, J (1973) Role differentiation as a system response to crisis: occupation and political roles of women *Social Inquiry* 13: 105-29
- McCormick A, Fleming D, Charlton J. (1995) Morbidity Statistics from General Practice: Fourth National Study 1991-1992. London: HMSO, series MB5 no 3.
- McGovern, P, Gratton, L, Stiles, P., Hailey, H. V., & Truss, C. (1997). Human resource management on the line? *Human Resource Management Journal*, 7 (4), 12-29
- Mental Health Strategies (2009) 2008/9 national survey of investment in adult mental health services
- Min, S. Y., et al (2007) Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*, 30, 3, 207-213
- Mintzberg, H., Quinn, J., Ghoshal, S. (1998). *The Strategy Process*. London: Prentice-Hall.
- MRC (2000). A framework for the development and evaluation of RCTs for complex interventions to improve health. London: Medical Research Council
- Nembhard, I., Alexandeer, J., Hoff, T., & Ramanujam, R. (2009). Why Does the Quality of health Care Continue to Lag? *Academy of Management Perspectives*, 23 (1), 24-42.
- Patton, M. (1990). *Qualitative evaluation and research methods*. London, Sage.
- Phelan, M., Stradins, L. & Morrison S. (2001) Physical health of people with severe mental illness *BMJ* 322: 443-444
- Reay, T. et al (2006) Legitimizing a new role: Small wins and micro-processes of change. *Academy of Management Journal* 49(5), 977-998
- Repper J & Carter T (2010) Using Personal Experience To Support Others With Similar Difficulties: A Review Of The Literature On Peer Support In Mental Health Services (London: Together For Mental Wellbeing)
- Resnick SG, Rosenheck RA. (2008) Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services*, 59:1307-1314
- Ritchie J & Lewis J (2003) *Qualitative Research Practice* Sage: London
- Sayce, E. & Morris, D. (1999) *Outsiders looking in?* London: Mind
- SCIE (2007) A common purpose: Recovery in future mental health services. London: SCIE
- SCMH (2007) Mental Health at Work: developing the business case. Policy Paper 8. London: SCMH
- Sells D, Davidson L, Jewell C, et al (2006) The treatment relationship in peer-based and regular services for clients with severe mental illness. *Psychiatric Services* 57: 1179-1184
- Sheaf, R. (2008). Medicine and Management in English Primary Care: A Shifting Balance of Power. In L., McKee, E. Ferlie, & P. Hyde. *Organising and Reorganising Power and Change in Organisations*. Hampshire: Palgrave Macmillan.
- Skills for Health (2009) Examining the impact of 'personalisation' on the health sector
- Starkey, K. & Madan, P. (2001) Bridging the relevance gap: aligning stakeholders in the future of management research, *British Journal of Management*, 12, S3-S26
- Strauss, N.C and Corbin, J. (1998) *Basics of Qualitative Research: techniques and procedures for developing grounded theory*. Sage: Thousand Oaks
- Truss, C. (2003) Strategic HRM: Enablers and constraints in the NHS. *The International Journal of Public Sector Management*. 16 (1), 43-61.
- Turner R (1990) Role Change *Annual Revue of Sociology* 16: 87-110
- Turton P, Demetriou A, Gillard S et al (2009) One size fits all - or horses for courses? Recovery-based care in specialist Mental Health Services *Social Psychiatry & Psychiatric Epidemiology* DOI 10.1007/s00127-009-0174-6
- Wanless, D. (2002) *Securing our Future Health: Taking a Long-Term View*
- Yin, R (1994) *Case Study Research: design and methods*. Thousand Oaks: Sage.

Summary for the non-expert

Mental Health NHS Trusts and voluntary sector mental health organisations are increasingly employing people who have used mental health services themselves to work in or alongside existing mental health teams. These people are often known as Peer Workers. This has happened partly

because there is some research evidence to show that Peer Workers can support others in their mental health recovery, and partly because the NHS needs to find cheaper ways of providing services. Health policy just published by the new Coalition government has suggested that the need to make savings, alongside giving patients more say in their care is more important than ever. This policy also says that the NHS should buy more of its services from voluntary sector organisations. However there is other research that says the introduction of new types of workers into established teams or alongside other roles does not always go smoothly, with existing professional groups often resisting the change. Members of this research team recently finished a study looking at how Mental Health Trusts support people to take care of their own mental health needs. We found that, while Peer Workers offered lots of benefits, service users, mental health professionals and Peer Workers themselves were often unsure of exactly what their role was. Mental Health Trusts also had some difficulties in supporting Peer Workers. It might be said that the Peer Worker is developing as a new role in mental health services, but without enough knowledge about what the role involves and how it is best supported. Research about new roles says that if they are not introduced and supported carefully there is risk that the new role will not offer the meaningful benefits that were intended.

In this project we will explore the introduction of the role of Peer Workers in twelve case studies in different parts of England, six cases in or supported by Mental Health NHS Trusts and six in voluntary sector organisations. Case studies in Mental Health Trusts will include services where Peer Workers will replace mental health professionals on existing clinical teams, services where Peer Workers will have a specific and limited role (e.g. training service users to develop recovery plans), and services where Peer Workers will be employed by other organisations in partnership with Mental Health Trusts. The voluntary sector projects will include service user-led projects (for example, providing crisis support, peer support and training) that are wholly independent of NHS Trust services, as well as projects provided for specific Black and Minority Ethnic communities. We will conduct one to one interviews with Peer Workers, mental health professionals, service users and managers so that we can test existing research evidence on how Peer Workers should best be introduced and supported. Through this research will develop guidelines and training tools for employing Peer Workers and make these widely available to Mental Health Trusts and voluntary sector organisations in the form of a handbook and online resources.

The research team includes experienced mental health services researchers and organisational researchers, NHS managers and clinicians, and experienced Peer Workers and service user researchers. A group of mental health service users - PEER - have helped design the study and a service user researcher will be employed and supported to undertake the research. This is because we think it is important that a service user perspective informs the design, conduct and findings of a study about service users working in mental health. NHS research ethics approval will be sought for this study to ensure the wellbeing of participants and researchers throughout the project.

This project is modestly costed to employ an experienced service user researcher fulltime for 21 months, funding for the time that other members of the team will put into the research and to pay service user participants for the time they will give to the study. There are also some costs involved in holding feedback workshops in each of the areas where the study takes to ensure that people involved in using and delivering services locally can benefit from the research, as well as a final National Peer Support Conference and a website to share our findings with service users and mental health service providers nationally.

Related grants

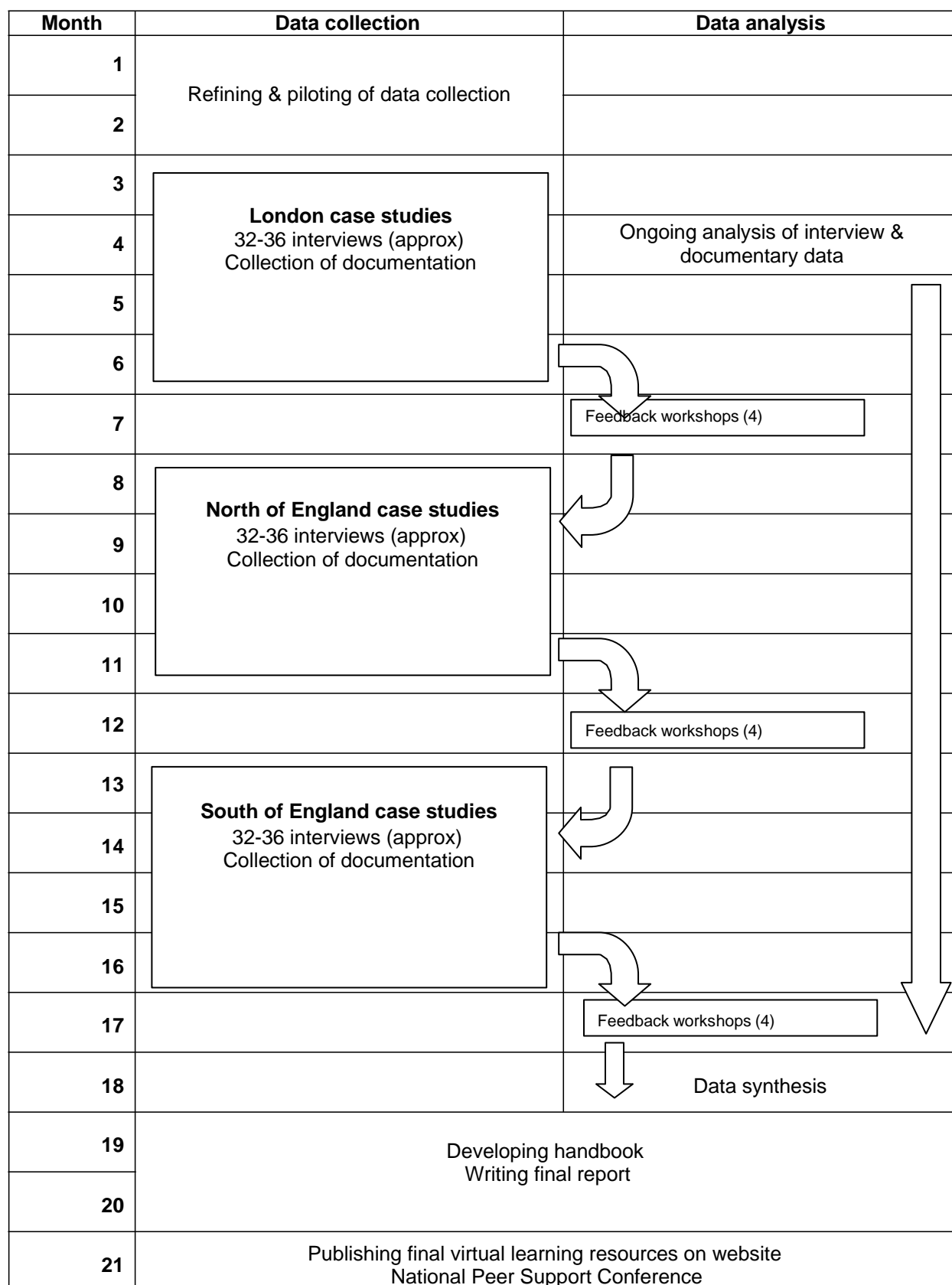
The recently completed SDO funded research project *Supporting Self Care in Mental Health NHS Trusts* project (SG, CE, ML, KT) informs the conceptual framework for this study, indicating factors that might impact on effective use of PP in delivery of MHS. This work is being continued in a HEFCE funded PhD studentship looking at the relationship between implementing personalised health and social care policy in mental health and the service user/ mental health professional relationship (SG, CE). Members of the team (CE, SG) are currently undertaking SDO funded research exploring the way in which NHS managers use information (including research evidence, stakeholder feedback and policy guidance) to develop and implement change in service delivery, and hold an NIHR Management Fellowship exploring research user engagement in knowledge transfer in support of that work. The team are directly involved in a body of planned and ongoing research in the field of peer support, recovery, and social inclusion and mental health, including planned projects measuring productivity and exploring service user experience in Peer Support Worker interventions (CW, SG,

KT) and evaluating the outcomes of Peer Support Worker interventions (MR). Other current grants include improving access to self-help in primary care through setting up an infrastructure to provide feedback on patient progress during psychological therapies, as well as exploring self management strategies used by patients with recurrent depression (ML), and as a site a PI on the RfPB funded ENDEAVOR study exploring vocational outcomes for young people with a first episode of a psychosis (MR). Members of the team (CW, SW) have been involved in a number of national and international research studies considering complex interventions in terms of service components and models of care for those with mental health problems. These have included consideration of the views and consensus levels of all involved stakeholders about effective interventions; statutory and non-statutory sectors; economic evaluations of interventions and models of care; and model fidelity and organisational analysis. Together For Mental Wellbeing (AB, ES) are currently undertaking research on peer support in partnership with Nottingham University, the Peer2Peer Group network and the National Survivor User Network, including literature review, and focus groups and interviews with user led organisations, commissioners, funders, academics and professionals to explore outcomes, challenges and evidence around peer support, in statutory and user led environments. This work also includes conducting a mapping of peer support initiatives in the third sector nationally. Other organisational change research is taking place in partnership with the departments of Psychiatry, Public Health and Engineering in the University of Cambridge CLAHRC focussed on *Clinical Leadership in Applied Health Research and Care* (EO), including a policy implementation analysis of the current IAPT process in East of England area.

Network collaboration

We would expect the study to be adopted by the Mental Health Research Network (MHRN). Adoption would give the project access to Clinical Studies Officers (CSOs) employed by, or working on behalf of Mental Health NHS Trusts whose service users and staff were participants in the study. We would work with CSOs in order to facilitate the recruitment of study participants and arranging interviews, especially at case study sites remote from SGUL. This greatly improves the cost efficiency of the study as it removes the need to employ research assistants at each site. Members of the team (CW, MR) have links with the Rehabilitation and Recovery clinical research group within MHRN. Collaboration with the Recovery and Rehabilitation clinical research group will provide a forum within which to share knowledge from this study with other clinicians, academics and third sector organisations working in the broad area of peer support, as well as provide opportunities for using the findings from this study to inform the development of future projects in the area.

Flow diagram



Project timetable

Month Task	2011										2012										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Project management	TM PB			TM		IR	TM			TM PB		IR	TM			TM		IR	TM PB		FR
Data collection			Case studies London					Case studies North					Case studies South								
Data analysis							FW					FW					FW				
Dissemination										Virtual learning resources								Developing Handbook		NC HB	

Key: PB – Project Board (comprising Research Team & Project Advisory Group)
 TM – Research Team Meeting
 IR – Interim Report
 FR – Final Report
 FW – Feedback Workshops
 NC – National Conference
 HB - Handbook