WHAT ARE DECISION MAKERS’ BARRIERS, FACILITATORS AND EVIDENCE NEEDS REGARDING PEER SUPPORT WORKING?

A report commissioned by the Scottish Recovery Network

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Executive Summary

A note on terminology
For the purposes of this report, the term peer support working refers to a formalised role involving individuals with personal experience of mental health problems being employed to support others in their recovery.

Throughout this report, the term service user is frequently used to refer to people who are the intended target group of, or who have used, a peer support service. We use this term to differentiate those individuals from the peer support workers themselves. However, we recognise that the term service user is a contested one we and have attempted to use ‘people’ and ‘individuals’ where we can.

Background
The Scottish Recovery Network (SRN) has commissioned this research to help it understand the basis for decisions regarding the introduction of peer support working (or not) and whether/how SRN might engender wider use of peer support working through distilling and disseminating evidence.

Research aim
The purpose of the research was to identify whether decision-makers in local areas have, or were perceived to have, any evidence needs that, if met, might lead to the introduction of more peer support services across Scotland.

Research methods
The research methods were qualitative. One-to-one telephone interviews were conducted with a total of 19 stakeholders working in one of two (selected) Scottish health board areas. One of these health boards ['Mags'] was selected because of its known progress in using peer support workers. The other health board area ['Cluny'] was selected because it was known to have not (yet) introduced such a service. A focus group was also run with the Scottish Government’s Involvement Implementation Group: Peer Support Sub-group.

Key findings
Perceived strengths of peer support working
The arguments for peer support working were generally well understood in terms of the intended, likely or actual benefits that these would be bring to those receiving such support.

The relationship between peer support workers and those they support was seen as authentic and equal, and as engendering and supporting holistic and service user-led recovery.
Identified challenges of peer support working
Establishing and delivering a peer support worker service was seen as presenting some significant challenges. Some of these concerned misconceptions or fears. Others were more about the practicalities of establishing or delivering a service.

Key themes related to:
- concerns about and definitions of professionalism;
- acceptance by, and wider integration into, wider multidisciplinary teams;
- balancing close relationships between workers and service users with information-sharing requirements within the wider team;
- workers’ wellness and well-being; and
- absences through becoming unwell.

In Cluny, lack of financial resource was considered to be a significant obstacle.

Addressing challenges and lessons learned
Drawing on their local experiences, Mags interviewees highlighted the importance of:
- communicating with strategic stakeholders and multidisciplinary teams in order to ensure cross-organisational buy-in and support, in particular as the service evolves;
- policies and practices to reinforce that peer support workers are equal partners in the multi-disciplinary team;
- providing ring-fenced time to ensure formal and informal support for workers, including mutual support and personal recovery planning; helping develop workers out of the role so that their experience can be used as a springboard to other things, such as capitalising on future employment opportunities.

Factors underpinning local decisions whether or not to introduce peer support working
Factors associated with, and possibly explaining why Mags has established peer support working services include:

- the board area’s and strategic partners’ willingness to innovate - which is at odds with the risk averse cultures that believed to be characteristic of other, most notably small, health boards;

- a local champion who is well connected to strategic planning structures for mental health locally and also to SRN;

- a commitment to service user involvement and to recovery values and practices which made the establishment of peer support working a logical extension to what they were already doing;

- cross-agency buy-in, including with third sector agencies;

- co-production values as indicated by its shared governance arrangements;

- peer support working being perceived as a national priority as discussion on the area’s progress featured in its review meetings with the Scottish Government.
Factors associated with, and possible reasons for Cluny having not established peer support working include:

- being financially stretched and associated considerations of costs and cost-benefits;
- the dominance of a medical model in strategic decision-making for mental health services;
- a perception and experience that the Scottish Government do not hold peer support working as a policy imperative, at least not for Cluny;
- involvement rather than co-production with the third sector;
- timing – insofar as Cluny is not so far along the road (as Mags, for example) in embedding its recovery work.

**The role of evidence in decision-making: what would be useful?**

Decision-makers’ judgements and choices were influenced by a range of factors including: available budget and flexibility; perceived risk and willingness to take risk; costs and cost-benefits; strategic importance and accountability; value-base; and alignment with local priorities and activity.

Interviewees and focus group participants identified needs for evidence regarding: how peer support working contributes to not just recovery but also other agendas; cost, cost-effectiveness and cost-benefits; and how to set up a quality service, including the required governance arrangements.

Suggestions for the future included:

- providing and tailoring evidence that is relevant to the roles and responsibilities of the range of decision-makers;
- creating a business case for peer support working, including ‘hard’ facts (e.g. on cost-benefit issues);
- building on the learning from board areas about what works (or not) in terms of delivery;
- making it easier for board areas to establish a peer support service by providing resources and templates so that they do not need to start from scratch;
- continuing peer support workers’ participation in evidence sharing and combining this with evidence on ‘harder’ matters as indicated above.
Conclusions and reflections
Evidence needs have to be understood within the context in which decisions are made. Thus, evidence is needed to show how peer support working is aligned with, and contributes to strategic priorities and outcomes.

Furthermore decision makers operate within a governance structure; they are accountable for the choices that they make and for the way in which their policies and services are implemented. Management of risk is a key dimension to this. As a consequence, their needs may be addressed by providing evidence on cost issues, quality assurance and risk management etc.

Developing a peer support service is not an easy thing to do. Providing evidence on effective implementation would help. Not only would this avoid health boards having to start from scratch (and save staff time in the process), such evidence would contribute to service improvement.

Currently there is a dearth of Scottish evidence on peer support working. It would therefore be useful to strengthen local evaluations and thereby build the Scottish evidence base.

This research has pointed to gaps in the evidence base, and how these might be usefully plugged. However, it would be naïve to assume that if decision makers were given the evidence that addresses the requirements of their professional roles (and they found this convincing), then they would employ peer support workers. This ‘if then’ theory is a gross oversimplification of the way decisions are made. In view of the competing priorities faced by decision makers in health boards and partner agencies, we may only see health boards across the country employing peer support workers if they are held accountable for this. SRN may wish to discuss the desirability and feasibility of doing so with the Scottish Government.

In the interim, SRN might also consider:

- developing indicators for a quality peer support service to guide commissioning, implementation and to frame evaluation and learning;
- harnessing the buy-in of other agencies with complementary agendas; and
- the extent to which it should push for health boards to be held accountable for progress on recovery more generally.
1. **Background and context to research**

The Scottish Recovery Network (SRN) has embarked on a programme to engender wider acceptance and application or recovery-focused evidence. By doing this, it hopes to encourage wider adoption of policies and practices that are of known effectiveness.

Accordingly, SRN intends to distil evidence on specific priority issues to specifically address the needs of key stakeholders, and to disseminate it in ways that will lead to the application of this evidence base. We call this evidence translation.

The first topic for SRN’s evidence translation programme is peer support working. For the purposes of this report, we are using the term peer support working to refer to a *formalised* role involving individuals with personal experience of mental health problems being *employed* to support others in their recovery.

SRN has a long-standing and ongoing commitment to promoting peer support working across the mental health sector in Scotland.¹

Peer support working is a national priority² and yet its adoption across Scotland is patchy. It is SRN’s view that while some areas are making significant progress, in other areas this is not so.

SRN is keen to understand the basis for decisions regarding the introduction of peer support working (or not) and whether/how it might engender wider use of peer support working through distilling and disseminating *evidence*.

**Purpose of research**

The purpose of the research was to identify whether decision-makers in local areas have, or were perceived to have, any evidence needs that, if met, might increase the use of peer support working. As such, this research was based on a series of inter-related assumptions

- if we identify decision-makers’ views on peer support working, then we will have a better idea of any gaps in their understanding and any concerns that they might have, or challenges that they envisage or have experienced

- if we identify how concerns and challenges have been addressed (and how effectively), we can build a stronger and more convincing evidence base

- if we select two contrasting health boards (one with, the other without, peer support working) then we might better understand the reasons for these differences, and thereby identify other inroads for SRN to consider in promoting peer support working

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¹ For details on the range of ways in which SRN promotes and supports peer support working, please visit [http://www.scottishrecovery.net/Peer-Support-Working/peer-support-working.html](http://www.scottishrecovery.net/Peer-Support-Working/peer-support-working.html)

² The Mental Health Strategy for Scotland identifies a focus on increasing and embedding peer support working across Scotland. See: [http://www.scotland.gov.uk/resource/0039/00398762.pdf](http://www.scotland.gov.uk/resource/0039/00398762.pdf)
• if we establish what evidence decision-makers want and/or would find persuasive (and the format in which this evidence should be provided) and meet these needs, then the uptake of peer support working can be increased.

Format of this report

In the remainder of this report, the research methods are outlined (Chapter 2) and then the report is broadly structured around the assumptions detailed above. Thus: Chapters 3 and 4 present views, respectively, on strengths and weaknesses of peer support working; Chapter 5 distils lessons learned in overcoming issues that were identified as challenging; Chapter 6 takes a case-study approach, illuminating why one health board area chose to introduce peer support working and why another one has not gone down this line (to date); the focus of Chapter 7 is on the nature, focus and format of evidence that decision makers might find useful, and more specifically, engender higher levels, and more effective, peer support working across Scotland. The report concludes (in Chapter 8) with some short reflections from the independent researcher who authors this report.

Quotations are included in Chapters 3 – 7 on order to help bring the findings alive and in the interests of transparency. However, for a quicker read, these can be skipped without any loss of meaning.

A note on terminology

Throughout this report, the term service user is frequently used to refer to people who are the intended target group of, or who have used, a peer support service. We use this term to differentiate those individuals from the peer support workers themselves. However, we recognise that the term service user is a contested one we and have attempted to use ‘people’ and ‘individuals’ where we can.

Intended use of this report

This report is not an end-point. It has been commissioned by SRN in order that it, together with its expert advisory group and other colleagues, can decide on the implications for SRN, in particular regarding its evidence translation function. It is hoped too that it will provide interesting reading for those who are embarking on, or already running local peer support services.
2. Research methods

Overview

The research methods were qualitative and took the form of 19 one-to-one telephone interviews with stakeholders in two (selected) Scottish health board areas. In addition, a focus group was run with the Scottish Government’s Involvement Implementation Group: Peer Support Sub-group as its members were acknowledged as having informed perspectives on issues (including barriers) relating to the introduction of peer support working in local areas.

Recruitment

SRN identified two health board areas for inclusion in the research: one which is known to use peer support workers and another health board which does not.

In view of the potential sensitivities on reporting on barriers experienced in relation to peer support working, from the outset we assured prospective interviewees that not only would their personal anonymity be protected, we would not disclose the names of the two participating health boards.

A note on reporting

Each health board area taking part in this study has been given a pseudonym to preserve anonymity. For the remainder of this report:

- The health board with no peer support workers will be referred to as Cluny.
- The health board with peer support working will be referred to as Mags.

Within each of these two health board areas, it was intended that up to twelve decision-makers should be interviewed. By decision-makers, we meant people in a position of influence about the nature of services that are made available locally. Thus, we anticipated that these are likely to largely comprise individuals holding high-level strategic positions.

However, as job titles are roles are likely to vary from one health board area to the other, it was agreed that the identification of appropriate people for interview proceeded along the following lines:

- SRN’s Director made the initial contact (by email) to an individual in each health board area who is known to SRN, explaining that the research involves hearing the views of people who are (or are likely to be) key to making decisions about whether or not to introduce peer support workers locally
- SRN passed the email response from these two individuals to the researcher (JG)
- the researcher asked these initial contacts which other individuals she should (ideally) be speaking to (and obtaining the contact details of these individuals, if possible)
- the researcher asked these secondary contacts whether there are other individuals to whom she should also talk.
To help inform the identification of appropriate decision-makers, the researcher used a checklist describing possible relevant roles. Thus, decision-makers were described as having high-level responsibility (in the health board, local authority or third sector) for things like:

- deciding on/setting the level of funding for recovery initiatives / services
- allocating funding for recovery initiatives / services
- funding third sector mental health / recovery services
- funding volunteer programmes.

Research participants

Ten took part in a telephone interview in Cluny and nine in Mags. As no new information or insights emerged from the last of the interviews in each of these two health board areas, a decision was taken to recruit no more people to the research. This is conventional practice in qualitative research when such ‘saturation’ is achieved.

Interviewees spanned a number of roles, all senior, and working in the health board, local authority or third sector. These included people with roles in commissioning, mental health service planning / leadership (in psychiatry, nursing, occupational therapy and social work), governance, and service specification, management and supervision.

As the focus of this research was on understanding the basis for decisions to introduce /use peer support working, the vast majority of interviewees worked within the statutory sector, mostly as health board employees. (For a breakdown of interviewees by role, please see Appendix 1).

As indicated earlier, this research included a focus group with the Scottish Government’s Involvement Implementation Group: Peer Support Sub-group. It was agreed that although a member of this group, the SRN Director would not participate. This decision was taken in order to ‘free up’ participants to talk openly about what SRN could and should do (better) to encourage peer support working across Scotland. Focus group participants included individuals working for the Scottish Government, local health boards, and third sector organisations (including peer support workers).

About the interviews and focus group

Interviews and the focus group were semi-structured. The main issues explored in the interviews and focus group are summarised in Table 1 (over).

Following consent from research participants, all interviews and the focus group were audio-recorded. Interviews ranged in length from 24 minutes to 1 hour and 9 minutes, with an average of 38 minutes. The focus group lasted just over one hour. All interviews and the focus group were transcribed in full to ensure that the full range of comments was integrated into the analysis.

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3 The topic guides are available, on request, from SRN.
Analysis and reporting of findings

Transcripts were read through several times and emergent issues identified. Where themes were identified, these were considered on the basis of whether they were cross-cutting issues or whether they were specific to a particular health board area (Cluny or Mags), sector (health board, local authority or third sector) or indeed individual.

Table 1: key issues explored in interviews and focus group

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Focus group</th>
</tr>
</thead>
<tbody>
<tr>
<td>• knowledge, attitudes, experiences and insights regarding peer support working;</td>
<td>• factors underpinning local decisions to use / not use peer support working;</td>
</tr>
<tr>
<td>• factors underpinning local decisions to use / not use peer support working;</td>
<td>• whether and how evidence might be targeted and tailored to meet the needs of local decision-makers, and engender their wider use of peer support working; and</td>
</tr>
<tr>
<td>• whether (lack of) evidence is a barrier to developing peer support working, and if so, what type of evidence would be useful (and persuasive); and</td>
<td>• how SRN might expand/refine its role in distilling and disseminating evidence on peer support working, in particular - for local decision-makers.</td>
</tr>
<tr>
<td>• how SRN might expand/refine its role in distilling and disseminating evidence on peer support working, in particular - for local decision-makers.</td>
<td></td>
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</tbody>
</table>

Unless stated otherwise, the reporting of an emergent issue or theme can be taken to be one that was shared across health board areas, sectors, and therefore individuals.

At times the report highlights a perspective expressed by (just) one individual. While this is acceptable / conventional practice in qualitative research, in the interests of transparency this report explicitly indicates any views that were unique to one interviewee.

Anonymised identifiers are provided after any quotations. These indicate whether the interviewer works in Cluny or Mags, but provide no further identifying information so that views cannot be attributed to any individual.
3. **Perceived strengths of peer support working**

This chapter first summarises interviewees’ views on positive aspects of peer support working before moving on, in the next chapter, to the challenges that they identified.

**Some context setting**

A wide range of strengths were identified. Generally these were described in relation to the benefits conferred for people with lived experience – both those service users who receive support from these workers and for the peer support workers themselves. In addition, interviewees in Mags highlighted benefits for the wider services in which peer support workers are employed, in particular, by contributing to stigma reduction.

‘People who have a lived experience are suddenly no longer just their patients, they’re also their colleagues, and I just think this should be an age of having peer support workers around, it does encourage people to think a wee bit more about their day to day thoughts, about the language they might use, about how they interact with their clients.’ [M.I4]

To set the views in context, it is important to also highlight here that the **additionality** of peer support working was often stressed. Thus, interviewees frequently framed the benefits of peer support working in terms of added value rather than as an alternative to existing service configurations and staffing: they viewed peer support working as an **expansion** of their multi-disciplinary approach.

‘I think it (peer support working) gives people another choice, another invitation, that there’s a different way of looking at things and a different way of working through whatever current problems that you’re having. ...it’s very much a part of the kind of multi-disciplinary approach, you know, it contributes well.’ [M.I8]

‘I think probably what makes it powerful is that where we’re coming in from a professional capacity, someone’s coming in from a very personal point of view as well, so it’s the same message, but it’s perhaps in a different context, which could just make it a bit more powerful.’ [C.I7]

For the **purposes of reporting**, the findings below differentiate benefits for, on the one hand - ‘recipients’ of peer support, and on the other – the workers themselves. Importantly however, a key benefit of peer support working that was identified was its **mutuality** i.e. that peer support working is a reciprocated (two-way) relationship that is mutually beneficial. So while the term ‘receiving support’ is used at various points below, it is used within the context of a **partnership** that involves active participation by those employed to provide peer support (the workers) and those receiving it (the service users).

*It’s that true partnership with the person using the service - the person-centred health and care part, you know, when what’s written in the care plan is a true reflection of where this person is and where they would like to go, you know, and how they would*
like to move forward, and who they would want to involve in their care. I think sometimes it's a bit - who’s responsible for this or who’s credit is this to, but it has to be the person using the services, and we all need to be embracing working together, you know.’ [M.J8]

The worker-service user relationship as a bedrock for support

Interviewees highlighted attributes of the peer support worker-service user relationship that they considered to offer benefits to those receiving support.

First, the fact that peer support workers have lived experience was seen to engender among service users a sense of being supported by someone who understands how they feel because that individual has ‘walked in their shoes’.

‘Very often when you’re sitting within your mental illness you think that no one else can possibly feel the way you feel, and while you have to recognise that we’re all different and our own journey will be different, it’s sharing that personal experience and the realisation that they’re not on their own, is a major thing.’ [M.I3]

Next, the understanding that peer support workers have due to their lived experience was considered to help build rapport and bring (added) authenticity to relationships with service users. This, in turn, offers a strengthened basis for providing support:

‘I think when you get into the heart of what peer support working is, fundamentally it’s about the relationship between the peer support worker and the peer…. You can’t support somebody, you can’t work with somebody unless you have a very strong, therapeutic or working relationship with the individual, and that lies at the heart of the relationship, and when you combine that with other experiences it brings an authenticity to the relationship that cannot be manufactured.’ [M.I5]

It was not just authenticity that was considered to be a key positive feature of the relationship however, but also that the relationship is more equal.

‘I think it’s a non-judgemental... the person’s on an equal footing with the patient or the person that they’re supporting... so I think it’s more about having that, you know, sense of someone who sits alongside you and who understands you completely.’ [C.I10]

The absence of the power differentials that can exist in traditional practitioner-patient relationships was seen to open the door to individuals talking about what matters to them and in turn, providing opportunities for the support that they receive to be more holistic and service user-led:

‘They (peer support workers) have a different perspective and therefore they’ve got a slightly different relationship and a different kind of link that maybe allows additional information or additional support that maybe the more formal professional staff groups might not always be able to achieve ...it’s more equal... I think it gives them a more holistic just...view of...and you can get some information that you maybe wouldn’t get about patient’s lives and about what their aspirations are and what
they're looking for, and what they need in terms of support, where they want to get to... [M.16]

In fact, the peer support worker was seen to approach individuals’ needs from a different starting point altogether (from an appreciation of the people’s aspirations) and offer support in a manner that is intensely human, person-centred and flexible:

They’re an absolute breath of fresh air and people who do come into contact with them will say ‘that was great, that was just fantastic and the way they dealt with it was just unbelievable’, and yeah...it’s just so different, they’re not tied down to some of the policies and procedures that we have to adhere to! They see people as people, whereas we still tend to see people as something to be fixed, clients that are there that you solve problems with, you know? Whereas peer support workers...they do it in a different way, they approach things in a different way, they’ll sit down and tell stories and talk about people’s hopes and dreams, you know rather than saying “now what’s the problem, how can we fix it?, take them with them... [M.12]

Thus, from interviewee accounts, the relationship between peer support worker and service user was considered to be not only qualitatively different to that developing between service users and others who more traditionally provide care, but importantly – that this relationship enables service users to consider a wider range of options than might be the case otherwise. Importantly, the options that are likely to be considered will be self-help ones:

‘While we can look at evidence based treatments and medications, psychological therapies and interventions, they are more in tune I think with more of the kind of self-help and self-management techniques that people understand.... I think it just adds something, a different dimension to people’s care and treatment that they otherwise wouldn’t have.’ [M.17]

There was therefore a view that peer support working contributes to self-management approaches, and therefore individuals’ self-efficacy and empowerment both directly (as indicated above) and also indirectly, through influencing the mind-sets of others in the multi-disciplinary team:

‘It’s also about challenging services to keep the person in the centre of all the decisions that we make, so it's that reminder of doing that. ...act as a prompt and a reminder as managers, to keep that in mind, that whatever it is you’re developing, you’ve got to keep patients at the centre of that. ’[C.17]

Supporting recovery

Across all Mags interviews and among those in Cluny who were better-informed about the peer support worker role was the contribution that this supportive relationship makes to recovery.

First, by dint of their lived experience, peer support workers were viewed as role modelling recovery and as a consequence - engendering hope both among service users (as indicated in the quote below) and also their families and carers.
‘A lot of people feel that when they’re in a very dark place, there’s no way out of it, but to have someone to say ‘I’ve been where you have been and there is light at the end of that tunnel’ can be a really quite powerful message to give someone.’ [C.I7]

Peer support workers were also regarded (primarily by Mags interviewees) as contributing to the recovery of those they support in more instrumental or practical ways. Thus, peer support workers were considered to play an important role in supporting people with their own recovery planning.

There were two dimensions to this assistance with recovery planning – first, helping people develop their own plans, and second, providing support in putting these plans into action.

‘The peer support worker will actually provide practical support to stand shoulder to shoulder with the person through that period of actually then connecting and overcoming some of the barriers that may prevent them from making that connection in the first place, so I think peer support workers have a really important part to play in helping develop those plans, but to actually help the person see those plans through, in a practical way also, which are completely person-centred …’ [M.I4]

In part, the support that workers offered involved signposting people to information and resources within local services and communities. In fact, there were instances in which workers were regarded as being better informed about what is available (and useful) locally than the health and social care professionals, particularly those working in acute settings.

The fact that peer support workers could capitalise on their experience and local knowledge to (re)integrate people back into their communities was therefore seen as a further strength.

Finally, the contribution that peer support working makes to the workers’ own recovery was highly valued. There were two inter-related aspects to this – the positive contributions to peer support workers’ sense of worth including their increased confidence and self-esteem (affective impacts) and also on their knowledge, skills and future employability prospects (instrumental impacts).

Interviewees talked about how these benefits of peer support workers are readily understood and appreciated within a dual-continua model of mental health (i.e. one that does not just consider the presence/absence of mental illness but includes a focus on wellbeing). There were interviewees (in Cluny) who were concerned that those who hold values that are deeply entrenched in a medical model may not value the strengths of peer support working as highly.

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4 The fact that Mags is using peer support working probably explains why these interviewees talked more than Cluny ones about tangible ways in which workers can contribute to recovery.

5 The dual continua model offers an alternative conceptualisation of mental health to a uni-dimensional clinical / medical model (one that defines health wholly in terms of the presence or absence of illness).
4. **Identified challenges of peer support working**

Initially this chapter was to be entitled ‘perceived weaknesses of peer support working’ – a heading that perhaps conveys a more balanced and objective reporting position in view of the previous chapter’s focus on identified strengths. However, as will become clearer below, participants stressed that they did not view peer support working, or aspects of it, having drawbacks, so much as believing that there are some issues that could present challenges. The title, then, reflects the views of participants and not a bias in reporting.

The challenges that interviewees identified most commonly were in relation to **implementation** i.e. ‘the problem’ with peer support working did not relate to the ‘idea’ of a peer support worker, but rather concerned some ‘hows’ of establishing and/or running a peer support service, including minimising risks.

‘Developing a service based on this model doesn’t come without exercising a lot of caution and thinking deeply about how you’re going to manage it.’ [M.I3]

The absence of evidence on effective implementation was highlighted as a key factor.

‘it (the evidence) was more about the concept of peer support. The setting up of the service – we were in the dark, really.’ [M.I2]

Both in Mags and in Cluny, interviewees talked of the challenges regarding processes that need to be put in place to make such a service effective i.e. governance and management challenges.

Importantly, Mags’ interviewees talked about challenges that had been experienced in their implementation of peer support working and, to some extent, addressed. What follows is a report on all challenges identified however, including outstanding ones.

**Funding**

One key challenge was the one of funding: in Cluny, there were interviewees who talked of the significant challenges of ‘finding’ the money to run such a service in the first place, in particular, within the context of their over-stretched budgets. In fact, in Cluny, there were interviewees who cited this as the main obstacle, and indeed barrier, to the introduction of peer support service in the area.

‘It’s all well and good for the Scottish Government to put this into the Delivering for mental health - it’s all very well them doing it but if they’re not backing it up with hard cash to help us pay for this then we ain’t going to play the game’” [C.I2]

**Getting the multi-disciplinary team on board**

In both health board areas, there was acknowledgement that even if a health board funds a peer support service, there can be challenges in engendering buy-in and support from the wider multi-disciplinary team.
‘It did take a wee while for…definitely some staff struggled with their role and with them being part of the team, and it took a while for that to get established, some staff were very supportive and very inclusive and it was absolutely fine, but some staff did struggle with it ....’ [M.I6]

One reason for this is that front-line staff can feel that their own jobs or that of others in the team – for example, health care support workers who are also on similar pay scales - might be at risk of being replaced by peer support workers.

Another challenge that was voiced was in needing to overcome staff concerns that the involvement of peer support workers may result in increased workloads. Such worries were based on a belief that their professional caring responsibilities would extend to having to care (and manage) these workers.

‘Frontline staff were worried that the expectation would be that they would end up carrying this person, almost as if they were an extra patient. So you’d have to do some really clear work around that.’ [C.I2]

Finally, integrating the peer support worker ‘as an equal and valid member of the team’ was identified as a challenge. The issue here was not just about convincing the multi-disciplinary team to accept peer support workers but, importantly, ensuring that that the workers’ perspectives are respected, their input is valued, and their involvement is not tokenistic.

**Professionalism**

There was a view that others’ concerns often had their roots in a misconception that the role is not a professional one and that all that is required is lived experience i.e. a lack of appreciation that the role specifically entails attention to (and compliance with) matters of governance, safeguards and quality.

**Confidentiality**

The issue of patient confidentiality was raised with attendant fears that peer support workers might breach these unless there was support and supervision in place.

‘I guess my only concern would be about making sure that if they had peer support workers in place that there’s very clear lines of where your personal stuff finishes and where your peer support worker role starts.....It’s not an obstacle because you can get through it – it’s a concern that if that wasn’t in place you could have someone who is in a vulnerable position, not really quite clear what their role is, and perhaps overstep the confines of that role....So if you have that clear supervision framework around that post, then you should be able to manage that.’ [C.I7]

However, there was an acknowledgment that while these are challenges that need to be overcome, they apply equally to all members of staff. Furthermore, one interviewee recounted a breach of these professional codes by a staff member, illustrating that challenges around role boundaries are not specific to the employment of peer support workers.
Peer workers’ wellness and wellbeing

In both health board areas, interviewees identified the need to consider workers’ own mental health.

‘When you have people with existing problems, they do need extra support in the workplace’ [M.I3]

As such, viewing this as a problem or an obstacle was seen to be symptomatic of the pervasiveness of a risk-averse culture in mental health decision-making and service design more generally.

‘We’ve got this kind of maternalistic view of we need to keep everybody safe and everything safe and on our heads be it.....I think there has to be a strong voice to work with HR and others through the bureaucracy of the service in terms of saying “we can safely do this, this has been tested in other areas, we can safely do this.”’[M.I7]

Notwithstanding the general risk-aversion principles underpinning service redesign, the need to ensure recruitment of individuals who are sufficiently resilient to deal with the emotional impact of hearing others’ experiences and stories was highlighted as a significant issue and that once in post – that workers stay well.

‘I suppose sometimes people’s own recovery journeys...they might think they’re slightly further on than they actually are.... I they sometimes can overestimate how well they are, how robust they’re feeling, and how strong they are to take on the roles. ...The only other thing I suppose is revisiting perhaps their own illness through other people’s stories. That can be difficult as well but I also...although it’s a...maybe slightly a downside, I think it’s also something that can be managed through good support, through good supervision and things like that. So there can be disadvantages, but I don’t think they’re insurmountable’. [C.I3]

There was also a view that the emotional demands of the role might be compounded if workers find themselves working in the ward in which they had previously been treated, and indeed – with the staff who had cared for them at that time. This scenario was seen as a distinct possibility in smaller health boards in particular. Furthermore, there was a view that if a worker had had a bad experience in the ward, they could be especially vulnerable.

However, interviewees also highlighted the likelihood of there already being people with lived experience in the multidisciplinary team, and in some cases – people with undisclosed mental health problems e.g. nurses on the ward with a history of, or currently experiencing, mental health problems.

‘Now how many people that are employed by NHS XXXX (Mags) have mental health problems, you know, have had a diagnosis of depression, anxiety, other disorders? We’ll have umpteen people, and yet we probably feel more confident, because it’s a robust organisation with our HR processes and policies, that if somebody goes off because of stress of work or stress in their life, or something happened, it’s that “let’s try and support them, that’s unfortunate’, but that’s the way it is”. [M.I7]
Thus, while supporting the mental wellbeing of peer support workers was seen as a challenging issue because of their lived experience, the issue here was that such concerns should not prevent their employment. Rather the issue is the need to put in place appropriate systems of support. This is not to diminish the contribution that they make: an interviewee (in Mags) talked of peer support workers themselves saying that they do not want to be wrapped in cotton wool.

Importantly, while ideologically-speaking the need to provide workers with support was seen by many as an acceptable part of the ‘deal’, the intricacies of actually providing this support were identified as challenging, even among those who were extremely positive about the value of peer support.

‘I don’t mean that in that you can’t be unwell, of course that can happen, that’s a very realistic part of their role, but I think getting the right supports in places and when they’re new you don’t know people as well, so that sharing might be difficult for them because you’ve not built those relationships yet, so I think that’s not without its challenges, but I’m not sure what the solutions are forgetting that better, maybe it’s an experiential thing.’ [M.18]

In fact, in view of instances of Mags workers becoming unwell, there was a concern there that the challenges of maintaining peer support worker wellness had not been adequately resolved.

‘We immediately as a health service want to put hundreds of stuff around them and policies and procedures and guidelines, and it’s that kind of balance that we have to get, and I’m not sure that we’ve got the balance right yet, we’re still learning what that balance is. I suppose my only concern is that there might be some human beings who become part of the fallout from that, you know, there’s a couple of people who have become quite unwell when they were peer support workers and were readmitted into admission beds. That’s hard, that’s difficult for that human being, and you have to stop and ask yourself, did we contribute to that? [M.11]

From this last account, although not voiced, it might be inferred that if a worker becomes unwell, a further service requirement is to debrief staff members from the ‘core’ team both in terms of their own feelings about any part that they might have played in this, and also to reinforce the value of peer support working itself.

‘They have to go off sick obviously, you would anticipate that that’s possible, because of the nature of being a peer, ... and also that kind of I suppose fuelled a little bit the doubting people who felt -why would you have this role? It kind of just gave them a wee bit of fuel for an argument, “well there you are, you see, it’s not going to work because you’re not going to be able, you’re going to become unwell.”’ [M.16]

**Continuity and fragmentation**

In addition to the very real human concerns about the mental wellbeing of peer support workers, challenges were also raised in terms of the implications for the service itself if workers become unwell. One key issue here was the risk of service fragmentation and discontinuity for the service as a whole and in terms of the input service users receive.
Furthermore, as the following extract illustrates, while the possibility of sickness absence is a very real one, absences can colour how peer support is regarded:

‘They have to go off sick obviously, you would anticipate that that’s possible, because of the nature of being a peer, but it then made it a bit fragmented... and also that kind of I suppose fuelled a little bit the doubting people who felt – “why would you have this role?”... But that's the nature of peer workers, and that's why you’re wanting them to be there, because they've got that experience!’ [M.I6]

Thus, although absence may be accepted as an inevitable part of the package among those who value the role, among those who are more sceptical - absences were problematic not just for the service but in reinforcing ambivalence and even negativity.

For reasons of service continuity and ensuring staff buy-in to the service, the issue of peer support workers becoming unwell was identified as challenging and needing to be addressed.

**Threats to role fidelity: role blur and role dilution**

Two opposing forces were identified as potentially problematic – peer support workers forging friendships with those they support (role blur) and peer support workers becoming overly influenced by the values and practices of the health care team (role dilution). Each of these undermined were threats to the fidelity of the role i.e. the role being performed as intended.

First then, the matter was raised about the boundaries between providing a support role and something more akin to a friendship, and the implications that this might have for sharing relevant information with the multi-disciplinary team.

‘If somebody told you something in confidence but actually it’s quite important to that person’s care, or risk or whatever, so I suppose there’s just that slight danger of smudging the kind of relationship a little bit... it becomes more difficult if it becomes a friendship, it becomes slightly more difficult sometimes to be supportive in a more objective way I guess, it becomes much more subjective and sometimes that can make things harder.’ [M.I6]

In contrast to this, there were concerns that if they stayed too long in post, workers may lose their fresh perspective and start thinking of themselves as, and ‘morphing’ into, NHS employees.

‘In hindsight we realised that there is that point where you say if somebody’s in a post as a peer support worker, and they stay in that post, ... there become a point where they become an employee and not... they’re maybe so far away from their experience that that peer support part is smudged more towards them being a member of the team.’ [M.I6]

Thus, there were concerns that staying in the post of peer support worker for a prolonged time was not good for the service as workers’ input could become diluted.
Finally there were concerns about workers becoming burnt out, and therefore how to prevent this.

‘If you’re different, whether it’s a professional difference or a role difference, I think it can be very very challenging for individuals, and I think there’s a danger that people can get quite worn out, and that’s not about the individual, that’s about organisation and the culture, and I suppose my anxiety is how do we protect and support people so that their roles stay meaningful and productive for them as individuals, but also for the organisation, especially in times of significant organisational change.’ [C.I4]

In Mags, interviewees said that they thought that the role of peer support worker should be a time-limited one. Doing so, they said, would not only address the potential problems of burn out and role dilution, it would serve to allow workers to use their experience as a springboard to other things, including other employment opportunities.

It is notable, that this focus on future employment would seem to be a local viewpoint rather that an intended outcome of peer support services more generally\(^6\).

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\(^6\) Personal communication with SRN Director.
5. **Addressing challenges and lessons learned**

The findings in this chapter are based on the accounts of interviewees in health board area Mags and focus on the experiential learning that has emerged as it has commissioned and implemented peer support services in (local) hospital and community settings.

**Communicate, communicate, communicate**

The imperative to communicate was a dominant theme in addressing challenges and preventing and overcoming problems in achieving buy-in to peer support working. Therefore, interviewees stressed the importance of communicating to stakeholders both at strategic and operational levels.

‘Peer support working is so different and it’s taken a while for some of the professionals to appreciate that it actually works, and it’s a wee bit about chipping away and telling these rich stories so that the statutory services start to appreciate what it can actually do for people.’ [M.I2]

More specifically it was considered important to ensure that those ‘at the top’ (such as executive and non-executive board members) understand what peer support working is and appreciate its alignment with, and contribution to, the agendas to which the strategic partners are working (such as person-centred care and patient safety work streams). In fact, communicating with people at these highest levels was considered to be an ongoing necessity to ensure a strong two-way connection that would reinforce and sustain their understanding of peer support working and help engender a common / shared language.

‘It’s about connecting in with them, then they get that understanding.’ [M.I7]

Mags interviewees indicated that in the early days, there had been an underestimation of the importance of linking directly with the teams themselves e.g. staff on the ward and in community mental health settings. With the benefit of hindsight, interviewees stressed that it is vital to communicate to these teams what the service actually is and what peer support workers do. It was therefore considered incumbent on line managers, such as ward managers and practice nurses, to inform the whole team in writing about the role. Importantly, this should not be the responsibility of the peer support workers themselves.

**Identifying individuals with the hearts, minds and skills for the role**

In the previous chapter, it was highlighted that that there can be a misconception that all that is required in a peer support worker is that s/he has lived experience and that this misunderstanding can serve as an obstacle to commissioning services in the first place. The point was made that while lived experience is a requirement, it is not the only pre-requisite. Rather, it was felt that the selection process needs to identify people possessing a range of competencies that will enable them to develop a therapeutic alliance with the service user as well as working effectively within a wider team.

‘We want people to have insight into their own conditions, to understand their own recovery, to understand coming back to work might be stressful, and it might have a negative impact on their mental health. I think people need to have a clear…a very
good self-awareness coming into the role. I think that...the same kind of prerequisites that you’d look for in a support worker coming into the role - a genuine passion to operate in the field, being able to demonstrate empathy, a desire to support people and understanding recovery; and you know, good listening skills, an ability to keep and maintain records and understanding the requirements of maintaining records. The full range of skills or understanding that you would require from any support worker, any professional worker in the mental health field, you would be looking for the same skills. It's just that...well I'd be looking for somebody who has lived experience and being able to translate that into a therapeutic alliance.’ [M.I5]

As the above quote illustrates, the importance of workers having the hearts, minds and skills to perform the role was emphasised.

**Beyond tokenism**

In the previous chapter, one of the challenges highlighted is in overcoming a tokenistic involvement of the peer support workers in the team. To avoid this, Mags interviewees stressed that ward managers (in the case of inpatient services) not only describe the peer support worker role, but also endorse their meaningful integration as equal partners. Thus, it was seen as vital to: nurture / promote the right mind-set among team members; convey the expectation that the whole team will work in a supportive and professional manner; and send a clear message that any behaviours that undermine this will not be tolerated. In addition, the point was made that in order to engender peer support workers’ contribution as equal partners may require reasonable adjustments to workplace policies and practices.

‘... giving a strong message that we have commitment to this and we have an expectation that staff will embrace it, and staff will design and develop their day to day working in a way that embraces it. An example would be that because often the peer support worker will start at a different time from when the staff do their handover, we’ll need to be flexible about that so that we’ll need to be flexible and work in a way that ensures that when the peer support worker comes into the ward environment that we’re creating a space for an appropriate handover, for that to happen. So it’s not just for that...a values base and a philosophical perspective that...but the day to day way or working also matches practically the hours that the peer support worker works, and also specifically the work that they’re undertaking.’ [M.I4]

**Supporting practice and wellness**

Mags interviewees identified a number of specific considerations that they felt were key to supporting workers both in their day-to-day practice and in their own wellness.

Interviewees underlined that peer support workers have to be (re)assured of their own value and of the contribution that they can make to the multi-disciplinary team – more specifically that they are of equal value to other team members (a perspective that may be significantly at odds with the feelings of disempowerment that they have experienced when they themselves used mental health services).

It was recognised that generally speaking mental health wards are very busy places with ‘a lot of coming and going’. This can make these wards very stressful places to be. However, within
each ward, it is likely that there are specific dynamics at play. As a consequence, it was suggested that workers’ support must take cognisance of, and be appropriate to, the ethos, activity and challenges of the individual ward (or other setting) in which they are to work.

Day-to-day support for the peer support workers was felt to be essential, with measures in place to ensure both formal and informal support. Following some teething problems, Mags realised the need for ongoing visibility of the workers’ line manager both in terms of providing direct support and also to enable any emerging difficulties to be discussed and solutions found.

‘When it was new, the service, they (peer support workers) did report feeling quite isolated, and at times not feeling like part of the team, but that has definitely got better. And it got better with the more visible the person supervising them linking in- so having a supervision session, looking at what’s working well, looking at what the challenges are, agreeing with the person “are you ok for us to take this to the staff or the ward manager and see if it’s something that we can improve on.”’ [M.I8]

It was further stressed that line manager support should not be at the exclusion of other support. Establishing support from within the multi-disciplinary team itself was considered beneficial.

‘... link peer support workers with a link member of staff...I suppose a kind of mentor really on the ward, so that they always knew there was somebody, and also with the practice development nurses, who they could link in with as well.’ [M.I6]

Finally, there were measures to empower workers in addressing their own recovery and to help in the wellness of others that were highlighted as necessary. Thus, it was considered advantageous to: start two or three peer support workers at the same time in order that they can provide support to each other during training and induction; encourage and support workers in the development of their own Wellness Recovery Action Plans (WRAPs), and agree with whom these should be shared; and create ‘space’ (i.e. opportunities) for workers to come together, share their experiences and support each other.

**Achieving shared understanding in an evolving service**

From the section above, it is evident that it was necessary for stakeholders in Mags to respond to challenges as they emerged. In fact, it was this flexibility that was considered to be a key factor in service improvement.

One of the lessons learned was the need for absolute clarity about management responsibilities and lines of communication. However, as Mags was operating in largely uncharted territory, there were adjustments that (inevitably) had to be made along the way in terms of the role of the worker, and (on the basis of teething problems), to line managements procedures. Thus, interviewees stressed that there is a need to clearly communicate roles and responsibilities at the outset and also the implications of these as they evolve.

**Focusing on longer term outcomes for peer support workers**

In chapter 3, it was highlighted that one of the strengths of the peer support worker role is in individuals developing confidence and skills that in turn might be used for pursuing employment opportunities. In chapter 4, a challenge that was raised was when peer support
workers perform the role for too long, and there was a suggestion that this should be a time limited role.

In view of these considerations, there were suggestions that attention should not only focus on the peer support workers as they perform their role, but importantly – how their experience can be used to help them take further steps in their own recovery journeys.

‘I think you would want to see peer support workers moving on and developing and continuing their recovery into other things, and not to be sitting in a post indefinitely.’ [M.I6]

It was felt therefore that there was merit in focusing on the outcome that individuals wished to achieve from their experience of being a peer support worker for a time-limited period, and then provide support to help them achieve their vision.
6. Factors underpinning local decisions whether or not to introduce peer support working: a case study of two health board areas

Previous chapters have indicated that in both health board areas, interviewees talked of the value that they placed on peer support working. Similarly, in both areas, there was acknowledgement that peer support working does not come without its challenges. In this chapter, we look at the factors that seem to be associated with and perhaps help explain, the position of the two boards i.e. why might it be that Mags introduced peer support working? And why might it be that Cluny has not introduced peer support working, at least not so far?

Each of the two case studies is based on (and restricted to) the interviews from their respective board areas.

Why has Mags introduced peer support working?

There were several factors that seemed to be associated with, and explain, the decision to introduce peer support working into the Mags health board area (and its success in doing so). These were:

- its ‘avant garde’ culture;
- Its value base, in particular:
  - its commitment to service user participation;
  - its well-established and robust relationships with the third sector;
  - its commitment to recovery, and associated positive and strong relationship with SRN;
- peer support working having a high profile nationally and locally;
- buy-in across partner agencies.

A more detailed description of these inter-related factors follows.

A forward-thinking board

A common refrain among interviewees was that Mags is a board area with a willingness to innovate. For example it was described as being ‘more adventurous in terms of what they’re prepared to do and what they’re prepared to commission…’ [M.I5] Others described it as ‘avant garde’. This pioneering spirit was regarded as something of a foil to the risk averse attitudes that can pervade health and social care planning, particularly in smaller board areas which might be less able to carry such risks.

A value base that is aligned with and conducive to peer support working

The value base in Mags was seen to offer a context that was conducive to introducing peer support working. In fact, it was felt that it is not just a case that the values of Mags were consistent with those of peer support working, but rather that such values were (and are) a pre-requisite:

‘It has to be aligned with the value base of the organisation, this is very much of a value-based approach.’ [M.I5]

More specifically, Mags has a commitment to, and history of, engaging with mental health service users and carers. The account below serves to draw the distinction between tokenistic
participation as opposed to the Mags ethos and practice which was consistently described as ensuring meaningful involvement.

‘I think we felt that there was a real wish to want to do this for patients and for services, and for meaningful engagement from peer support workers, because I think xxx (Mags) are very good at meaningful involvement with service users and carers, we’ve got a partner organisation for service users and carers, and I think XXXXX (Mags) certainly just doesn’t tick the box for that one, I think they do have meaningful engagement with service users and carers, which is one of the reasons I came to work here actually, because I felt that they, as a board, did that well.’ [M.I1]

Such service user engagement was part of a wider and long established relationship with third sector organisations. These were felt to provide an extremely positive foundation for peer support working. Although not explicitly stated, it would seem that there was a high level of trust too as the board did not assert its control of all governance arrangements but rather enjoyed what interviewees described as ‘a shared governance approach’.

The final key value that was aligned with peer support working and which was identified as a reason for its introduction was the Mags commitment to, and extensive activity, in terms of promoting recovery.

‘I think that this is recovery in action. This is putting their money where their mouth is. It’s also about understanding the finer detail of how recovery is enacted.’ [M.I5]

As a consequence, peer support working was seen as a way for Mags to embed its principles and give these tangible expression.

So what do you feel are the key drivers to the decisions to introduce peer support working then?[JG]

Determination, kind of a commitment, embedding your value as base principles. you know, promoting recovery in this way, sharing responsibility, you know, the self-management, there’s a value in people’s lived experiences, I can’t think of a greater example of how to do that is to employ somebody, you know, to do that.’ [M.I8]

Thus there was a sense that when the proposal to introduce peer support working was first mooted, decision-makers were extremely open and receptive to the idea, at least in principle:

‘There wasn’t really any dissenting voices at all around the concept of it.’ [M.I6]

In fact, peer support working was regarded as a logical extension to what they were doing already.

‘I suppose it was more of an evolutionary thing rather than a revolutionary thing’. [M.I1]

Policy influence
Peer support working was seen to be fuelled by its high profile nationally and locally. Thus, there was mention of the Scottish Government, in its review meetings, specifically inquiring about progress in relation to peer support working. This was considered to be a reflection of
its high national priority, and serve to keep peer support working high on the local agenda too. In addition, in telling the story about why Mags had introduced peer support working, time and time again interviewees named one particular individual in their local health board whom they credited with playing a pivotal role.

‘Having somebody like XXXX leading it was very powerful too, he kind of...he took it with him if you like, and I think that was very powerful ’ [M.11]

This person was described as a knowledgeable and highly committed champion for recovery and peer support working (with strong links to SRN that amongst other thing helped keep him abreast of emerging evidence without having to dig about to find this). Importantly, this individual has a voice and influence in relation to mental health strategic development and local service modernisation / redesign.

Buy-in across partners

Clearly there was a context and appetite for introducing peer support working in Mags. The only aspect that had initially been perceived as a challenge was how this approach should be implemented. There was now praise for new formalised commissioning procedures that had been used. This included the clearly detailed service specification, and the clarity of the performance framework, governance and reporting requirements on specific objectives.

‘It’s been a very very impressive and structured and a very well detailed and very well thought out process of getting it to the point of concept, through to the point of commission, through to the point of delivery.’ [M.14]

The close relationship between one of the third sector providers with both Mags statutory services and SRN was also seen as a real boon: it was felt that the third sector was operating from a well-informed position and was on the same page as the commissioning parties.

As a key lead in the third sector said about its funding bid for delivering the service:

‘We were playing to an audience that had an appetite for the ethos or the model of peer support work anyway, so we didn’t have to be hugely persuasive’.?

Why has Cluny not (yet) introduced peer support working?

The fact that Cluny had not introduced peer support working was attributed to a number of factors. These were:

- financial issues / limitations;
- being responsive to policy imperatives and targets;
- dominance of medical model;
- timing;
- service user involvement rather than co-production.

Before expanding on these issues, it is important to highlight that while Cluny has not introduced peer support working, this is not to say that it is averse to doing so. In fact, it was

7 Respondent identifier not shown as doing so would allow the reader to link other quotes to him/her and compromise anonymity
common for interviewees to say that the very process of talking about peer support working for the purposes of this research, had served to raise its profile locally. In turn, there was a belief that this heightened profile was likely to reinvigorate discussions amongst decision-makers.

As a consequence, the identified barriers to introduction are those that have been experienced to date.

**Financial considerations**

Certainly, the most significant obstacle to peer support working that Cluny has faced has been a financial one. Interviewees agreed that the main barrier or ‘sticking point’ was that (local) mental health service decisions were being taken within the context of a requirement to make cost savings.

‘At the moment, you know, every year on year, and I’m sure you’ve heard this from every single person you’ve spoken to – “how do we save money?! How do we save money?!” Not - how do we bring in something else that might cost us money? It’s how do we deliver in an organisation that is constantly seeking to cut things rather than to develop new things.’ [C.I9]

This pressure to reduce costs brought into sharp focus cost-benefit considerations – crucially which posts would need to be foregone to enable resource re-allocation to peer support worker instead.

‘The question is, how could we afford this? How could we move towards it? ... What other posts would I have to cut in order to finance that kind of role? So what we always have to consider is not always just about the costing benefits of these peer support concepts, it’s costing benefits of developing a peer support concept in combination with the cost benefits of making changes and probable reductions to something else within the services, in order to pay for it.’ [C.I1]

The fact that Cluny is a relatively small health board and therefore has low numbers of staff from specific professional groups (such as occupational therapists) was seen to limit its flexibility to convert an existing post to that of a peer support worker.

**Perceptions of peer support working being of low strategic priority**

In view of financial pressures and indeed the fact that decisions were made within the context of competing demands, interviewees reflected on the fact that peer support working was not reinforced as a strategic priority by the Scottish Government in its review meetings with them.

‘I think XXXX (civil servant) has pushed it a little bit, but clearly not very hard, otherwise...you know, normally when the Scottish Government say “jump” the health board says “how high?”, and the last mental health review meeting that we’ve had in

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8 Note – this is in stark contrast to the both the perspective and the experience in Mags.
XXXXX (Cluny), they just were not interested in some of the softer stuff; it was all about meeting HEAT targets and stuff like that.⁹

It was felt, therefore, that if the Scottish Government not only asserted peer support working as a priority but made health boards more accountable for delivering on this commitment, this would elevate its position above other competing priorities.

‘If there’s a Government directive, then of course we have to work towards that.’ [C.I9]

‘Until there’s an ultimatum, I don’t think people are going to just do it’ [C.I4]

Dominance of a medical model
The next issue that was raised was of NHS mental health services in the area being strongly underpinned by a medical model. In fact, this was an oft-recurring theme.

‘I think that the medical model is still the dominant model in mental health service provision here ...the power still sits with the medical professionals’ [C.I4]

Interviewees talked of the leads within the NHS largely assuming the responsibility for service design and of there being very limited opportunity for other partners to play a significant role in the decisions taken. The absence of a joint mental health strategy with the local authority was seen to both reflect and contribute to this – a point made by interviewees in both these services. It was felt that one of the implications of this was that clinical outcomes assumed a high priority and that they did so at the expense of also prioritising the holistic needs and preferences of service users.

‘An illustration of the different priorities would be like two inverted triangles against each other where all the ‘softer’ stuff (holistic needs and preferences) of what is important to service users and carers would be in a triangle with its point down and it would be the reverse for managers and finances that would represent clinical outcomes and financial ‘efficiencies’. So at the end of the day it feels like it’s the HEAT targets versus user carer involvement.’ [C.I2]

In fact, there was a view that one of the reasons that peer support working had previously been rejected was that there had been a perception that service users might ‘not take the side’ of the medical profession. This was not just seen as an issue of lack of trust, but also indicative of a culture clash.

Interviewees reflected on the fact that Cluny has introduced recovery practices in the area. Despite this progress, however, an outstanding need to embed recovery across the health board area was specifically identified as a further (and more specific) issue. Without this, it was felt that peer support working would not have the necessary foundation.

‘I suppose it’s what comes first - the horse or the cart? Until they really get recovery, they’re never really going to get peer support working, and I’m not convinced that they get recovery.’ [C.I4]
This non-conducive value base could, at times, discourage even those who believed in peer support working to actually champion it. One reflected that there was little point ‘trying to push something that was dead before it even rose out of the water.’ Certainly, among some of those who were extremely keen to see peer support working introduced locally, there was a sense of resignation. This took the edge off their appetite to continue pushing for it.

At the time of these interviews, however, there was talk of recent progress in relation to recovery: although recovery-focused practices were not considered to be embedded, it was felt that now there was more ‘openness’ to supporting people in different ways. Thus, there was a view that although Cluny had not previously introduced peer support working, the culture is more conducive to doing so than it was before.

**Timing**

It was suggested that timing is critical, and that Cluny was not (yet) ready to embrace peer support working when it started to assume a national profile.

‘*When peer support work started to be promoted nationally, this organisation wasn’t ready for it.*’ [C.14]

It was noteworthy that in contrast to Mags position as an adventurous board area, interviewees talked of Cluny often being slower in taking on the thinking and developments that might take place in more progressive or pioneering board areas – a factor that was particularly acute now due to the financial pressures that it faces. This might suggest then that the issue one of timing.

Support for this comes from another line of reasoning. It was suggested that once many boards have peer support working, Cluny is more likely to feel compelled to follow suit. It was felt while previously there had been few examples of (other) board areas introducing peer support working, the landscape is now different. Nevertheless, as it stands now, the absence of peer support working in Cluny seems to be partly explained by the fact that a ‘tipping point’ has not yet been achieved nationally i.e. because peer support working is not the norm, Cluny does not feel driven to fund such posts.

**Service user involvement rather than co-production**

There were views that service user involvement in strategic decision-making is not strong in this health board area. That is not saying that it doesn’t happen; it was considered that attempts are made to obtain service users’ (and carers’) views on specific issues rather than more active and ongoing involvement with them in decision-making processes. The absence of co-production between the NHS and the third sector was seen not only as a missed opportunity for achieving shared understanding and focus, but, more specifically, as a barrier to peer support working being introduced locally.

‘*I’m always wondering why the NHS and the third sector don’t work hand in glove and allow that empowerment and that co-production to actually take place. ... Joining those two forces together would give huge empowerment to both of those organisations, to allow, I think, complete peer support to take place...*’ [C.13]
7. The role of evidence in decision-making: what would be useful?

The research being reported here was underpinned, in part, by assumptions that if we establish what evidence decision-makers want and/or would find persuasive (and the format in which this evidence should be provided) and if meet these needs, then the uptake of peer support working would increase.

This chapter therefore presents views on a range of issues concerning peer support working evidence. In doing so it looks at not only what kinds of evidence people feel they would find useful, but also views on what might be influential in terms of persuading other decision-makers to introduce peer support working.

The findings are based on the interviews and also the focus group10.

On definitions

Interviewees were generally very well informed about what peer support working is. There were however, two grey areas that emerged from (some) interviews in Cluny despite the researcher explaining at the outset the distinction between informal peer support and the formalised and paid role of peer support worker (and emphasising that the focus of the interview lay exclusively on this very specific role).

Among some interviewees there was at times, a blurring between the formalised role of a (paid) peer support worker as compared with other types of peer support. Therefore occasionally the term peer support work was used to refer to the provision of informal support (such as 'meeters' and 'greeters' in hospitals) and to advocacy support.

In contrast to this, there was a misconception amongst some that the term 'peer support worker' refers solely to those who have been through the accredited training course.

Finally, it was notable in Cluny, that when interviewees talked about peer support working, their descriptions referred to working in hospital settings only. This may suggest that when people think of this role, they do not immediately think of the potential role of peer support workers in other settings such as the community, primary care services etc.

Decision-making – a hearts and minds affair

Interviewees and focus group participants were asked what they thought about the assumption that lack of information or evidence on peer support working is a significant obstacle barrier to local decision-making.

To set these within context - we need to bear in mind the other factors that influenced decisions.

10 As described in the Methods chapter, the focus group was the Scottish Government's Involvement Implementation Group: Peer Support Sub-group.
So, we have already seen that a key reason for Mags introducing peer support working was because doing enabled it to build on their wider recovery-focused principles and practices.

‘It’s not only about the hard evidence, and about the type of evidence you look at, but it’s first and foremost also about the philosophy and value base about which you want to provide your services from.’ [M. I4]

Thus Mags’ decision was underpinned by value-based considerations. Similarly, within Cluny, there was an openness to peer support working because it was seen as a laudable approach.

‘The issue that we’re talking about now is the sort of thing that even without the strongest evidence, it’s worth considering because it’s got a degree of face validity.’ [C.I1]

It would seem then that the process of deciding to, and then develop, peer support working is a hearts and minds affair and that peer support working requires a supportive value base first and foremost. More specifically, as we have seen in the case study presented in Chapter 6, a strong value base combined with a culture that was not overly risk averse was sufficient to tip the balance to Mags introducing peer support working including extending its use to a setting wherein it had not been tried and tested previously (in Scotland).

‘...so we just took a leap actually! We really took a leap because it's never happened before, that kind of service was never commissioned before, but we knew it worked because we'd evidence in XXXX because of our peer support workers in hospitals, so we knew it worked, and we took a leap, and absolutely it has worked out for us.’ [M.I2]

From this research it would therefore appear that there is an issue of the extent to which decisions to introduce peer support working are actually driven by evidence. While this was considered to be a sensitive issue, some interviewees talked of decisions at times being taken in the absence of a sound evidence base. Furthermore, there was a view that while evidence is useful, lack of evidence should not necessarily preclude action.

‘I do think that in your face evidence is really the way forward with decision makers, but I do also think that sometimes it's just do it, you know.’ [Cl.3]

**What evidence is desirable or needed?**

The arguments for peer support working were generally well understood in terms of the intended, likely or actual benefits that these would be bring to those receiving such support. Thus even interviewees who, by their own admission, were not well-informed about the topic were able to articulate the anticipated benefits both for those providing and those receiving support.

‘I can see the potential benefits of peer support workers...potentially in all of those areas. I can see how, as I said earlier how the understanding of the current patient could be enhanced and the comfortableness of the current patients to talk about
things could be enhanced potentially in some patients. I can see that as a...if you like, as a theoretical potential gain, yeah.’ [C.I1]

Among those - and this was the majority of interviewees - who strongly believed in peer support working, there was a view that the evidence that decision-makers ‘need to hear’ comes from personal testimonies. Such personal stories were highlighted again and again as being highly impactful. Accordingly, there was a groundswell of opinion that evidence should come from the workers themselves telling real-life stories that testify to the positive impacts on the lives of service users and workers. This was seen to serve to make the evidence ‘alive’, ‘not just abstract’ and more memorable.

While such stories were generally considered to be extremely powerful, this does not necessarily mean that these will be persuasive, at least not by themselves to those who have the power / influence to make decisions on what is funded and/or on service redesign.

‘I’ve heard a lot of people speaking about their experiences, and I’m sure that my colleagues have heard a lot of those personal stories too, not all of them, but I would say most of the decision makers at some time have heard those stories, and that’s what does it for me, but it obviously hasn’t done it for them!’ [C.I4]

Furthermore, as we have already seen the barriers to introducing peer support working at a local level do not arise from a failure to understand key benefits for those providing and receiving this support. People largely seem to ‘get’ these.

‘I can’t imagine much negative attitudes towards it. I don’t think there’s any issues in that sense, but as you say – actually getting people to do it. We all say. “yeah, good idea”, but unless someone gives us some money, we don’t do it. But I think implementation is the key.’ [C.I6]

Therefore, although personal stories were seen as extremely useful for presenting recovery journeys and for illuminating how the input of a peer support worker can contribute to these, there was acknowledgement that these may fail to address what matters most in the minds of decision makers.

‘We’re talking about commissioners here, we’re taking about bean counters, we’re talking about procurement teams, and senior executive management teams. They’re not interested particularly in the softer side of things, how well a peer support worker will support someone, as opposed to a support worker themselves.’ [M.I5]

‘It’s the quantitative evidence that clinicians are looking for, and that’s what will speak to them... if we’re going to convert the thinking of clinicians, that’s the type of evidence that they’re used to looking at, and value.’ [Focus group participant]

The role of evidence in addressing decision-makers’ barriers to introducing peer support working
From this research, the main barriers to peer support working seem to relate to three key issues:
A perception (or misconception) that peer support working is not a high government priority.

Funding and resourcing, including weighing up the cost-benefits of peer support working as compared with other service options and/or staffing configurations.

How to develop and deliver a peer support service, in particular, in view of the pervasiveness of risk averse cultures.

The sections that follow present views on how these barriers may be tackled via evidence.

**Strategic position and promotion**

We saw that Mags interviewees made reference to the Scottish Government enquiring about progress with its peer support working. This was not the case in Cluny. Reportedly, in Cluny’s review meetings, the Scottish Government does not actively enquire, pursue and hold them to account on this matter.

Interviewees felt any (effective) drive to encourage more boards to have peer support workers should involve a stronger steer from the Scottish Government; and that they should champion this with commitment, conviction and evidence that is relevant to, and convincing, in view of areas’ local circumstances.

‘Even though it was in the very original mental health strategy of Delivering for Mental Health all those years ago, that still needs to be balanced with ‘is it right for us in this particular local area?’ So there needs to be a directive or an endorsement or an encouragement, but that needs to be balanced with a genuine enthusiasm and an evidence base that it’s something that is right for us as well.’ [C.I9]

We saw too that in Mags, the importance of ‘talking the language’ of decision makers was considered to be important. In particular, this involved indicating the contribution that peer support working could make across key policies.

Because of these issues, it was suggested that there be improved explication of the linkages between peer support working and complementary agendas.

‘Do you know maybe we’re missing a trick. We need to sell it in a more modern .... the NHS in particular are looking at improvement methodology, small bits of change and things, so maybe we need to brand it around a test of change and improvement methodology and follow that process through’.

‘If you think of what’s happening with assets just now, and it’s the big buzzword, and everybody’s talking about assets at the Scottish Government, and that’s the big...and what’s the evidence base (for) asset based approaches... is there something about that framework that can market it...’

[Exchange between two focus group participants]

Thus, there was a sense that peer support working should be promoted in a more joined up manner. In part, this is about being more explicit about the evidence for how peer support working contributes to a range of outcomes (e.g. learning, employment, volunteering, asset-building etc.) and uses the language appropriate to these.
Decision making within the context of budgetary constraints and unmet needs

We have seen that financial considerations and constraints were cited as a significant barrier to introducing peer support working into the Cluny area. In fact, among those holding most authority / power in making decisions about local NHS mental health services there was a concern that any assumption that lack of evidence explained Cluny’s position, failed to reflect the local situation.

‘.... I would refute that assumption.... The case has already been argued about how valuable this is. The main issue for us is around how we actually resource this; how we actually fund it. That’s the big issue for us.’ [C17]

Without a doubt, resourcing was a salient issue in Cluny. Accordingly there were calls for information on funding opportunities or streams.

‘... if there is any other funding source that we can be advised of, that we could tap into, or any creative ways of being able to tap into some other funding that would be really quite useful. [C.17]

The reference to thinking creatively about funding streams resonates with the point made in the earlier section about capitalising on the alignment of peer support working with other agendas.

The other set of needs arising from the pressure to make decisions within financial constraints was in relation to weighing up things like social return on investment, cost effectiveness and cost-benefits.

‘I think evidence would be the key thing, especially if it could be linking access to peer support with improved, more efficient use of services, financial efficiencies.’ [C.16]

Accordingly, interviewees highlighted the need for a financially robust argument or case that presented information on matters regarding cost effectiveness and efficiency.

‘If you could demonstrate by the introduction of a peer worker into an acute admission unit, that your average length of stay dropped by 7% over the course of the year following the introduction and there were no other attributable factors, then that would move people to introduce them, because they were getting a cost saving then.’ [M.15]

It was therefore felt that the evidence that was needed to make decisions about allocation of funding should include information on outcomes and how peer support working compares with other approaches i.e. what service or staff configuration would yield the ‘best’ outcomes within the available budget, or what additional outcomes would be achieved through additional funding

‘I think there is the business case to develop, and that gives those in authority the ability to justify the decision, and we don’t always do that very well.’ [Focus group participant]
It perhaps needs to be restated here – concluding that there is a need for a 'business case' does not suggest that there is currently a lack of interest in personal, including recovery, outcomes for service users and carers. The issue is how these outcomes might be better realised through introducing peer support workers e.g. redeployment of existing resources (such as converting posts) or through additional funding.

‘Well the board being the board tend to like a balance of what I would call hard measures and soft measures. I mean your hard measures might be some of the things that I’ve mentioned around reduced admissions or reduced length of stay, less hours spent receiving care. Everything’s got a cost attached to it, so for instance, something that’s gone from X number of CPN visits a week to a much more reduced level. So those kinds of hard measures that from a service point of view would say that person has recovered more than another person if you like, as well as the kind of soft measures like, you know what you said to me, testimonies from service users as to what was valuable to them, and how they felt, and what their experience was like.’ [C.I9]

Evidence on the full range of outcomes was therefore seen as important, and this included evidence on the difference that peer support working makes to people’s recovery.

To reiterate then – the point being made here is of an unmet need for ‘hard data’ of the sorts described above, for those making decisions on budget allocation and service (re)design, particularly within the context of a budget-squeeze.

**Developing and delivering a peer support service in a risk averse culture**

We have already seen that one of the explanatory factors for Mags introducing peer support working was that it was viewed as quite a pioneering health board area. In contrast, there was a view that other areas can be far more risk averse.

*A lot of the local authorities are hugely risk averse because of accountability, they’ll come back with accountability issues, you just need to look at the media when something goes wrong and social workers are up there trying to account for what they did wrong, or health board staff, and the amount of times they turn round and say “no, I’m not going to stand in front of the cameras and take the wrap”, so I think whilst it may seem trivial, it is a huge issue, people will not stick their neck out on something that is risky.’ [Focus group participant]

In Chapter 4, we saw that people did not identify any weaknesses or concerns about the peer support worker role in theory. Rather, they identified some risks – mostly risks to peer support workers themselves but also to service related issues such as professionalism, patient confidentiality, and service continuity.

As such, while their concerns about these possibilities may arise from a risk averse stance, it is notable that they were all not about the concept of peer support workers per se but rather about how to make this role operate (well) in practice. Importantly then, interviewees identified an unmet need for evidence on implementation.

*There’s not a lack of evidence around about its appropriateness and effectiveness... there is a lack about then “how do we go about making it happen?”* [M.I4]
As such, there was acknowledgement that setting up the service is neither quick nor straightforward, and therefore can be quite a daunting proposition.

‘There’s a few (priorities in Delivering for Mental Health) that we’re kind of slow on, but there’s certain ones that are very easy to do, and this is one that doesn’t feel easy to do.’ [C.I9]

Thus, while interviewees talked of the Experts by Experience guidelines being useful, there was nevertheless an unmet need (including among those who had read these guidelines) for evidence in relation to **setting up a service**.

‘To start at the beginning and have to go to the effort, and it is a big effort in a lot of areas to find out, well, who employs peer support workers, “but have they a job description, has that been through agenda for change, will HR accept it, is there the governance structures?”’, and actually, if you’ve got somebody that’s swithering, they’ll say “do you know what, we’re as well just going and getting a support worker”’, so I think if you’re building a business case, a business case is not just from a financial basis, but how easy it is to do that and how you can evaluate it as well.’ [Focus group participant]

**Building on learning**

Within Mags – a board area that we have seen is at the forefront of using peer support workers, the situation there is one of emerging insights, reflections and service-related adjustments. For example, in terms of managing / reducing risk, while local decision-makers had become more knowledgeable, there was acknowledgement that they did not have all the solutions, and as a consequence, there was still scope for (further) service improvement.

‘I suppose the same governing structures aren’t there for unregistered staff. I think that’s always going to be the dilemma between that very structured organisational want to put I think a safety net round it, and also to let peer support workers be peer support workers, and I don’t know what the answer is, and I think we have learned a lot, I don’t think we’ve got the answers, we’ve got more questions!’ [M.I1]

While many lessons have been learned, these have not been formally captured (through evaluation) and the embryonic evidence on implementation is based on the tacit intelligence of those involved. Nevertheless interviewees considered that their local insights should be shared in order that people – including other areas, could learn from, and build on, these.

The involvement of peer support workers themselves in this process of evidence sharing was further emphasised. It was felt that their role here should not be limited to them describing how the role had contributed to their and to service users’ recovery, but also to identify issues to do with what works well and less well in terms of their ability to carry out the role – i.e. aspects of, and implications for, service delivery.

‘It was very useful to hear them talking about what they did and how that influenced service users, and how they developed their role and how they developed their position in the staff team and all that kind of stuff. I found that certainly stuck in my mind more
in a memorable way .... Folk were saying “there was this barrier” or “this worked really well”, ... or “there was barriers because of this” and “this is how we tried to overcome them” and it worked or it didn’t work, you know?” [M.16]

It was further suggested that this emerging evidence should be *complemented* with practical resources such as protocols and templates.

‘I genuinely feel that we need to have an up to date kit if you like, that gives a job description, gives an agenda for change banding, gives you a specimen business case...’. [Focus group participant]

The key point was that it would help make things as easy as possible for areas in actually setting up a service and thereby *encourage* them to do so.

‘It’s just sometimes people are under pressure to do things, and actually, unless you’ve been nursing this gem for years and you’re given this opportunity and you’re willing to work all night on a Friday night, through the weekend, to have something for Monday that you have to validate with everybody and their auntie, you know, we need to make it easier.’ [Focus group participant]

**Targeting key stakeholders and tailoring evidence to their needs**

The importance of targeting key decision-makers was raised. As such, it was acknowledged that decision-making processes can be prone to power dynamics: issues to do with democratic decision-making (or the absence of this) and skewed influence (for example by individuals with the ‘loudest voice’) were seen to be important factors. Furthermore, the designation of the individual(s) whose remit it is, or might be, to decide on the introduction of peer support working can differ from one health board area to the next.

The quote below refers to a health board area in which there was considerable interest, and indeed ‘a push’ from the third sector but no steps have been taken (by the NHS and partners) to actually introduce a service.

‘I know that XXXX who is the NHS developer in XXXX is really keen to try and develop it, but there’s a view that it’s a commissioning role within XXXX health board. So if somebody’s got it into their head that this is a commissioning role, ok, let’s influence how we commission it, and that’s why I was saying to XXX, ok, let’s not spend any more time trying to influence people to employ peer support workers ....let’s look at what you commission and how you commission it, and support that process. And that’s what I mean about different areas will have different needs.’ [Focus group participant]

The conclusion then was that efforts (including evidence) must be directed to the root of local decision-making i.e. there is a need for a **targeted approach**. As suggested by the last quote, such targeting first requires an appreciation of the dynamics of (each) local area in order that the ‘right’ people are reached.

Moreover, interviewees highlighted the necessity for evidence that was *relevant*. As such, the notion of relevance pivoted on two axes:
• evidence that is, and is deemed to be, appropriate to the circumstances of the board area; and
• evidence that is useful in view of stakeholders’ specific roles and responsibilities.

In terms of the need for evidence that is relevant to local circumstances, there were contrasting perspectives. The first of these was the need for more evidence from Scotland. While those who were more familiar with the available evidence on peer support talked of the document *Experts by Experience* being useful, they felt that a stronger Scottish evidence base was needed. In contrast to this, there was a view that locally relevant evidence might be sourced from outwith Scotland or even the UK. Irrespective of the provenance of the evidence, it was considered that this should be made explicit in order to help people weigh up its appropriateness to local circumstances.

‘Certainly if it was me that was looking at stuff, I’d be looking for stuff that had come from similar areas to ourselves... it’s horses for courses. I think it’s just about being transparent about what it is that’s being offered.’ [C.I5]

Interviewees highlighted that they would want evidence on peer support working in urban and rural areas. In terms of the latter, particular challenges were anticipated in relation to maintaining confidentiality within tightly knit communities and the feasibility of serving geographically dispersed populations, including areas not well served by public transport. Although not made explicit, it would seem that these concerns relate to community- rather than hospital- based services.

There was recognition that the nature of evidence that is needed (and desired) by stakeholders is likely to be highly variable, and importantly, largely dictated by their roles and responsibilities. So, for example, as indicated earlier, those with a commissioning role were considered to be, and indeed indicated their preference for evidence on cost and cost effectiveness and efficiency, whereas those with a direct role in governance had particular needs around things like risk minimisation. Clinicians and the wider multi-disciplinary team might have a slightly different set of priorities. They may be particularly interested in service outcomes (such as length of hospital stay) and the difference that peer support working can make to people’s lives – insights that are unlikely to be provided by quantitative data alone and require qualitative data. In order to be persuasive, it was conceded that evidence needs to be *tailored* to meet these needs, and indeed preferences. As a focus group participant summed up - ‘we do have to play the game’.

Finally, the issue of credible and impartial evidence was stressed as important.

‘I’d prefer we’d select independent evaluation, where nobody’s got axes or agendas that they’re particularly trying to promote...... The written stuff (testimonies from peer support workers and users) is fine, but how do I know that that person’s written that? How do I not know that somebody who has got a particular agenda has helped them write that or has written it for them?’ [C.I5]

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11 We have seen from the other findings that this strengthened evidence base would be one that demonstrates the impact of peer support working across the *range of outcomes* that are going to be persuasive to stakeholders, and to aid planning and delivery (i.e. implementation issues).
There was a feeling that there is an outstanding need to generate the types of evidence that are needed. Independent evaluations were considered to be costly, and producing the cost effectiveness evidence even more so.

**How should evidence be shared?**

Overwhelmingly, those who were already convinced of the value of peer support working – indicated that workers themselves were those who would be the most effective conduits for sharing the evidence: it was felt their personal testimonies speak volumes and serve to illustrate the myriad benefits. Furthermore, as already reported, there were Mags interviewees who talked of how peer support workers could share learning not only on the impact of this role, but also on what works well and less well in terms of processes / implementation.

As the range of key decision-makers may not attend those events around the country which provide a platform for peer support workers to talk about their experiences (such as SRN conferences), it was suggested that it would be a good idea for SRN together with peer support workers to have a slot at the appropriate strategic planning meetings.

‘I think one of the options might be to bring a peer support worker speaker to one of our board meetings, and make sure that the people that can make the decisions are exposed to it. I think there’s been events here in the past where there’s been good attendance, but the bulk of people that have attended the events, whether they’re recovery events or they’re about peer support working, have come from the third sector. There’s not been huge input from statutory services. So it’s about how do you get the right people in front of you to hear what you want to say. ……it’s getting the right audience, and I think if you invite people to an event, people selectively don’t attend, like ‘I don’t have to worry about it’, but if you bring it to them in their forums, their meetings, they’ve got no choice but to listen!’ [C.I4]

Notwithstanding convictions that peer support workers are the most appropriate ambassadors for peer support working and central to sharing lessons learned on implementation, it is evident from the findings of this research that their personal testimonies alone will not lead to the introduction of peer support workers in all health board areas.
8. Conclusions and reflections

This research was commissioned to help understand and overcome barriers to introducing peer support working through evidence. As such, a key driver for this research was an assumption that decision-makers’ lack of understanding about the evidence on peer support working is a significant contributory obstacle to the adoption of this approach.

The Mental Health Strategy (for 2012 – 2015) identified a need to better understand the role and benefits of peer support working. Although it is would be inappropriate to generalise from the experiences of just two health board areas, this research would appear to suggest that failure to understand, in general terms, what peer support involves and the benefits it confers may not be the most significant barrier to the adoption of peer support working locally, at least not for all health boards. On the basis of the interviews in this piece of research, it would appear that SRN’s job in terms of describing what peer support working is and indeed the ways it can benefit individuals may well have been achieved with key decision-makers. That said, there were a few issues where more clarity may be required: the fact that peer support workers have a set of skills / competencies beyond simply having lived experience, that they operate within a governance framework, are paid, and can work in hospitals and community settings etc.

However, to realise the strategy vision for increased and embedded use, this research has indicated that such knowledge may be insufficient to trigger change across all health boards in Scotland.

Our research focused on the views of ‘decision-makers’ and yet the notion of decision makers’ needs is a difficult one as this might suggest that they are a homogeneous group. This is not the case. This research captures and reflects the diverse roles, responsibilities and interests of ‘decision makers’ for peer support working. Importantly, the evidence that would be persuasive to them varies according to the jobs that they hold. This signals the importance of producing evidence that is tailored to their respective needs. So, for example, those making decisions about service configuration are likely to require evidence on cost and cost effectiveness whereas those responsible for governance may be looking for evidence on risk minimisation.

Context for decision making
To understand where the potential lies for making a difference in the use of peer support workers, we cannot divorce the decision-making processes from the contexts in which these decisions take place. Hovering above the findings indicates three key contextual considerations that seemed to shape decisions:

- Strategic fit - the extent to which boards and their partners feel motivated or compelled to adopt a particular approach, in this case – peer support working
- Accountability – on best use of resources, governance, and indeed the degree to which health boards are answerable to the Scottish Government on delivering on policy priorities
• Capacity and capability – the extent to which health boards and their strategic partners know how (and feel equipped) to develop and deliver a service.

Unmet evidence needs
The contextual influences on decision-makers’ judgements and choices regarding the introduction of peer support working had specific implications for the evidence that research participants felt is needed.

• For strategic fit, evidence is needed on how peer support working is aligned with and can contribute to strategic priorities and outcomes, both the obvious ones like recovery, but also others such as stigma reduction, promotion of human rights (through empowerment), asset building, self-directed care, learning, employability etc.

• To address accountability considerations, evidence is needed on matters to do with making judgments on use of money and other resources such as costs, cost effectiveness, quality assurance, risk management etc.

• For capacity and capability, evidence is needed on what works well in establishing and running a service (as well as providing the information and tools that make it easy to do so).

Importantly, the evidence that is needed to overcome concerns / anticipated challenges about peer support working must address implementation. Doing so is vital not just to ensure that services ‘work well’: evidence on implementation is essential to encourage the more cautious / risk averse decision makers to opt for peer support working at all.

Supporting the creation of a stronger evidence base
Mags’ interviewees felt that they had learned a lot, but that they had still some way to go in refining their peer support services. So although Mags is something of a forerunner, it is not yet at a point at which it can provide unequivocal evidence of what works. There would be merit therefore for some formative, action-research in Mags. This may be something SRN might consider supporting.

Evidence dissemination
When it comes to sharing the evidence, personal stories were considered to be highly impactful, and those who were most committed to promoting peer support working locally saw such live testimonies as likely to be influential. However, some reservations were also expressed concerning the provenance and authenticity of such stories (and some cynicism that a peer support worker might be briefed and used simply as a spokesperson). Thus, while peer support workers have a crucial perspective and are effective in communicating this, a broader range of conduits for sharing evidence is required.

Beyond evidence considerations
Meeting the needs for evidence is not the whole story, however. As we have seen, the major stumbling block for Cluny was money. Therefore it is likely that decision-makers would welcome opportunities to tap into fresh / alternative funding streams. Articulating the links
that peer support working can make to other agendas may be helpful in this regard. However, it may not be sufficient to move a health board onto the starting blocks.

The extent to which recovery principles and practices are embedded was identified as a key factor. Quite simply, the commitment to, and enactment of, recovery principles and practices do more than just provide fertile soil for developing peer support working; they are pre-requisites.

In Cluny, imperatives to deliver on HEATs and other competing priorities for which it is held accountable prevented or undermined consideration of peer support working. Interviewees indicated that for peer support working to be introduced within the context of financially over-stretched services requires more than simply written statements in Scottish Government strategies; rather it needs to be a policy imperative, and like HEATs, one to which boards are held accountable e.g. at the review meetings with the Scottish Government.

This is not to say that there are no other ways to keep the profile high: it was noteworthy that in Cluny, interviewees said that participation in the research was serving to rekindle discussions about whether it should/could be introduced locally. SRN clearly can play a significant role in maintaining a profile for peer support working.

Mags has a long-standing history of working collaboratively with the third sector, whereas in Cluny such involvement seems to fall short from the principles of full co-production. As third sector organisations are likely to have a wealth of experience in service user involvement and peer support, they are a huge part of the solution to getting a service up and running. As part of a wider push to encourage the introduction of peer support working, it would seem sensible to reinforce this point. Working in close partnership with third sector organisations and to common outcomes may also present opportunities to capitalise on wider charitable funding opportunities.

**Concluding comments**

When producing a research report, there is always the hope to identify the ‘one key thing’ that, if addressed, will lead to the vision for large-scale change. This research has instead uncovered a whole host of issues that are likely to impinge on not only decisions on whether or not to introduce peer support working, but on how to do so in a meaningful and inclusive manner. Some of these are issues to do with evidence.

In view of the evolving nature of peer support working and the learning associated with this, there is something of the chicken and egg about the current situation. While we may have a pretty good idea what a quality service looks like, we may not yet have strong evidence on how (best) to achieve this. An interim step for SRN may be to develop consensus on, and indicators, of such quality in order to guide commissioning, implementation and to frame future evaluation and learning.

This research has reinforced that peer support working is a logical extension of recovery principles and practices. It would seem likely that the health boards that are most likely to be receptive to peer support working are those most committed to recovery values and practices. For just now, these perhaps offer the most promising place to start with encouraging wider use of peer support working, and as part of this, an investment in evaluation so that over time, we
can build a more sophisticated understanding of how to ensure a quality service in different contexts – urban and rural, hospital and community.

It would miss a trick to view peer support working as only being a recovery issue. Rather, there would seem to be added value in harnessing ‘the buy-in’ of partner agencies and through increasing and expanding explicit references to peer support working in complementary policies and agendas. Doing so would serve to increase the profile, support and potentially, funding of peer support services.

For peer support services to become the norm across territorial health boards may require more than simply local interest. From this research, it would seem that if we want to see all health boards having peer support services, a key mechanism to achieving this is increased accountability.

As such, it would make little sense to single out peer support working by itself to being a ‘must-do’; rather, any imperative to deliver peer support services would need to take place within the context of a focus on, and an imperative to enact, recovery principles and practices. The final issue is whether health boards should be called to account for their progress on this as well as other recovery practices.
## Appendix A: Details of interviewees’ roles

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<thead>
<tr>
<th>Cluny</th>
<th>Mags</th>
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<tr>
<td><strong>NHS</strong></td>
<td><strong>NHS</strong></td>
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<tr>
<td>General Manager for mental health</td>
<td>Performance manager</td>
</tr>
<tr>
<td>Clinical lead and director for mental health</td>
<td>Nurse with responsibility for practice improvement in mental health</td>
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<tr>
<td>OT service manager</td>
<td>Associate director of nursing</td>
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<tr>
<td>Lead for mental health nursing</td>
<td>OT lead in mental health nursing</td>
</tr>
<tr>
<td>Strategic planning and commissioning manager (across NHS and Local Authority)</td>
<td>Public mental health manager</td>
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<tr>
<td>Manager in service development / quality improvement</td>
<td>Council</td>
</tr>
<tr>
<td>Inpatient services manager</td>
<td>Service manager</td>
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<tr>
<td>Head of Adult Social work</td>
<td>Senior Social worker</td>
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<tr>
<td><strong>Council</strong></td>
<td><strong>Third Sector</strong></td>
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<td>Two managers in third sector mental health organisations</td>
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