**Title:** Welcoming peer workers in NHS settings; Facilitating readiness with an Early Intervention in Psychosis team

**Authors and affiliations:** Kyt Proctora\*,Rachael Wood**a,** Katherine Newman-Taylora,b

**a**Southampton Psychology Service, Southern Health NHS Foundation Trust, College Keep, 4-12 Terminus Terrace, Southampton, SO14 3DT, UK. Tel: +44 (0) 23 8231 0788.

bPsychology Department, University of Southampton, Shackleton Building, Highfield Campus, Southampton, SO17 1BJ, UK. Tel: +44 (0)23 8059 5108.

\*Corresponding author: Kyt Proctor, Southampton Psychology Service, Southern Health NHS Foundation Trust, College Keep, 4-12 Terminus Terrace, Southampton, SO14 3DT, UK. E-mail: kyt.proctor@southernhealth.nhs.uk

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# Welcoming peer workers in NHS settings; Facilitating readiness with an Early Intervention in Psychosis team

**Abstract**

***Purpose***

A pilot project commissioned to assess feasibility and impact of peer support in an Early Intervention in Psychosis service highlighted the importance of team readiness. This paper reflects on the lessons learned in recognising and facilitating team readiness in an NHS setting.

***Design/methodology/approach***

The literature suggests that mental health teams need to be ready to implement peer support, if this is to be done successfully. We describe the process of preparing for peer support, obstacles that arose, and ways that the team found to address these.

***Findings***

The team had actively sought to develop peer support for some time, and negotiated with Trust managers to agree these roles in principle. However, initially unspoken concerns about duty of care emerged as a key obstacle. An arguably paternalistic desire to protect potential peer worker colleagues from stress and distress could have resulted in unnecessary risk aversion and a narrowing of the role. Willingness and opportunity to reflect on the change in relationship from service user / professionals to colleagues enabled these concerns to be aired, and practical solutions agreed.

***Practical implications***

Team enthusiasm is not the same as team readiness. The team’s willingness to identify and reflect on implicit concerns facilitated an acceptance of the change in relationship with peer workers, which in turn enabled the development of standard operating procedures to ensure safe and effective peer support as ‘business as usual.’

***Originality***

This paper considers the process of welcoming peer workers in an Early Intervention in Psychosis team, and offers practical suggestions that may be of value to other teams seeking to implement peer support in similar adult mental health settings.

**Keywords:** Peer support; team readiness; early intervention in psychosis; adult mental health; service development; recovery

**Background**

Establishing peer support roles may be the single most effective way to drive recovery-focused change across mental health services (Repper et al., 2013; 2014; Shepherd, Boardman & Burns, 2010). The value of peer support is now recognised by national policy guidelines in the UK (Department of Health 2011; 2012; Schizophrenia Commission, 2012) as well as in Europe, Australia, New Zealand and the United States (see Repper et al., 2013).

In early 2016, our local CCG funded a year-long pilot to assess the feasibility and impact of peer support with the Early Intervention in Psychosis (EIP) team. This pilot yielded a six-session training package, three rounds of training, initial recruitment to voluntary roles, and a standard operating procedure (including all role-associated paperwork) for acute and community teams across the area.

The pilot scheme indicated that:

* peer support can have a considerable impact on a person’s recovery in a relatively short space of time
* many individuals are committed to this approach, including those who wish to offer peer support and multi-disciplinary team (MDT) staff who wish to see this be made widely available
* individuals’ commitment does not necessarily translate into team or organisational readiness for peer support.

Are we ready for peer support in NHS adult mental health services? This paper reflects on the EIP pilot in a way that we hope will be of use to others seeking to introduce peer working in their teams.

**Recognising readiness for peer support**

The EIP team had been discussing the need for befriending and peer support as a means of improving recovery outcomes since 2014. The following year, the Trust agreed a ‘Psychosis Pathway’ (Rathod et al., 2016), which included peer support in line with best practice guidelines (NICE, 2014). This was welcomed by the team as a basis for discussions with Trust managers to agree peer support roles as an integral part of the EIP team.

The team also responded promptly when offered training places for prospective peer workers, nominating candidates and starting to raise awareness of peer support with people accessing the service. All involved assumed the team was ready to commence peer support.

As the first round of people completed their training and started to look for roles in the service, many questions were raised about the logistics of employing peer workers. It became clear that further work was needed to prepare the team to work alongside people with lived experience as colleagues; while staff advocated for peer support, it is likely that some concerns remained unvoiced and that this might block successful implementation.

Teams need support to prepare for peer working (Repper et al., 2014). In consultation with the team lead, meetings were held to enable staff to express any professional and personal concerns, and reflect on these in a safe environment.

### What about our duty of care?

### Meeting as a team to consider questions or worries about peer support proved useful. The team were willing and able to be open about their concerns including:

* what if the person becomes unwell but does not recognise this – how do we respond?
* what if a service user’s distress causes the peer worker to become distressed themselves?
* can we be both care co-ordinator / support worker and colleague to someone?
* what about confidentiality – how much access will peer workers have to notes, and will service users be happy with this?
* what will they make of current practice in the team – will they be critical of us?
* will this change the feel of the team – will we be walking on egg shells?

The perceived tension between team members’ duty of care and their broad wish to welcome peer workers as colleagues was named, recognising the dialectic between seeing the person as a vulnerable adult who needs protecting, and a competent colleague who can be relied upon.

Some staff initially thought they would need to ignore knowledge of incoming peer workers in order to work effectively as colleagues. Others were concerned that our collective duty of care requires us to identify people’s vulnerabilities explicitly to safeguard against risk (The Care Act, 2014), yet as Morgan (2004) warns, our fear of harmful outcomes can interfere with positive risk taking. Prior to peer working, members of the team may be aware of a person’s skills beyond the role of service user, but will have had limited direct experience of the person other than as someone who accesses services, and this may also contribute to an unintentional limiting of our expectations of peer workers.

It is of note that during the peer worker training, these concerns were mirrored by some of those attending who underestimated their ability to self-manage and contribute to others’ well-being. Recognising that most managed their mental health for the 165+ hours each week when not seeing EIP staff, and reflecting on the impact of supporting each other over the course of the training, was useful in addressing these concerns.

When the question of duty of care was put to the pilot steering group, it was suggested that peers work with teams other than those they had accessed. This option was discussed in the training, though many people wanted to work with the teams that knew and understood them well.

Reflection on the change in relationship with peer workers from service users to colleagues enabled practical issues to be addressed in this context (see below). Concerns about the impact on the culture of the team were also explored, and a general consensus was reached that such change would be valuable, and that MDT staff and peer workers would be able to navigate these changes together.

Following these discussions, the first peers were recruited to the team and were genuinely welcomed. As with other colleagues, individuals’ privacy was respected, including with regard to personal knowledge acquired through previous relationships, and peers’ skills and strengths were used to inform the development of their roles.

**Practical issues**

***Confidentiality and access***

*Access to the team base* – Will peer workers be given independent access to the team base? If access was reliant on other members of staff, would this be undermining? As with all employees, peer workers have independent access to the team base on completion of routine recruitment checks (including DBS check and signing of confidentiality agreement). Peer workers sign in and out of the base, as do all members of the team, and follow the lone working policy. Their supervisor, usually the peer lead for the team (see below) is aware of their working hours and duties.

*Access to information about service users* – How much is shared with peer workers about those on their caseload? If office based, will they have access to more information than is needed for the role? Do peers attend team meetings where service users are discussed? The Trust volunteer policy informed discussions about these questions. Peer workers complete statutory and mandatory training expected of all staff, including training on information governance and confidentiality. Peers have access to information about service users, including current risk, to inform their work. Attendance at team meetings is agreed jointly by the team manager, peer lead and peer worker. If working as a volunteer, this may not be the best use of limited time. Those in paid roles have the same rights and responsibilities as all other paid staff and negotiate use of their time with their manager. We have found that peers’ attendance at team meetings supports the development of a culture in which each discipline is valued for the experience and skills brought.

*Access to electronic records* – Will peer workers have independent access to notes? Is this too much to ask of a volunteer? How will intervention sessions be recorded? Will Trust demands regarding note keeping impact on the work load of peers and their supervisors? At this time, volunteer peer workers do not access electronic records; notes are entered by their supervisor during debrief sessions after the day’s contacts. This was agreed as a means of reducing the administrative burden on part time peer workers, but may reflect remaining concerns about the role. Paid peer workers have the same access as all paid staff.

***Day to day support for peer workers***

The peer support training includes time allocated to develop a work-based WRAP (Copeland, 1999). The aim is to consider wellness at work, what is needed to maintain this, and what would be most useful in the event that they become unwell. When people apply for peer support roles, they are invited to share their work-WRAP with their supervisor, and discuss working arrangements in line with this.

The pilot evaluation included funding for an assistant psychologist to help establish peer support in the team. When peers were recruited, the assistant psychologist initially spent much of her time supporting their induction and supervising day-to-day duties. In this way, she was able to respond promptly to questions, concerns and difficulties that arose. It became clear that having one person acting as peer lead for the team was helpful to peers and the rest of the team in ensuring a smooth induction to roles that were new to all involved. The peer lead role has been included in the standard operating procedure (SOP – see below), with the expectation that the person is familiar with the detail of the local training and have a good working knowledge of the SOP. We hope that this role may be taken by someone with lived experience in the future.

***Trust responsibilities***

The risk of acting on individuals’ or teams’ enthusiasm for peer working without organisational level commitment is that peer support may be offered unsafely or ineffectively. This is not to say that we wait for Trust Board level direction, but that we need to ensure fit-for-purpose governance arrangements are in place, and that the organisation approves and is thereby required to implement these.

### An essential part of the pilot (if not as enjoyable as working directly with peers and teams) has been the development of a SOP. This outlines the evidence and benefits of peer support, specifies roles and likely interventions, and gives detailed guidance on the recruitment, supervision and referral procedures needed to ensure safe and effective practice. Liaison with our commissioners, recruitment team, human resources, occupational health and finance department was both time consuming and essential. The document was written to be applicable to community and acute care teams across the Trust. Key elements include:

### *Training and support for peer workers –* Peers applying for voluntary or paid roles are expected to complete our local training or equivalent. This outlines the core principles and impact of peer support (following Repper et al., 2013); invites people to reflect on their own recovery and readiness for peer working; considers how lived experience can be used to facilitate others’ recovery; enables people to develop their own work-WRAP; and rehearses key elements of the SOP regarding relevant policies and procedures.

### *Peer lead role* – Each team identifies two paid members of staff who are responsible for:

* induction, management and supervision of peers
* screening referrals
* facilitating initial meetings between peers and service users
* day-to-day oversight and support of peers to ensure adherence to Trust policies and team arrangements e.g. regarding lone working, check-in/check-out, record keeping
* monitoring professional wellbeing and development in line with the person’s work-WRAP.

*Peer interventions and referral procedure –* Clarification of what peer support might look like (cf. Repper et al., 2013), and how these interventions can be accessed, has proved to be valuable in developing the team’s understanding and appreciation of peer support, and:

* allows people accessing the service to say how peer support may be most useful to them
* sets out possible interventions and the parameters around these
* protects the role by naming specific duties distinct from broader support worker tasks
* allows discussions about the best fit between peers and service users
* enables peers to prepare for likely expectations from service users
* provides a basis for monitoring uptake, delivery and impact of peer support in the team.

*Routine evaluation of peer support* – The aim of peer support is to improve people’s personal recovery. It is therefore important to assess whether this is the case. We use the co-produced ‘Hope, Agency & Opportunity’ tool (Newman-Taylor et al., 2017) to assess impact of peer interventions for people accessing these and the peer workers themselves. This has proved to be a quick and simple way to measure the work done, which in turn is useful in reviewing peer support within the team, as well as demonstrating impressive outcomes to the wider service and senior managers responsible for funding decisions.

The initial peer support SOP will undoubtedly require updating as other local teams adopt this, but provides our current governance framework and represents organisational commitment for peer working in the Trust. This is available on request.

**Current situation**

We have recruited two peer support workers to the EIP team. This has proved extremely successful. The team have observed peers’ confidence and skill grow as they work and address novel situations e.g. what to say to someone struggling with hopelessness or poor motivation. The people who access EIP services are often young and may not have had many opportunities to manage situations and relationships in which others depend on them, yet people bring more than their mental health experience, and many have to work hard to adapt to the pressures that ill-health can bring. Services may assume readiness, and both teams and peer workers may underestimate the readiness of the worker. As the first peers have settled into the team, it has become clear that peer support benefits service users who find peers a credible source of hope, peers themselves as they realise their distinct contribution, and the team as a whole which now embraces peer working as a key component of what we can offer young people struggling with psychosis.

## Key learning and recommendations

Examples of enthusiastically agreed but insufficiently planned peer working arrangements highlight the importance of ensuring peer, team and organisational readiness if we are to offer peer support safely, effectively and equitably. With respect to preparing teams for peer support, we suggest:

* team readiness is key to successful implementation of peer support
* enthusiasm is not the same as readiness
* teams may benefit from opportunities for safe reflective practice
* willingness of teams to reflect openly and honestly allows identification of possibly unspoken worries that may otherwise present obstacles to implementation
* commitment from team managers in both principle and practice is essential
* development of a SOP is time consuming and necessary, and represents a degree of organisational commitment
* clarity regarding the detail of training and SOP (including all necessary paperwork) also facilitate team readiness and confidence in the safe roll out of peer support
* routine use of a brief recovery measure can be extremely valuable in demonstrating that peer working improves recovery outcomes
* with the right support, willing teams embrace the challenge to offer peer support, and benefit in many ways as a result.

**Conclusion: Are we ready for peer support?**

The EIP team had sought to establish peer support as an integral part of the service for some time prior to the pilot project, and we assumed team readiness on the basis of this. When arrangements started to be made, a number of duty of care concerns emerged. While undoubtedly important, we understood these concerns, at least in part, as an expression of unresolved concerns about peer support. The team were courageous in voicing questions that could be seen as politically incorrect, given an overarching desire to offer peer support. In the context of a safe environment, staff were able to reflect on the evolving nature of their relationships with potential peers. Well-intentioned but arguably paternalistic intentions to protect people who had been service users from possibly stressful interactions could have resulted in a risk averse approach and narrowing of the peer support role. The team’s willingness to name and reflect on these questions helped prepare the team for peer support, and form the basis for robust practical arrangements to be agreed. While still in the relatively early stages of peer support, this is becoming ‘business as usual’ for the EIP team, and we are now working on longer-term sustainability plans. This will involve liaising with other teams and seeking further organisational commitment to ensure structural support across the Trust. We hope that our experience and reflections to date may be of value to others.

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