Navigating institutional logics: an ethnography of mental health peer support worker implementation

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Table of contents

TABLE OF CONTENTS I
ABSTRACT III
ACKNOWLEDGEMENTS V
ABBREVIATIONS VII
LIST OF FIGURES VIII
LIST OF TABLES IX
GLOSSARY X
CONFERENCES AND PRESENTATIONS XII
CHAPTER 1: INTRODUCTION 13
1.1 RESEARCH AIMS AND OBJECTIVES 18
1.2 STRUCTURE OF THE THESIS 19
CHAPTER 2: MENTAL HEALTH RECOVERY AND PEER SUPPORT 23
2.1 WHAT IS RECOVERY? 23
2.2 RECOVERY IN MENTAL HEALTH POLICY 32
2.3 EMPIRICAL EVIDENCE ABOUT RECOVERY 39
2.4 SUPPORTING RECOVERY 50
2.5 PEER SUPPORT 61
2.6 WHAT ROLES DO PSWS PERFORM 77
2.7 EMPIRICAL EVIDENCE FOR PSW ROLES 79
2.8 IMPACT OF ORGANISATIONAL CULTURE ON PSW IMPLEMENTATION 86
CHAPTER 3: THEORETICAL REVIEW OF INSTITUTIONAL LOGICS 107
3.1 RATIONALE FOR CHOOSING INSTITUTIONAL LOGICS 109
3.2 INSTITUTIONAL LOGICS THEORY 113
3.3 INSTITUTIONAL LOGICS USE AND EVOLUTION 117
3.4 STUDIES USING INSTITUTIONAL LOGICS 124
3.5 APPLYING INSTITUTIONAL LOGICS TO PSW ROLE IMPLEMENTATION 134
CHAPTER 4: EPISTEMOLOGY, METHODOLOGY AND METHODS 139
4.1 UNDERPINNING EPISTEMOLOGY 139
4.2 METHODOLOGY 142
4.3 DESIGN RATIONALE 151
4.4 ETHICS 154
4.5 METHODS 160
4.6 RECORDING AND MANAGING DATA 169
4.7 DATA ANALYSIS 170
4.8 PRESENTATION OF FINDINGS 178
CHAPTER 5: FINDINGS: THE CONTEXTUAL SETTING 181
5.1 THE TEAM 181
5.2 THE PSW ROLE IN CONTEXT 184
5.3 WALKING THROUGH THE HOSPITAL 188
5.4 INSTITUTIONAL LOGICS IN USE 204
CHAPTER 6: THEME ONE: TIME'S UNIFYING URGENCY AND CROSS-CUTTING CONSTRAINT 213
6.1 DIFFERING ROLE REMITS IN RELATION TO THE USE OF TIME 214
6.2 GOAL-ORIENTED THERAPEUTIC INTERACTIONS 218

6.3 Perceived time benefits of the PSW role 227
6.4 Rapid connection with the nature of distress 234
6.5 Role of PSW in alleviating growing time constraints 241
6.6 PSW 'gifts' time 250

CHAPTER 7: THEME TWO: ILLUMINATING MULTI-DIMENSIONAL ASPECTS OF RISK 260

7.1 Clinicians understanding of risk 261
7.2 PSW approach to risk 267
7.3 PSWs experiential knowledge of risk 272
7.4 PSW as a risk mitigator 281
7.5 PSW 'gifts' time for risk-related tasks 288
7.6 There is only one PSW 294
7.7 The mechanisms of time and risk in peer support work 300

CHAPTER 8: DISCUSSION 303

8.1 Identifying and understanding the intersections between logics 304
8.2 Illuminating the austerity constraints exposed by intersecting institutional logics 317
8.3 Highlighting the potential of the PSW role in ameliorating systemic constraints 324
8.4 Discovering multiple institutional logics and their dynamic nature 334
8.5 Critical reflexivity and positionality 341
8.6 Strengths and limitations 357
8.7 Recommendations 360
8.8 Conclusion 368

Bibliography 370

Appendix 1 - Participant information sheet and consent form 422

Appendix 2 - Letter of Health Research Authority Approval 427

Appendix 3 - Observation template 431

Appendix 4 - Interview guide sheet 432

Abstract

Peer support worker (PSW) roles are increasingly implemented in mental health services in the United Kingdom. While existing studies suggest that organisational culture (OC) plays a pivotal role in shaping PSW implementation success, there is a lack of theoretical clarity regarding what constitutes OC in this context. To address this gap, this thesis applies the theory of institutional logics as one approach to exploring aspects of OC and its impact on PSW role implementation within a community mental health team. A qualitative ethnographic approach was employed, collecting data over a five-month period through four hundred and thirty-two hours of non-participant observation, thirteen semi-structured interviews, informal interviews, and sixty-eight documents and artefacts. To clarify what constitutes OC in relation to PSW implementation, this thesis highlights three intersecting and sometimes competing institutional logics: managerial, therapeutic, and professional. *Time* and *risk* were identified as key mechanisms that intersected with each logic, bringing their nuances into sharp focus and exposing areas of tension and alignment, influencing the implementation of the PSW. *Time* emerged as a critical mechanism affecting role boundaries and interactions, with the PSW facilitating swift, meaningful connections with service users, alleviating time pressures on clinicians, and enabling them to focus on tasks aligned with their expertise. Similarly, *risk* was reconceptualised, with the lived experience of PSW providing an alternative perspective on risk, enhancing overall risk management, and allowing clinicians to focus on their roles while relying on the PSW's additional capacity for managing certain risk aspects. Three processes were used to navigate competing institutional logics, including (1) eliminating, (2) reframing, and (3) reassigning. Despite challenges relating to the limited number of

PSWs, the findings suggest that PSWs can help mitigate broader systemic constraints, particularly in austerity-impacted environments. This thesis is the first to apply institutional logics to PSW implementation, offering an in-depth theoretical understanding of how aspects of OC influence this integration. Two key recommendations are proposed: (1) organisations should develop clear guidelines that outline how PSWs may operate differently to other team members, in order to maintain the integrity of the PSW role and ensure their unique contributions - especially in relation to risk and time - are recognised and effectively utilised, and (2) managers should be trained to understand when and how to adapt team processes to support PSWs, fostering a collaborative environment that enhances their cross-team impact. This thesis contributes new theoretical insights into PSW role implementation and provides guidance for policymakers, clinicians, and organisational leaders to enhance the impact, sustainability, and contributions of PSWs in mental health services.

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Abbreviations

AI - Artificial intelligence

CAG - Confidentiality Advisory Group

HRA - Health Research Authority

HTT - Home treatment team

IPS - Individual Placement Support

NHS - National Health Service

OC - Organisational culture

PIS - Participant information sheet

PS - Peer support

PSW - Peer support worker

RAG - red, amber, green

RC - Recovery College

RCT - Randomised controlled trial

SDM - Shared decision making

SMI - Severe mental illness

VCSE - Voluntary, Community and Social Enterprise

TMs - Trialogue meetings

UoN - University of Nottingham

WTE - Whole-time equivalent

List of Figures

Figure 6-1 - Recovery folder..... 232
Figure 7-1 - Sub-headings for documentation..... 285
Figure 8-1 - Logic relations..... 307

List of Tables

Table 2-1 - Definitions of personal recovery 26
Table 2-2 - Challenging traditional recovery assumptions 39
Table 2-3 - Core values and principles of peer support 67
Table 2-4 - Peer support worker roles in mental health services 78
Table 2-5 - Studies identifying organisational culture as a key influence (n=19) 88
Table 3-1 - Key concepts 112
Table 3-2 - Examples of cross and intra-level conflicts 123
Table 3-3 - Key insights from studies utilising institutional logics 131
Table 3-4 - Preliminary typology of institutional logics 135
Table 4-1 - Differentiated model of the 'real' 141
Table 4-2 - Ethical approval process 155
Table 4-3 - Non-participant observation hours 163
Table 4-4 - Six-phase process of thematic analysis 172
Table 4-5 - Data source labels 180
Table 5-1 - Roles providing direct mental health support 183
Table 5-2 - Preliminary typology of institutional logics 204
Table 5-3 – Professional logic characteristics 205
Table 5-4 - Managerial logic characteristics 208
Table 5-5 - Therapeutic logic characteristics and uses among different roles 211
Table 6-1 - Overview of findings in relation to time 213
Table 7-1 - Overview of findings relating to risk 260
Table 8-1 Four knowledge contributions 341

Glossary

Term	Definition	Page number
Austerity	A difficult economic situation caused by a government reducing the amount of money it spends (Cambridge Dictionary, 2024).	313
Epistemic injustice	The harm inflicted when individuals are undermined in their capacity as knowledge bearers, reasoners, or contributors to a shared understanding (Fricker, 2010).	48
Formal peer support	Structured support provided in specific settings like hospitals, community-based services, or standalone peer-run organisations with explicit rules and often within paid roles (Sunderland and Mishkin, 2014).	64
Informal peer support	Naturally occurring, spontaneous, and voluntary relationships where mutual support is governed by implicit rules, such as friendships or self-help groups.	64
Institutional logics	Historically contingent and socially constructed patterns of assumptions, expectations, material practices, values, rules, and beliefs held by actors, often unconsciously, which shape their reasoning frameworks (Suddaby and Greenwood, 2005, Thornton and Ocasio, 2008).	16, 113
Lived experience	Personal experience of mental health distress, whether formally diagnosed or not, and/or experience of using mental health services.	14, 62
Multi-disciplinary team	A mix of health and care professionals come together to plan and coordinate services for patients (Lloyd et al., 2023).	99
Neo-liberal	A world view that promotes market-based principles and individual autonomy, as the most reliable and justified means to address societal challenges (Rutar, 2023).	30
Peer	Someone with lived experience - meaning first-hand, personal experience, either past or present, of a specific issue or injustice (Sandhu, 2019).	14, 61
Peer support	A mutually beneficial relationship where individuals with shared experiences come together to provide support, especially during challenging times (Riessman, 1990).	14, 61

Peer support workers	Individuals employed in mental health services who use their lived experiences of mental health problems and/or mental health services to support others through their recovery journey.	14, 49, 65
Professionalisation	The development of skills, norms, and identities associated with being part of a professional group (Levine, 2001).	102
Role integrity	Clarity and distinctiveness of a job role, ensuring that the responsibilities, expectations, and tasks of a position are well-defined, consistent and preserved over time (Elswick et al., 2024).	98
Shared decision making	A collaborative process where mental health professionals and service users make joint decisions regarding care plans and treatments (Charles et al., 1997).	49
Social recovery	The ability of individuals to lead meaningful and contributing lives as active citizens while experiencing mental health problems (Tew, 2013).	43
Support	Genuine empathy, validation, and assistance are offered within an equal, reciprocal relationship (Penney, 2018).	61

Conferences and Presentations

Charles A, (2024) *An ethnography of mental health peer support worker implementation: PhD findings*, Peer Development Day: Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, UK, December 12. [Presentation]

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Chapter 1: Introduction

This introductory chapter provides an overview of the thesis, which uses an ethnographic approach to explore the implementation of mental health PSWs within a mental health organisation. Grounded in the theoretical lens of institutional logics, this thesis investigates how aspects of OC influence PSW role implementation in a mental health service. This chapter outlines key concepts central to this thesis, including mental health recovery, peer support (PS), OC, and institutional logics, while also reflecting on my positionality. The research aims and objectives are presented, alongside a roadmap of the thesis, providing a guide to the content and structure of the subsequent chapters.

Mental Health Recovery

Mental health recovery has become a core principle guiding mental health practice, services, and systems (Department of Health, 2014a). Unlike traditional clinical recovery models that focus on symptom reduction, treatment, and functional improvement, personal recovery emphasises the individual's unique journey towards living a meaningful life, irrespective of ongoing mental health problems (Anthony, 1993). Personal recovery centres on connectedness (social support, inclusion, and integration), hope (belief in recovery), identity (rebuilding a sense of self), meaning (in one’s life), and empowerment (control over one’s life) (Leamy et al., 2011). The recovery approach informs the role of mental health PSWs, who are gaining recognition worldwide as a valuable resource for supporting social inclusion.

Peer Support

A peer is someone with lived experience - meaning **first-hand, personal experience, either past or present, of a specific issue or injustice** (Sandhu, 2019). In mental health, a peer typically has personal experience of mental health distress, whether formally diagnosed or not, and/or experience of using mental health services. This lived experience is one form of knowledge. Other forms of knowledge have been described as learned, laboured, and loved experiences (Killackey, 2023). Learned experience is acquired through academic study or research into mental health and related systems. Laboured experience refers to insights gained through professional roles, such as those of a nurse or teacher. Loved experience comes from being a carer, family member, friend, or colleague of someone with mental health problems. In some cases, the term ‘peer’ in mental health includes those with loved experience.

PS has gained recognition as a valuable component of mental health services in the United Kingdom (UK). PS is **a mutually beneficial relationship where individuals with shared experiences come together to provide support, especially during challenging times** (Riessman, 1990). PSWs are i**ndividuals employed in mental health services who use their lived experiences of mental health problems and/or mental health services to support others through their recovery journey**. PS has been defined as "*a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful*" (Mead, 2001). PS centres on the mutual exchange of emotional and practical help, fostering

relationships that encourage dialogue and growth (Mead and MacNeil, 2006), making it distinct from other forms of support.

The formal inclusion of PSW roles within mental health services has increased. Evidence about their cost-effectiveness may drive this growth (Trachtenberg, 2013), and their potential to enhance organisational productivity (Department of Health, 2009a). They also have a vital role in supporting personal recovery (Repper and Carter, 2011) and promoting recovery-oriented service transformation (Shepherd, 2014). PS is seen as a key facilitator for recovery across a range of social and healthcare policy agendas (HM Government, 2011a, NHS England, 2016, Department of Health, 2007b, Health Foundation, 2011). Despite their growing integration into mental health services (The NHS Benchmarking Networking, 2023) - challenges remain, particularly regarding the influence of OC, which can limit the role's effectiveness and transformative potential (Ramesh et al., 2023).

Organisational Culture

The evidence base for PSW is most positive in relation to recovery outcomes, as discussed in Section 2.7. However, embedding PSW roles within established mental health services presents significant challenges. Section 2.8 highlights how OC is consistently identified as an essential factor in determining the success of PSW role implementation (Ibrahim et al., 2019). For instance, maintaining the integrity of the PSW role is essential. Yet, the prevailing OC often undermines the distinctive nature of PS, which can lead to

the role being diluted to fit traditional clinical practices, limiting its effectiveness (Byrne et al., 2016).

Addressing this challenge requires a deeper understanding of how OC interacts with PSW role implementation. However, given the complexity and multifaceted nature of OC, a theoretical framework is needed to better understand its impact. To address this, institutional logics has been chosen as a theoretical lens to explore the relationship and dynamic between PSW role implementation and OC within a mental health setting.

Institutional Logics

Institutional logics offer a theoretical lens for understanding the belief systems, norms, and practices that shape behaviour within organisations (Thornton et al., 2012a). They are defined as **historically contingent and socially constructed patterns of assumptions, expectations, material practices, values, rules, and beliefs held by actors, often unconsciously, which shape their reasoning frameworks** (Suddaby and Greenwood, 2005, Thornton and Ocasio, 2008). A more detailed discussion of institutional logics theory is presented in Chapter 3.

In mental health settings, multiple - and sometimes competing - institutional logics may coexist, presenting both opportunities and challenges when introducing and implementing new roles, such as that of the PSW. This thesis applies the theoretical lens of institutional logics to examine the implementation of PSW roles within a mental community health team. While

institutional logics have been widely used to explore various OCs, they have not yet been applied to implementing mental health PSW roles. By examining the interplay between institutional logics and OC, this thesis aims to offer valuable insights into the factors that shape the effective implementation of PSWs, ultimately contributing to strategies that can better support their role in promoting recovery-oriented care.

Positionality

Positionality is defined as the researcher's relationship to the social and political context of the study (Coghlan and Brydon-Miller, 2014). In this thesis, my positionality is shaped by multiple intersecting identities: mental health nurse, informal PSW, and researcher. My interest in PSW roles emerges from both personal and professional experiences, providing diverse perspectives on the opportunities and challenges they present. Having worked as an informal PSW within a campaign and activist group, I have witnessed firsthand the transformative power of PS and gained some insights into the PSW role. Additionally, my experience of using physical and mental health services, albeit in a smaller way, also gives me some insights into the service user role. My professional background as a mental health nurse further enriches my understanding of the complexities of integrating PSWs into statutory services, and my significant nursing experience also makes me particularly sensitised to nursing-specific phenomena or topics.

Acknowledging my positionality is crucial, as it has influenced the research question, methodology, and interpretation of findings. By situating myself

within this thesis, I aim to provide the reader with an understanding of my motivations and the experiences that have led me to pursue this research. Section 8.5 provides a detailed discussion of how my positionality influenced the study design, including my methodological choices, fieldwork experiences, ethical challenges, role conflicts, and data analysis process.

1.1 Research Aims and Objectives

The central research question guiding this thesis is: **How do institutional logics influence the implementation of PSW roles in mental health organisations?**

The objectives are:

1. To identify the institutional logics that relate to PSW implementation which are present in a mental health organisation
2. To characterise how these institutional logics support, compete with, or conflict with PSW implementation
3. To describe how PSWs navigate and negotiate competing institutional logics

By addressing these objectives, the study will clarify relevant aspects of OC in relation to the implementation of PSW roles within a mental health service setting, providing insights to support the effective integration of these roles.

1.2 Structure of the Thesis

The thesis is organised into seven chapters:

Chapter 2 provides a narrative review of mental health recovery, focusing on personal recovery and its integration into international and national policies. The review explores how recovery principles are applied and examines empirical evidence supporting individuals' recovery. The chapter also delves into PS, highlighting the roles of PSWs, the value of their lived experience, and evidence of their impact. OC is discussed, emphasising its crucial role in shaping the successful implementation of PSW roles while identifying four key challenges. The chapter concludes by noting that the implementation of PSW roles and the role of OC are under-theorised, presenting a critical knowledge gap.

Chapter 3 addresses the knowledge gap identified in Chapter 2 by introducing institutional logics as a promising theoretical lens to explore the complexities of implementing PSWs. It begins with a reflection on the review methodology and justifies the selection of institutional logics as a theory. The chapter then provides a detailed discussion of institutional logics, including its definitions, evolution, and the existence of multiple, often conflicting logics within organisations. Empirical examples that have used institutional logics are also presented, demonstrating how the theory has the potential to offer nuanced insights into aspects of OC and the opportunities and challenges of implementing PSW roles in mental health settings.

Chapter 4 outlines the epistemology, methodology, and methods guiding this qualitative ethnographic study. It begins by presenting my epistemological stance, which informs the study's philosophical and methodological foundations. The chapter then discusses the selection of ethnography as the most suitable approach to address the research question, followed by a critical evaluation of the methodology's strengths and limitations. The rationale for the research design and ethical considerations are then addressed. A detailed account of data collection methods is provided, which includes participant observation, formal and informal interviews, document collection, and diary entries. The chapter concludes by explaining the thematic analysis approach used to analyse the data, focusing on how the themes and sub-themes will be identified and explored.

Chapter 5 provides an empirical overview of the context in which the PSW and multi-disciplinary team function. It is structured into four parts: Section 5.1 focuses on the team itself, detailing the composition of the MDT, the various roles, and corresponding salaries. Section 5.2 situates the PSW role within this context. Section 5.3 delves into the working conditions of the PSW, offering insights into the office environment and emphasising key features of this space through detailed descriptions. Section 5.4 identifies and describes the three primary institutional logics that emerged as the most influential within the community mental health team setting. Together, these sections paint a vivid picture of the dynamics in this mental health setting and the dominant institutional logics at play, setting the stage for empirical findings in Chapters 6 and 7.

Chapter 6 introduces Theme One: times unifying urgency and cross-cutting constraint. This empirical chapter investigates the vital role of time as a mechanism influencing the implementation of the PSW role, revealing time as a fundamental factor shaping the practices and interactions of the PSW with team members. It presents several dimensions of how time impacts the team, from the goal-oriented therapeutic approaches used by clinicians to the ability of the PSW to build rapport with service users swiftly. Additionally, the chapter explores how the PSW might help alleviate time pressures and the notion of 'gifting' time back to clinicians within a fast-paced and resource-constrained mental health environment. Through these insights, the chapter highlights the complex interplay between time, team functionality, and aspects of OC.

Chapter 7 presents Theme Two: illuminating multi-dimensional aspects of risk. This empirical chapter delves into the multifaceted concept of risk as a critical mechanism influencing the implementation of the PSW role. It explores the various ways risk is conceptualised, navigated, and managed within this context, offering insights into clinicians' understanding of risk alongside the unique approach adopted by the PSW. Central to this discussion is the significance of lived experience in mitigating risk effectively and the capacity of the PSW to 'gift' time back to clinicians, thus alleviating some of the risk-management pressures experienced by the team. However, it also brings to the forefront a critical limitation: the challenge posed by having only one PSW on the team. This chapter reveals the intricate dynamics at play and underscores the importance of risk in the context of the PSW role.

Chapter 8 synthesises the key findings, emphasising the four knowledge contributions of the thesis. It outlines the interactions among identified institutional logics, revealing the broader systemic constraints and the potential of PSWs in addressing these challenges through the novel lens of institutional logics. I also reflect on my positionality and its impact on the research. A discussion follows around the study's strengths and limitations while providing recommendations for policymakers, practitioners, and future researchers. The chapter concludes with a comprehensive synthesis of the findings and their broader implications, including the PSW's role in enhancing mental health care delivery.

Summary

This introductory chapter outlined the key concepts of recovery, PS, OC, and the institutional logics theory underpinning the thesis. It also provided an overview of the thesis structure, introducing the central research question and objectives. The following chapters will explore these in greater depth, beginning with a narrative review in Chapter 2 focusing on mental health recovery and the role of PS in promoting recovery-oriented care in mental health services.

Chapter 2: Mental health recovery and peer support

Introduction

This chapter reviews mental health recovery as a central approach within contemporary mental health services. It examines the two types of recovery, focusing on personal recovery and its integration into international and national policies. The chapter also presents empirical evidence on recovery, investigating the essential factors needed to support individuals on their recovery journey. Following this, PS is explored in detail, including the various roles PSWs fulfil, the value of their lived experience, and the evidence of their impact. Particular attention is given to the influence of OC, highlighting its pivotal role in shaping the implementation and success of PSW roles, alongside a discussion of four empirically established PSW implementation challenges related to OC. The chapter concludes by identifying the implementation of PSWs and the role of OC as under-theorised and not yet fully understood, thereby highlighting a critical knowledge gap that will be further examined through a theoretical lens in Chapter 3.

2.1 What is recovery?

Contributions from researchers, service providers, mental health workers, academics, and primarily people with lived experience of mental health problems and/or services have shaped the evolution of recovery's meaning. Early contributions to clinical recovery emerged from research groups. This understanding of recovery emphasises the restoration of premorbid functioning and the alleviation of mental health symptoms (Young and Ensing,

1999). Referred to more recently as ‘clinical recovery’ (Slade et al., 2008a), this understanding encompasses traditional ideas of being ‘cured’ or recovering ‘from’ illness, situating it within the bio-medical framework (Liberman et al., 2002, Secker et al., 2002). Clinical recovery has four central features: (1) it is a state or an outcome - someone is either 'in recovery' or not; (2) a mental health clinician rates it, not the service user; (3) it is observable - in clinical terms, it is objective, not subjective; and (4) the definition of recovery is fixed, not changing between individuals.

The service user movement gave rise to a new conceptualisation of recovery. From the 1970s onwards in Western countries, people personally affected by mental health distress voiced that their symptoms or vulnerabilities need not impair their fulfilment of personally valued life goals and that their identity should not be limited or defined by disability (Deegan, 1996, Ridgway, 2001, Coleman, 1999, Davidson and Strauss, 1992). As a response to the perceived failures of mental health systems and broader society, service users protested that the clinical understanding of recovery as a return to ‘normal’ was an ‘alien concept’, characterised by prognostic pessimism, low expectations, and inadequate social inclusion (Coleman, 1999).

This alternative vision critiqued traditional mental health systems as excessively focused on illness and symptoms and insufficiently on the person, their hopes, strengths, and capacity for self-determination (Roberts and Boardman, 2013, Chamberlin, 1978). Influenced by the ideas of the Independent Living Movement (Gerben Dejong, 1979), these collective voices

paved the way for a system-wide paradigm shift which embraced recovery as something other than the absence of illness and something possible for all (Roberts and Wolfson, 2004). Instead, it was proposed that recovery can occur without necessarily returning to 'normal' functioning, eliminating symptoms, or achieving a full 'clinical recovery' (Deegan, 1996, Chamberlin, 1978, Perkins, 2012).

Personal recovery represents a contemporary understanding of recovery. A widely utilised definition by Anthony (1993) describes recovery as "*…a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*" (Anthony, 1993). While these effects may change an individual's lives irrevocably (Davidson et al., 2005), the definition emphasises the importance of person-centredness and the pursuit of an identity that incorporates the mental health experience as central to personal recovery. As Deegan points out: "*the goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human*" (Deegan, 1996).

Personal recovery has been defined in various ways, with some well-known definitions outlined in Table 2-1. The concept of recovery has also been explored and culturally adapted across different countries, including Japan (Kanehara et al., 2022), Poland (Nowak et al., 2017), Spain (Saavedra et al.,

2022), South Africa (de Wet and Pretorius, 2021) and Taiwan (Chao et al., 2022).

Table 2-1 - Definitions of personal recovery

Country	Personal recovery definition
England	Recovery involves living as well as possible (South London and Maudsley NHS Foundation Trust, 2010)
United States of America	"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." (Substance Abuse and Mental Health Services Administration, 2004)
Canada	"Recovery involves a process of growth and transformation as the person moves beyond the acute distress often associated with a mental health problem or illness and develops new found strengths and ways of being**."** (Mental Health Commission of Canada, 2009)

At its core, personal recovery is a deeply individual experience. While there may be commonalities between individuals, recovery is marked by subjective interpretations, understandings, and narratives unique to each person. It is often described as an ongoing, non-linear process or continuum, emphasising the individualised journey toward living a personally meaningful life, regardless of whether mental health problems persist or not (Onken et al., 2007). Unlike clinical recovery, personal recovery is self-directed: the person experiencing mental health distress defines, measures, and takes the lead in their recovery.

Personal recovery does not necessarily depend on formal mental health services. Many individuals find pathways to recovery through natural supports

such as family, friends, or peer groups offering mutual support. However, integrating a recovery approach within mental health services holds significant value. Services that adopt a recovery-oriented approach provide support and care that is holistic, person-centred, and acknowledges the broader context of an individual's life. This approach considers factors such as employment, education, social relationships, spirituality, and community involvement, ensuring that the care provided aligns with the individual's personal goals and values (Slade, 2009a).

Recovery can also be understood as a collective experience with both personal and political dimensions. It extends beyond overcoming mental health problems to addressing the broader socio-political and economic impacts of a mental health diagnosis, such as stigma, discrimination, unemployment, and disempowerment (Perkins, 2012). This broader lens reframes recovery as a collective process aligned with a rights-based approach grounded in international human rights standards.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, explicitly acknowledges the structural, attitudinal, and environmental barriers that limit the participation of persons with disabilities, including those arising from mental health problems (United Nations, 2006). The CRPD obligates signatory governments to remove these barriers, ensuring equality, access (e.g. independent living and justice), non-discrimination, and participation in public life (e.g., education and voting). Articles 12 and 14 are especially pertinent, as they affirm the right to exercise

legal capacity and safeguard against unlawful or arbitrary deprivation of liberty, presenting significant challenges for existing mental health practices (Funk and Bold, 2020).

Despite the adoption of the CRPD by 185 UN Member States, successive United Nations reports (United Nations General Assembly, 2020, United Nations General Assembly, 2019, United Nations General Assembly, 2017), reveal persistent human rights violations within mental health systems worldwide. Issues such as institutionalisation, isolation, and reliance on coercive measures, particularly for individuals in crisis, remain prevalent (Mion and Ventura, 2024). In response to widespread CRPD non-compliance, the World Health Organization (WHO) introduced the QualityRights framework in 2012, aimed at improving care quality and respecting human rights within mental health services.

The recently updated e-training toolkit, launched in 2022, addresses core areas such as recovery, legal capacity, freedom from coercion, and abuse, alongside specialised modules on practices such as supported decision-making (World Health Organization, 2022a). The global implementation of the QualityRights approach has shown promising results. Evidence suggests the training fosters positive shifts in attitudes towards recovery-oriented, rights-based care (Poynton-Smith et al., 2023, Pathare et al., 2021). Moreover, its integration with global initiatives, such as the World Psychiatric Association programme promoting alternatives to coercion, underscores a growing

international commitment to reforming mental health care systems (Gill et al., 2023).

Both recovery and human rights frameworks emphasise choice, participation, and the value of lived experience. They advocate for individuals with mental health problems or disabilities to be treated with the same respect, dignity, and opportunities afforded to others. Achieving this vision necessitates collective action and significant social change, requiring a shift away from traditional clinical recovery models toward approaches that are more inclusive and equitable. This perspective reinforces the understanding that recovery is not solely a personal process but a collective effort to address structural inequalities, advance human rights, and build inclusive environments, including mental health services, where everyone can thrive.

However, there are concerns about the concept of recovery in mental health. While its language and principles have gained widespread acceptance, questions remain regarding its applicability across diverse populations, the influence of neo-liberalism, limitations in current recovery approaches, and the integration of lived experience.

First, some argue that a recovery approach may not be applicable, accessible, or relevant to specific individuals. For example, some mental health workers express concerns about recovery with individuals whom they consider ‘too unwell’ to engage in recovery, such as people experiencing psychosis (Hamann, 2008). Critics further question the appropriateness and challenges

of applying recovery in different mental health settings, such as forensic environments, where issues of choice and autonomy are more complicated by increased risks associated with service users (Senneseth et al., 2022). Furthermore, personal recovery may not be relevant across different countries. For example, non-Western culture-oriented people may interpret recovery differently, highlighting the need for cultural adaptation (Tang, 2019, Kuek et al., 2023).

Second, there are concerns that the original meaning of recovery has been redefined, hijacked, and/or co-opted. Critics point to the influence of those without lived experience, including mental health services, clinicians, policymakers, and academics (Mental Health "Recovery" Study Working Group, 2009). Critics suggest that the recovery narrative is being leveraged as a tool of social control, used to justify policy changes, such as cuts to benefits or advancing capitalist and neo-liberal ideologies and policies that emphasise individual responsibility (Recovery in the Bin, 2019). Neo-liberalism, **a worldview that promotes market-driven solutions and individual autonomy over government intervention to address societal challenges**, is said to have weakened social safety nets for those with severe mental health problems while sidelining the broader political and structural factors that underpin mental health (Rutar, 2023, Cohen, 2024). This, some argue, has led to a decontextualised version of recovery that overlooks social processes and fails to consider the material and cultural contexts necessary for healing (Topor et al., 2022).

Third, some scholars highlight the limitations of current recovery approaches. They advocate for a new paradigm that situates mental health distress within the real-life contexts of those experiencing it. This paradigm seeks to address structural disadvantages, such as systemic violence and harmful environmental factors that impact mental health (Rose and Rose, 2023). Additionally, it calls for the recognition of service users' lived experiences as valuable expertise in understanding distress and evaluating treatment options, a shift requiring mental health clinicians to transcend traditional methods to engage with the full complexity of recovery.

Fourth, concerns about integrating lived experience reveal a gap between expectations and the realities of lived experience roles. For example, in research, peer researcher roles are often perceived as opportunities to share lived experiences, yet for some, the reality predominantly involves navigating complex bureaucratic systems, administrative tasks, and institutional structures, leaving little space for sharing experiential knowledge (Voronka and King, 2023). Additionally, peer researchers can face the dual pressures of balancing academic professionalism while simultaneously representing their communities (Ross et al., 2023).

Similarly, while there is increasing recognition of PS in policy and research, PSWs in mental health practice express frustration with slow progress in dismantling oppressive practices and persistent exclusion. Scholars argue this discrepancy stems from inconsistencies in how inclusion is conceptualised and implemented across different contexts and stakeholders. For example, in

PS research, inclusion is often framed as ‘assimilation’ or ‘integration’, which, building on the notion of co-optation, may have delimiting effects for PSWs and leave power relationships unexamined (Sinclair et al., 2023).

A final concern about recovery and lived experience is the potential for ‘strategic essentialism.’ This is where individuals with lived experience are treated as a monolithic group, ignoring the diversity and complexity of their experiences. This essentialist view can undermine the nuanced understanding of mental health and recovery, failing to account for the multifaceted nature of these experiences (Voronka, 2016). These critiques and diverse perspectives have fuelled debates about the role of recovery in mental health practice and policy on both national and international levels.

2.2 Recovery in mental health policy

Recovery represents a new paradigm in mental health for transforming systems, services, and policies globally. Over the past decade, substantial evidence shows a significant transition toward recovery-oriented policy. This shift emphasises human rights and recovery-focused, person-centred mental health systems.

Recovery and rights-based approaches are reflected in various explanatory frameworks. For instance, disability models, particularly the social disability model (Perkins and Repper, 2003), emphasise the disabling constraints placed on individuals with mental health problems. These models focus on the social factors contributing to mental distress, advocating for societal rather

than individual solutions (Tew, 2015). For example, the capabilities approach (Sen, 1999), later applied to health by Martha Nussbaum, highlights the role of individual agency in achieving well-being and has been used to explore justice, social inclusion, and citizenship (Nussbaum, 2006). This approach is particularly relevant for marginalised groups (Mäki-Opas et al., 2022), including those with mental health problems (White et al., 2016). Research applying this approach highlights how mental health systems can sometimes limit individuals' agency as tensions arise between social, structural, and agentic factors (Brunner, 2017).

An influential citizenship framework developed at Yale University highlights the importance of rights, responsibilities, roles, resources, and relationships. This framework emphasises creating opportunities for marginalised groups to fully participate in society, promoting social inclusion, and fostering a sense of belonging (Rowe and Pelletier, 2012, Pelletier, 2015). The citizenship framework has been adapted globally to strengthen individuals' rights, roles, relationships, and resources through public and social institutions (Rowe et al., 2001). However, social models have had a limited impact on public mental health (Berghs et al., 2016), with the British Medical Association noting that societal issues like poverty and racism remain largely unaddressed (British Medical Association, 2024a).

International health agendas have also explicitly endorsed recovery. For instance, the WHO Comprehensive Mental Health Action Plan 2013-2030 includes enhancing recovery as one of its eight global objectives (World Health

Organization, 2021a). This action plan, endorsed by the World Health Assembly, highlights the importance of mental health in achieving broader health goals and aligns with the 2030 Agenda for Sustainable Development (Saxena and Setoya, 2014). The recovery approach has garnered broad support from WHO Member States (United Nations, 2013), and is aligned with the WHO vision for integrated, rights-based, people-centred mental health services (World Health Organization, 2020, World Health Organization, 2022b).

A focus on recovery is increasingly emphasised in national policies across various countries, including Australia (Australian Government Productivity Commission, 2020), Canada (Mental Health Commission of Canada, 2020), Hong Kong (Hospital Authority and Social Welfare Department, 2016), India (Government of India, 2014), and the United Kingdom (Department of Health and Social Care, 2023), as well as international guidelines (Pearson et al., 2021, World Health Organization, 2023a, World Health Organization, 2021b, United Nations General Assembly, 2020, World Health Organization, 2021a).

In summary, the recovery approach has become a cornerstone of global mental health reform, driving a shift toward rights-based, person-centred approaches that prioritise social inclusion, agency, rights, citizenship, and the lived experiences of service users while aligning mental health systems with broader societal goals.

Recovery in England

In the UK, recovery first appeared within mental health policy in 2001. The publication of *The Journey to Recovery* (Department of Health, 2001b) followed the earlier '*Mental Health National Service Framework*' introduced in 1999. This framework outlined a 10-year programme aimed at creating supportive and safe mental health services (Department of Health, 1999). While it included references to recovery, it was criticised for focusing too heavily on clinical recovery outcomes rather than personal recovery (Perkins and Slade, 2012). Nonetheless, the framework recognised the importance of service users' aspirations and acknowledged the impact of stigma and discrimination in preventing individuals from achieving their goals.

In 2009, mental health policy began to emphasise supporting recovery. Greater attention was placed on understanding how to support individuals facing structural disadvantages such as economic deprivation, social exclusion, and homelessness (Office of the Deputy Prime Minister, 2004). The '*New Horizons. A shared vision for Mental Health* (Department of Health, 2009b) was introduced as a cross-governmental effort to promote mental health and improve the lives of individuals with mental health problems. It underscored the need for collaborative action across government departments, asserting that mental health services should be recovery-focused and grounded in principles of justice, equality, human rights, personal empowerment, and the value of relationships.

In 2011, the coalition government launched the '*No Health Without Mental Health'* strategy. This strategy outlined six key objectives for improving mental health and well-being (HM Government, 2011b). One of these objectives explicitly stated that "*more people with mental health problems will recover*" (p.7), defining recovery as a state where individuals enjoy a good quality of life, manage their own lives, and have strong social relationships. Other objectives included enhancing service user experiences, improving physical health, reducing stigma and avoidable harm, and increasing the well-being of the wider population. In 2016, the National Health Service (NHS) introduced the *Five Year Forward View for Mental Health*. This strategy set out recommendations to improve mental health outcomes, including explicit recovery-focused targets to be achieved by 2020/21 (NHS England, 2016).

A significant independent review of mental health law and practice took place in 2017. This review called for a response to rising detention rates and the disproportionate use of the Mental Health Act 1983 (Department of Health and Social Care, 2018). In 2021, the government published the white paper *Reforming the Mental Health Act*, marking a pivotal moment for mental health law. It emphasised autonomy, choice, and the protection of service users' rights, proposing reforms that placed service users at the centre of care and treatment decisions and gave their wishes more legal weight. In 2022, the Government published a draft Mental Health Bill that largely aligned with the 2017 independent review (Department of Health and Social Care and Ministry of Justice, 2022). The Bill underwent pre-legislative scrutiny by a Joint Committee, which released its report in 2023. Despite progressive proposals

and a commitment in the 2024 King's Speech to legislate to modernise the Mental Health Act, some argue that these reforms have been repeatedly overlooked (All-Party Parliamentary Group, 2023).

In 2019, the NHS published its *Long Term Plan,* which set out commitments to mental health for 2023/24. This plan was backed by a government promise of £20.5 billion in additional funding (NHS England, 2019a). It was launched during a challenging time for the NHS, which faced workforce shortages, missed performance targets, and the impact of the COVID-19 pandemic (Alderwick and Dixon, 2019). Despite these challenges, it set ambitious goals for improving mental health services over the next decade, including a commitment to delivering patient-centred, purposeful, and recovery-focused care from the outset. The accompanying *Mental Health Implementation Plan* (2019/20 - 2023/24) details how a £2.3bn local investment fund would build on the *Five-Year Forward View for Mental Health,* supporting core ambitions of the NHS *Long Term Plan,* such as mental health crisis and liaison (NHS England, 2019b).

In 2021, the UK government further emphasised the importance of mental health in its white paper, which advocated for better integration of health and care systems to improve mental and overall health outcomes (Department of Health and Social Care, 2021a). Mental health recovery was also prioritised through the appointment of a national Recovery Champion tasked with advancing recovery efforts and supporting policies on drug misuse. The Recovery Champion's annual report, published in 2021, highlighted key

progress and initiatives to strengthen recovery pathways (Department of Health and Social Care, 2021b).

In 2022, the government released a call for evidence for a 10-year mental health and well-being plan (Department of Health and Social Care, 2023). However, by 2023, it decided to incorporate mental health into a broader major conditions strategy rather than creating a standalone strategy. The absence of a dedicated mental health strategy drew criticism from the All-Party Parliamentary Group on a Fit and Healthy Childhood, which highlighted the lack of concrete plans to address urgent mental health challenges (All-Party Parliamentary Group, 2023). Their report calls for a standalone 10-year mental health strategy, emphasising the need for integrated, holistic care and expanding the mental health workforce to meet growing demand. In 2024, the government committed to publishing a 10-year plan for the NHS, informed by Lord Darzi's independent investigation, highlighting the growing number of people affected by mental health demanding urgent attention (Darzi, 2024).

In addition to policy, recovery has become a central focus in mental health research and practice. It has gained support from various professional groups: social workers (Allen, 2014), psychologists, occupational therapists, nurses (Nursing & Midwifery Council, 2018b), and psychiatrists (Care Services Improvement Partnership, 2007) have all endorsed a recovery-oriented approach, reflecting its growing significance in mental health practice. In 2020, the National Institute for Health and Care Research (NIHR) outlined key mental health research goals for 2020-203, including enhancing choice and

access to care in hospital and community settings (National Institute for Health and Care Research, 2020). Building on this, NHS England published a research demand signal in 2022 for the national mental health programme (NHS England, 2022). In 2024, a demand signal report was released in response to the Chief Nursing Officer (CNO) for England's 2021 *Strategic Plan for Research* (NHS England, 2021a). The report highlighted three high-level priority areas for mental health nursing research, including person-centred practice and workforce, people and culture (NHS England, 2024b).

2.3 Empirical evidence about recovery

Traditional mental health research has relied on several key assumptions about treatment, professional roles, and the focus of care (Slade, 2009b). A recovery-oriented approach challenges these assumptions by shifting the focus to understanding individual recovery experiences and developing interventions that foster diverse aspects of recovery. Drawing on Slade (2009), Table 2-2 highlights these assumptions and demonstrates how they may be challenged through the lens of a recovery-oriented approach.

Table 2-2 - Challenging traditional recovery assumptions

Traditional assumption	How a recovery-oriented approach challenges it
Specialist treatment is necessary for mental health issues	Highlights the importance of social, cultural, and community-based support, showing that recovery often extends beyond clinical treatment
Mental health professionals are central to providing treatment	Recognise that those with lived experience can be equally or more impactful in fostering recovery

The focus should be on alleviating deficits or symptoms	Shifts the focus to strengths-based approaches, promoting personal growth, autonomy, and resilience rather than solely symptom reduction
Individuals are expected to adhere to prescribed interventions	Challenges the idea of a one-size-fits-all treatment and allowing for diverse and individualised journeys to recovery

This shift has widened the understanding of recovery experiences, fostering new insights, interventions, and roles in mental health practice.

Longitudinal studies have contributed significantly to understanding clinical and personal recovery rates. These studies measure recovery over time, treating it as a consistent and operational concept (Slade et al., 2008b). There is preliminary evidence characterising the relationship between clinical recovery and personal recovery. There is a positive but not strong association between these two types of recovery. For example, in people with schizophrenia, there is a small to medium association (Van Eck et al., 2017). However, this relationship may change in early versus later psychosis (García Mieres et al., 2022), and many mediators are under-researched (Leendertse et al., 2021). Current evidence indicates that a specific focus on personal recovery, in addition to the traditional focus on clinical recovery, is empirically indicated (Dubreucq et al., 2021).

New types of research challenge the clinical framing of recovery. This shifts the attention from focusing solely on symptom reduction to understanding the subjective and relational experiences and systemic aspects of recovery.

Qualitative studies and personal narratives provide valuable insights into the idiosyncratic and deeply personal recovery journeys. For instance, researchers have explored the challenges of coping with loss (Jenkins et al., 2007), while others have highlighted that recovery can occur with or without mental health services or professional intervention (Spaniol et al., 2002). Research on recovery from the perspective of those with lived experience highlights themes such as facilitators (e.g., faith and hope and barriers to recovery (e.g., stigma) (Wood and Alsawy, 2018), the importance of 'connection' in relation to a sense of self and the social world (Murray and Menadue, 2023) and the impacts of psychosocial problems such as stigma as part of their experience (Alyahya et al., 2022). Other qualitative studies have explored personal recovery meaning and the potential influence of clinical recovery status on this meaning twenty years after a first-episode psychosis (O'Keeffe et al., 2022).

Systematic reviews and meta-analyses have further deepened our understanding of recovery. For example, one systematic review found that individuals with schizophrenia viewed recovery as both a process and an outcome (Jose et al., 2015). While a meta-synthesis identified recovery as fundamental processes of living in terms of being, doing, and accessing resources (Sommer et al., 2021). A meta-synthesis of twenty-five systematic reviews on recovery specified the ecologically oriented features of recovery, including recovery as a transformation from a negative identity state marked by despair, brokenness, and helplessness to a positive state of psychological well-being (Dell et al., 2021)

Explanatory frameworks and theoretical contributions have also expanded recovery. Some researchers suggest mental health distress stems from trauma, spiritual crisis, environmental factors, and/or systemic inequalities (Jacobson and Greenley, 2001, Ridgway, 2001), while others report a shared understanding of recovery, which involves internal and external conditions (Badu et al., 2023). Different frameworks for recovery have also been proposed, such as a family-based recovery framework that considers recovery as a shared experience between family members (Wyder et al., 2022). Internationally, a Delphi study on key aspects of recovery found a shift toward person-centred recovery that considers social, political, and economic contexts, emphasising empowerment and user rights (Guerrero et al., 2024). Similarly, other researchers argue promoting citizenship, combating stigma, and creating environments for finding meaning and hope after mental health diagnosis are central to recovery (Williams et al., 2015).

Key processes underlying the recovery journey have also been explored. Concepts such as agency (the ability to regain control over one's life), hope (the expectation of a meaningful existence), and opportunity (leveraging circumstances to achieve personal goals) are suggested to be essential (Perkins and Repper, 2003, Shepherd et al., 2008). A systematic review identified five key processes known as the CHIME framework (Leamy et al., 2011) central to an individual's recovery journey. These comprise Connectedness (social support and integration), Hope (belief in recovery), Identity (rebuilding a sense of self), Meaning (in one's life), and Empowerment (control over one's life). To better capture these aspects of recovery,

standardised measures have been developed (Campbell-Orde et al., 2005, Williams et al., 2012, Shanks et al., 2013).

Several researchers have also proposed dimensional approaches to understanding recovery. These include taxonomies that classify different types of recovery - such as clinical, existential, functional, physical, and social recovery (Whitley and Drake, 2010). Among these, social recovery situates recovery within a broader social context. It is defined as **the ability of individuals to lead meaningful and contributing lives as active citizens while experiencing mental health problems** (Tew, 2013). Social recovery is closely aligned with issues of social inclusion, access to opportunities for societal participation, and the effects of stigma and discrimination (Ramon, 2018). Personal recovery emphasises individual experiences, self-defined goals, and meaning-making, typically at the micro level. Social recovery, by comparison, adopts a broader lens that incorporates meso (e.g., community and service-level) and macro (e.g., policies and societal) level influences. While conceptually distinct, the two are interrelated and co-exist: personal recovery frameworks such as CHME do include social elements like connectedness (Leamy et al., 2011), while social recovery recognises recovery on an individual level.

Models that consider both internal (e.g., hope) and external factors (e.g., recovery-oriented services) that influence recovery have also been proposed (Jacobson and Greenley, 2001). Additionally, other key recovery dimensions identified include (1) belonging and relating, (2) being and doing, (3) thinking

and feeling, (4) resources, and (5) satisfaction with services (Gordon et al., 2014). This body of research underscores recovery's multifaceted and individualised nature, emphasising the importance of achieving personally meaningful goals like securing employment, pursuing education, improving self-management, and enhancing social inclusion. These findings have spurred the development of research and interventions targeting specific recovery processes identified in the CHIME framework.

Recovery-oriented interventions

Recovery-oriented interventions emphasise the importance of social roles and embody a philosophy that seeks to transform traditional mental health practices by integrating lived experiences and fostering social inclusion. Two prominent examples are Recovery Colleges (RCs) and Individual Placement and Support (IPS).

RCs are a globally recognised innovation (Whitley et al., 2019). Grounded in the principles of mental health recovery, co-production between people with lived experience of mental health problems, clinicians, peer trainers, and adult learning, RCs offer unique support (Australian Healthcare Associates, 2018, Bester et al., 2022, Thériault et al., 2020). Instead of employing therapeutic models, RCs offer educational programmes focused on recovery and mental health management through adult learning principles. The first Recovery College was established in London in 2009, and its popularity has grown significantly. By 2021, there were eighty-eight colleges in England (Hayes et al., 2024), and as of 2022, 221 RCs exist globally across twenty-eight

countries (Hayes et al., 2023a). RCs have gained international recognition as a valuable resource for supporting personal recovery (Toney et al., 2018a, Hayes et al., 2023b). Research highlights the benefits of RCs, including skills development for the workforce, increased inclusivity, and enhanced competency to participate fully as citizens (Toney et al., 2018b, Mowbray, 2005).

Interventions aimed at employment and self-management also yield strong positive outcomes. For instance, Individual Placement Support (IPS) helps individuals with mental health problems secure competitive employment through personalised support. A Cochrane review of eighteen randomised controlled trials (RCTs) found robust evidence supporting the efficacy of IPS, indicating its generalisability across different countries (Brinchmann et al., 2020). Additionally, a six-country RCT demonstrated that IPS outperformed local alternatives in facilitating paid employment (Burns, 2007). A recent non-randomised pilot study on IPS with young mental health service users reported that nearly two-thirds secured competitive employment, with approximately half maintaining long-term employment (Simmons et al., 2023a). These examples were chosen because RCs use peer trainers and co-production, which aligns with PSWs use of lived experience. Whereas IPS challenges the assumption that treatment (to be 'ready' for a job) is necessary before social inclusion and living well is possible. Both interventions exemplify a shift in focus from symptom reduction to enabling individuals to lead fulfilling lives within their communities.

Active involvement of service users and their relatives, and friends in the care process is crucial for advancing recovery-oriented services, research, and practice (Thornicroft, 2022). This engagement has given rise to relational approaches that seek to maximise participation, foster partnerships, and alter traditional power dynamics in mental health care. Some relational approaches focus on enhancing involvement through networks and forums. For instance, Open Dialogue (OD) actively engages the support networks of service users - such as friends and family - at the onset of mental health distress. This approach prioritises understanding and listening over reliance on traditional medical interventions, emphasising the skilled use of personal experiences and emotions in dialogical encounters (Grey, 2019). OD is now in over twenty-four countries worldwide (Pocobello, 2021). Evidence from Finland, where OD originated, indicates positive findings, such as those receiving the service experienced lower rates of relapse and hospitalisation, used antipsychotic medication less frequently, and were more likely to return to work or education compared with those in traditional mental; health services (Seikkula J et al., 2003, Seikkula et al., 2006). Positive findings were also maintained at a twenty-year follow-up (Bergström et al., 2017).

Trialogue meetings (TMs), which draw upon OD approaches, are another example of a relational approach. TMs are held in community settings and focus on various mental health topics, such as trauma (Mac Gabhann and Dunne, 2021). They bring together service users, mental health clinicians, and family members to facilitate discussions that build a shared language and mutual understanding (MacGabhann et al., 2012). The aim of TMs is to

encourage dialogue, generate knowledge, and promote recovery-oriented communication, research, and practice changes. In German-speaking countries alone, over five thousand people participate in TMs (Bock and Priebe, 2005), with interest in this model growing internationally (Amering, 2012, MacGabhann, 2012). Anecdotal evidence suggests that TMs are often positive and transformative experiences (Bock and Priebe, 2005). Research also supports their value, with a mixed methods study showing that these meetings promote knowledge production and understanding (Von Peter et al., 2014).

Co-production represents another relational approach to transforming power dynamics in mental health care. This approach involves mental health clinicians and individuals with lived experience working together to plan, design, deliver, and implement projects, services, and/or research (Norton, 2022). Examples of co-production include engaging individuals with mental health experiences in developing services (Lwembe et al., 2017), co-leading and/or participating in research studies (Gillard, 2012), and participating in decision-making for mental health service commissioning (Loeffler and Bovaird, 2019).

At its core, co-production seeks to integrate various forms of expertise, including lived experience. While some scholars argue that traditional mental health practices can hinder the implementation of co-production (Rose and Kalathil, 2019), and others highlight its challenges in health research (Oliver et al., 2019) such as the emotional labour (Faulkner and Thompson, 2023),

this approach underscores the contributions of individuals with lived experience and their unique perspectives in generating valuable insights and knowledge.

A recovery approach places a greater emphasis on first-person knowledge. Personal recovery emphasises experiential understanding over traditional expert knowledge in mental health systems. This shift is fundamental and aligns with broader changes in identity politics. For instance, feminist standpoint epistemology argues not only that women should conduct research on women's issues but also that the experiences of those at the bottom of social hierarchies can illuminate power injustices in human relationships and social structures through their unique position (Harding, 1993). In the context of recovery, positionality becomes crucial.

Emerging academic disciplines, such as Mad Studies, have developed out of Canada (LaFrancois, 2013) and Europe (Russo, 2016). These fields prioritise the lived experiences of individuals with mental health experiences. Similar to debates within feminism, some proponents of Mad Studies argue for epistemic privilege, suggesting that those at the social margins possess a unique advantage in knowledge production (Bar On, 1993). Some argue against epistemic injustice, referring to **the harm inflicted when individuals are undermined in their capacity as knowledge bearers, reasoners, or contributors to a shared understanding** (Fricker, 2010), highlighting the imbalance by addressing the dominance of material about individuals labelled as "mad" by those who do the labelling or study them (Crepaz-Keay and

Kalathil, 2013). Recognising this injustice has fostered the concept of epistemic privilege, leading to the creation of roles that place knowledge value on the unique insights of individuals with lived experiences of mental distress.

The concept of expertise by experience is foundational to recovery and has led to the creation of new roles in mental health practice. For instance, shared decision-making (SDM) is an innovative role involving **a collaborative process where mental health clinicians and service users make joint decisions regarding care plans and treatments** (Charles et al., 1997). SDM acknowledges the importance of both parties' expertise, contributing to a joint and informed agreement on a particular decision. This approach has become a focal point in mental health policy (Coulter, 2011), with evidence showing that SDM enhances service user satisfaction with mental health services (Puschner et al., 2016).

The requirement of lived experience for specific roles has also emerged. For instance, PSWs are defined **as individuals employed in mental health services who use their lived experiences of mental health problems and/or services to support others through their recovery journey**. Initially developed outside traditional mental health settings, PS has been increasingly integrated into mental health services to promote recovery, and their unique roles are explored in more detail in Section 2.5. The emphasis on lived experience has expanded into other areas, creating a variety of roles, including peer researcher roles in mental health research, peer trainers, and peer leaders.

Overall, the recovery approach challenges traditional clinical understandings of mental health. Research indicates that recovery is a non-linear, individualised, and multi-dimensional process characterised by various subjective and objective outcomes that extend beyond clinical indicators. Importantly, recovery can be achieved with or without the intervention of mental health clinicians. This perspective has inspired the development of recovery-oriented interventions that emphasise the importance of new knowledge, innovative roles, and supportive approaches in facilitating recovery.

2.4 Supporting recovery

Supporting personal recovery necessitates a shift in how we approach ethics, power, and knowledge (Slade et al., 2014). It demands transformative changes in values and mental health systems beyond rebranding existing practices. Despite broad support, implementing recovery-oriented care has revealed significant challenges, including ethical dilemmas, risk management, coercion, structural inequities, and practical barriers (Jacobson and Greenley, 2001).

Supporting recovery introduces a range of complex ethical questions. For instance, clinicians' everyday practice often involves navigating ethical dilemmas related to beneficence, non-maleficence, autonomy, justice, confidentiality, non-discrimination, and trust. However, recent developments in mental health care have introduced new ethical considerations (Galderisi et

al., 2024). For instance, the development of digital tools and artificial intelligence (AI) presents both opportunities and ethical concerns. For example, predictive AI tools might assist in predicting specific behaviours, aiding treatment decision-making and resource allocation. However, their use may disrupt the clinician-service-user relationship, potentially eroding trust or introducing biases in care delivery (Timmons et al., 2023).

Similarly, involving individuals with lived experience in decision-making is increasingly recognised as vital for equitable and effective care. However, structural inequities continue to hinder meaningful participation and access to quality care (Kirkbride et al., 2024). Recovery challenges existing power structures, which may create difficulties for clinicians who feel their personal interests - such as financial gain, access to resources, professional status, and power - are being threatened. Addressing these barriers requires a departure from traditional hierarchical and paternalistic models of care, and clinicians need to develop new competencies to share power, engage collaboratively, and champion social justice initiatives.

Supporting recovery also raises concerns about epistemic injustice. This form of injustice undermines the ability of individuals with lived experience of mental health problems to participate in key epistemic practices, such as sharing their knowledge, interpreting their experiences, being acknowledged, and influencing the systems designed to support them (Grim et al., 2022, Lee et al., 2019a, Kurs and Grinshpoon, 2018). For example, reforms to the Mental Health Bill, as discussed in Section 2.2, aim to prioritise user autonomy and

knowledge. However, the proposed removal of the statutory advance choice documents - a key tool for empowering individuals to express their treatment preferences - raises such concerns. Instead of granting individuals a statutory right to request these documents, the government has placed a duty on integrated care boards to ensure they are offered (Department of Health and Social Care, 2024). This shift risks perpetuating epistemic injustice by further disempowering service users and denying them a meaningful role in shaping their own care, undermining the independence and self-determination central to recovery.

Recovery is closely tied to ethical considerations and issues of risk, raising several important questions. For instance, is recovery feasible for individuals who are acutely unwell, in crisis, or lacking the capacity or insight to address their challenges? Moreover, how can meaningful choice be provided to individuals who pose a risk to themselves or others? In particular, clinicians often grapple with ethical tensions of promoting hope and emphasising strengths while addressing immediate needs, such as ensuring safety or stabilisation. These challenges are further intensified by clinicians' responsibility and duty of care to manage perceived or actual risks, guided by professional frameworks, legal liability, and the need to protect individuals and others from harm (Galderisi et al., 2024). For example, tragic outcomes such as suicide following contact with mental health services are well documented (Nuffield Trust, 2024).

Risk management in mental health services remains a central focus (Royal College of Psychiatrists, 2008). Practices to manage risk range from explicit to implicit pressure to accept certain treatments to coercive measures like involuntary hospital admissions, community treatment orders (CTOs), and restraint (Gooding et al., 2020). The use of restraint is contrary to the recovery approach (Badouin et al., 2023), and coercive practices often conflict with the principle of autonomy, a cornerstone of the CRPD, discussed in Section 2.1, which emphasises empowering individuals to make their own care decisions. Coercion can be deeply traumatising, eroding trust in therapeutic relationships (Hammervold et al., 2019), and coercive measures such as CTOs, which are designed to manage individuals deemed "risky," have shown limited effectiveness (Burns et al., 2013).

This tension between recovery and risk management underscores a disconnection between policy rhetoric and practice. Perceptions of risk are often exaggerated by stigma (Penn and Corrigan, 2002), and othering (Tickle et al., 2014, Bhugra et al., 2023), a process rooted in negative preconceptions that objectify individuals or groups (Alpers, 2018). While recovery prioritises self-determination and independence (Corrigan et al., 2024), risk management can emphasise danger, risk, and restriction (Rose, 2021). Scholars question whether recovery is feasible under existing legislation (Perkins, 2012), with some labelling it discriminatory (Dawson and Szmukler, 2006, Disability Rights Commission, 2007) and others raising human rights concerns (Funk and Bold, 2020). Such critiques have fuelled international calls for alternatives to coercion in mental health care (Herrman et al., 2022).

Adopting a recovery approach requires a broader conceptualisation of risk. New insights into what constitutes harm can potentially bridge the gap between risk and recovery agendas (Sykes, 2015). A more balanced approach considers individual dignity, respects personal differences and promotes therapeutic risk-taking, encouraging service users to make decisions about their safety, fostering independence and supporting recovery (Felton, 2017). For example, SDM as a process of shared risk-taking has been proposed (Zisman-Ilani et al., 2021). Evidence suggests staff training, SDM interventions, and integrated care interventions can reduce the use of coercive treatments, demonstrating recovery-oriented alternatives can yield positive outcomes (Barbui et al., 2020).

There has been a shift from focusing on risk management to harm minimisation. Policies like the No Force First policy emphasise reducing restraint and seclusion in mental health practice (Ashcraft et al., 2012), with aims to eliminate restrictive practices, recognising the trauma and disempowerment coercive measures can cause. Evaluation of this policy has shown positive outcomes can have on staff practices (Haines-Delmont et al., 2022). A least restrictive model prioritises autonomy, rights, and dignity by advocating minimal use of restrictive practices. In 2014, the Department of Health published guidance promoting best practices to reduce restrictive interventions, recommending their use only as a last resort (Department of Health, 2014b).

Recovery has the potential to challenge and mitigate epistemic injustice by fostering environments where lived experiences are valued and respected. Recovery-oriented approaches can provide a platform for individuals to have their voices heard and knowledge recognised by prioritising meaningful participation and emphasising the importance of personal narratives.

Adopting a fully recovery-oriented approach in mental health systems requires fundamental change. Current clinical models often perpetuate long-term institutionalisation and "revolving door" scenarios, where individuals experience temporary stabilisation but are frequently re-admitted due to a focus on crisis and risk management rather than sustainable recovery (Smith, 2020). Efforts to "cure" mental health problems often fall short, as innovations are slow to materialise, and the rising prevalence of common mental health problems highlights the challenges within the system (Zipursky et al., 2018, Jorm et al., 2017).

Recovery, however, is not about achieving a traditional clinical cure. Instead, it prioritises being heard, engaging in meaningful activities, and fully participating in society (Boardman et al., 2010). This approach necessitates a shift towards a framework grounded in human rights, ethics, and social inclusion, as emphasised in international guidelines (World Health Organization, 2021b). The recovery approach represents a new way of thinking, creating opportunities for new knowledge, roles, and interventions. It has the potential to transform mental health services, shift professional practices, and yield positive outcomes more quickly.

The growing evidence base for recovery-oriented practices has led to the development of frameworks for systemic change to guide system transformation (Slade et al., 2014). One framework identifies four key domains for building recovery-focused systems: (1) supporting personally defined recovery, (2) transforming working relationships, (3) promoting citizenship, and (4) fostering organisational commitment (Le Boutillier et al., 2011). While each domain poses implementation challenges, it offers actionable pathways to embed recovery principles into mental health systems and practices, advancing meaningful change.

Domain one: supporting personally defined recovery

This domain focuses on empowering individuals by respecting their autonomy, values, and personal preferences, supporting their strengths, and promoting informed decisions within a holistic approach to care, as discussed in Section 2.1. Despite the availability of established interventions and practices, outlined in Section 2.3, such as RCs and therapeutic risk-taking, the implementation of this domain presents two main challenges: (1) clinicians often rely on traditional clinical understandings of recovery and bio-medical models that prioritise medical treatment over personal recovery, and (2) conflicting and competing care priorities and demands in daily practice can hinder the application of recovery principles. Recovery has, therefore, been described as a polyvalent construct, defined as one that disguises conflicting assumptions and expectations but superficially commands stakeholder endorsement (Slade, 2017).

Domain two: changing the nature of the working relationship

This domain involves shifting the mental health worker-service user relationship from a hierarchical to a shared partnership. The therapeutic relationship is central to supporting recovery, as it fosters a collaborative working partnership and promotes hope (Kirst et al., 2014, Schrank et al., 2012). This shift has been described as professional support being 'on tap' rather than 'on top.' (Shepherd et al., 2008). However, implementation challenges persist, including (1) traditional power dynamics and hierarchy in mental health systems, where clinicians hold authority, can hinder the development of equal partnerships, and (2) valued knowledge tends to be skewed toward professional expertise, marginalising service user's contributions and knowledge. As discussed in Section 2.3, interventions like SDM can help balance power and support autonomy by empowering individuals to take an active role in their care (Kambhampati et al., 2016).

Domain three: promoting citizenship

This domain advocates for service users to be active citizens, ensuring their full participation in society, as discussed in Section 2.2. It challenges the reductionist view of individuals as service users and/or their diagnosis to recognise them as individuals with rights and meaningful roles. In mental health, promoting citizenship involves:

- Challenging discrimination and societal stigma to help service users integrate fully into society.

- Supporting social inclusion, ensuring participation in community life, e.g., education, relationships, and other community activities.
- Supporting the identification of meaningful occupation and lifestyle
- Ensuring full rights are realised by providing advocacy.

However, there are challenges in implementation, such as (1) stigma, discrimination, institutionalisation, and restrictive mental health legislation that hinder full societal participation, and (2) some recovery initiatives overlook structural issues like poverty and health inequalities that affect people with mental health problems. As discussed in Section 2.1, these challenges can limit full societal participation and recovery. As discussed in Section 2.2, from a rights perspective, a priority for mental health systems is promoting rights, inclusion, and choice. One example of a recovery-oriented initiative that supports citizenship is the QualityRights Toolkit, which helps countries improve human rights standards and ensure full citizenship rights (World Health Organization, 2022a).

Domain four: organisational commitment

The fourth domain, organisational commitment, directly relates to OC, which is under-researched and the focus of this thesis. Organisational commitment focuses on embedding recovery principles into the culture and operations of mental health services, moving beyond token efforts or surface-level changes. Achieving organisational commitment requires significant, structural changes in how organisations function and prioritise recovery as a core goal rather than

treating it as an ‘add-on’ to existing services (Farkas et al., 2005). In a recovery-oriented organisation, the needs of service users must take precedence, with recovery principles embedded across all aspects of the system. Key actions include:

- Embedding recovery values in workplace structures and care pathways.
- Involving service users, family members, and carers in quality improvement initiatives.
- Prioritising staff training and development to build recovery-focused skills and competencies (Le Boutillier et al., 2011).

However, several challenges hinder implementation at an organisational level:

1. **Superficial commitment**: organisations may view recovery as a passing trend or model without embedding its core values and principles into the broader systems' values and operations.

2. **Balancing expectations**: striking a balance between the needs of the community and the individual needs of service users creates tension and complicates efforts in achieving genuine recovery-focused transformation (Meehan et al., 2008).

3. **Whole-system transformation**: recovery requires an entire system transformation, which challenges traditional organisations' views as mere infrastructure for service delivery. This raises questions about the role of mental health services and how their effectiveness should be measured.

This domain represents the most significant transformational challenge. Several initiatives have been launched to support the shift toward recovery-oriented care, with one of the most influential being the Implementing Recovery through Organisational Change (Imroc) approach. Developed in England, Imroc guides mental health services in adopting recovery-focused practices by targeting critical areas for organisational transformation, such as involving service users in decision-making, redesigning the workforce to support recovery, cultivating a recovery-oriented OC, and updating risk assessments (NHS Confederation Mental Health Network, 2012). A critical tool developed under Imroc is the Team Recovery Implementation Plan (TRIP), which helps teams translate recovery concepts into practice through resource identification, benchmarking progress, group action planning, and regularly reviewing goals to maintain alignment with recovery principles (Repper and Perkins, 2013, ImROC, 2024).

Central to Imroc's strategy is the recommendation to integrate PSWs to drive recovery-oriented change. Recognising the unique value that peers bring, Imroc emphasises that PSWs can play a pivotal role across various mental health services, improving the quality of care while potentially reducing costs

(Repper, 2013). The involvement of PSWs can help embed recovery principles into practice, making them essential agents in the broader movement toward creating a genuinely recovery-focused OC (Shepherd et al., 2010). Their lived experience can bridge gaps between service users and professionals and offer experiential insights that challenge traditional models of care. This unique perspective can encourage organisations to rethink their practices, fostering innovation and driving alignment with recovery-oriented care ideals, which will be explored further in the following sections 2.5-2.8.

2.5 Peer support

A peer is **someone with lived experience - meaning first-hand, personal experience, either past or present, of a specific issue or injustice** (Sandhu, 2019). Support refers to **genuine empathy, validation, and assistance offered within an equal, reciprocal relationship** (Penney, 2018). Together, PS is defined as **a mutually beneficial relationship where individuals with shared experiences come together to provide support, especially during challenging times** (Riessman, 1990). PS emphasises reciprocal understanding and encouragement, drawing on shared experiences to help one another navigate difficult situations.

PS can reflect the human propensity to respond empathetically to those facing similar struggles, such as pain or trauma. It can help people cope with various social circumstances, emotional challenges, life events, and health issues. For example, individuals with drug and alcohol addiction, those with physical

health problems or impairments, and individuals experiencing mental health problems. This process of offering and receiving support fosters a sense of value and validation for both parties, enabling personal growth for both the person providing support and the one receiving it (Riessman, 1965).

In mental health, a peer typically has lived experience as one form of knowledge, which is defined as **personal experience of mental health distress, whether formally diagnosed or not, and/or experience of using mental health services**. Other forms of knowledge have been described as learned, laboured, and loved experiences (Killackey, 2023). Learned experience is acquired through academic study and/or research into mental health and related systems. Laboured experience refers to insights gained through professional roles, such as those of nurses. Loved experience comes from being a carer, family member, friend, or colleague of someone with mental health problems. In some cases, the term ‘peer’ in mental health includes those with loved experience.

PS in mental health involves people who have endured, overcome, survived and experienced mental health distress and/or services working with others facing similar challenges. It can help individuals reframe and/or make sense of their experiences (Bradstreet, 2006). PS is distinct from other forms of social support as the source of support lies within the peers themselves. It is underpinned by relationships built on dialogue that fosters learning, growth, and openness, creating a synergistic understanding that benefits both individuals (Mead, 2001, Mead and MacNeil, 2006). This support is rooted in

a deep connection formed through shared experiences, creating a bond that conveys, “we have both been there.” This connection can help foster trust, safety, and empowerment, helping replace feelings of isolation or rejection with a renewed sense of hope, agency and personal control (Repper, 2013).

An influential perspective on PS, Intentional Peer Support, developed by Shery Mead in the 1990s, highlights the transformative potential of PS in fostering dialogue that challenges traditional understandings and relationships, driving social change. Intentional PS emphasises mutual support, learning, and exploration of new possibilities, shifting the focus of relationships from helping to learning together (Filson and Mead, 2016). The intentional aspect reflects deliberate communication that encourages stepping beyond individual narratives. As Mead (2014) explains, real dialogue allows us to step back from our truth, deeply engage with the truth of another, and discover insights neither could reach alone (Mead, 2014).

Different forms of mental health peer support

In this thesis, “peer support” refers to formal and informal types of support, while “peer support worker” refers specifically to individuals providing formal PS in paid roles within mental health organisations. The primary focus of this thesis is on formal PS delivered by PSWs.

PS in mental health can be categorised into three main forms, as identified in a meta-analysis of over 1,000 studies (National Voices, 2015):

(1) **Mutual support groups**: these are informal, voluntary, and non-hierarchical groups where peers provide reciprocal and naturally occurring support. Examples include family, friends, self-help, and mutual support groups (Pistrang et al., 2008).

(2) **Employed PSW roles**: these roles exist within traditional mental health organisations, such as hospitals, where peers are employed to provide structured support (Chinman et al., 2013).

(3) **Peer-run services**: these are organisations managed and staffed entirely by peers (Segal et al., 2011).

PS can be conceptualised as sitting on a continuum from informal to formal.

- Informal PS refers to **naturally occurring, spontaneous, and voluntary relationships where mutual support is governed by implicit rules, such as friendships or self-help groups**, as described in type (1) and have been explored in qualitative studies (Cooper et al., 2023).

- Formal PS refers to **structured support in specific settings like hospitals, community-based services, or standalone peer-run organisations with explicit rules and often within paid roles**, as outlined in subtypes (2) and (3) (Sunderland and Mishkin, 2014).

PSW refers to **individuals employed in mental health services who use their lived experiences of mental health problems and/or mental health services to support others through their recovery journey**. PSW roles involve explicit rules, such as those outlined in codes of conduct or within PSW job descriptions, ethical guidelines or boundaries stipulated in terms of employment or reached through mutual agreement. PSWs also receive remuneration for their work (Repper, 2013). In addition to providing PS, PSWs may take on other roles such as trainers, leaders, or supervisors. PSWs may also be known by various titles depending on the context and organisation. Some alternative titles used include peer specialists (Parks et al., 2007), consumer providers (Pitt et al., 2013), peer providers (Moran et al., 2013), advisors (Agrawal et al., 2016) and PS volunteers (Brunier et al., 2002).

Two foundational definitions capture the essence of formal PSW roles:

> "*Peer support is an emotional support, frequently coupled with instrumental support, which is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change"* (Gartner and Riessman, 1982).

> "…*a system of giving and receiving help founded on the key principles of respect, shared responsibility and mutual agreement of what is helpful*" (Mead, 2001).

PSWs occupy a unique liminal space between service users and care providers (Watson, 2017). Their work is guided by core values and principles that define the nature of PS relationships. These values and principles were identified through a thorough review of the PS literature and synthesised in Table 2-3.

Table 2-3 - Core values and principles of peer support

Core principles	Definition
Mutuality	PSWs share similar experiences with the service users, including understanding challenges like stigma, exclusion, and loneliness. Empathy, acceptance, and mutual respect are central to the peer relationship (Riessman, 1997)
Reciprocity	Peer relationships involve no claims of expertise. Instead, peers are open to exploring, listening, and problem-solving together (Holter et al., 2004)
Non-directive and non-hierarchal relationships	The peer relationship is underpinned by equal power. PSWs support individuals to recognise their strengths and resources rather than using a top-down, prescriptive approach (O'Hagan et al., 2009)
Recovery-focused and positive role modelling	PSWs engage in recovery-focused relationships by inspiring hope, role modelling recovery, empowering service users to take control of their own lives and future, helping to access opportunities, and participating in meaningful roles, activities, and relationships. PSWs use their experiential knowledge to help others with their recovery (Repper, 2013)
Strengths-based	The relationship focuses on identifying and building on the service user's unique qualities, strengths, and assets, emphasising opportunities for personal growth, development, and learning (Gillard et al., 2017)
Inclusivity and creating a sense of community	PSWs understand the importance of mental health experiences within the context of a person's community and help find or foster a sense of belonging in their community of choice (Repper, 2013, Holter et al., 2004)
Progressive	Peer support involves mutual discovery, collaborative problem-solving, and reframing challenges as learning opportunities (Repper, 2013)
Safety and trust	Peer relationships foster emotional safety, trust, and confidentiality, creating a space for open disclosure and support by demonstrating compassion, a non-judgmental attitude, and authenticity (Gillard et al., 2017)

Modalities of peer support

Formal PS can be delivered through multiple modalities. Modalities refer to how PSWs interact with service users and offer PS. Most PS is traditionally provided face-to-face in individual sessions or group-based models. In group-based PS, a PSW facilitates sessions with two or more service users, such as in a self-management course. Individual PS involves one-on-one interactions where a PSW offers tailored support, as in a case management role.

PS can also be delivered via telephone, allowing PSWs to provide verbal support directly to service users. Additionally, digital PS is becoming increasingly popular, utilising various technologies such as online peer-to-peer networks (Kaplan et al., 2011), online PS (Gammon et al., 2017, Grennan et al., 2022), and smartphone-supported interventions (Thomas et al., 2016, Gulliver et al., 2019). Digital PS has a growing evidence base (Fortuna et al., 2020), and is being investigated as an accessible and effective approach for PS. Furthermore, PS can combine two or more modalities, allowing service users to choose their preferred method. For example, individuals with social anxiety might opt for online or telephone support instead of face-to-face interactions.

The history of peer support

PS in mental health has origins tracing back to the late 18th century. At Bicêtre Hospital in Paris, Jean-Baptiste Pussin, a former service user, recognised the value of employing recovered patients as staff members. Similarly, in England, the York Retreat, led by the Tuke family, prioritised treating individuals with

mental health needs with dignity and respect (Digby, 2018). These approaches starkly contrasted with the cruelty common in asylums of that time, marking the beginning of the "moral treatment" era in mental health care (Davidson et al., 2010).

Throughout history, formal PS has re-emerged in various contexts. In Canada, between 1870 and 1940, records show that former patients frequently assisted others in both formal and informal capacities (Reaume, 2000). Similarly, in the United States, during the 1920s and 1960s, recovered patients and trained lay counsellors were employed to support mental health service users (Davidson et al., 2010, Carkhuff and Truax, 1965).

Informal PS is often undocumented due to its grassroots nature. Some early examples include self-help groups in addiction recovery, with Alcoholics Anonymous being particularly notable (Borkman, 1999, Ferri et al., 2006). In the UK, the Alleged Lunatic Friends Society, established in 1845, was among the first documented informal peer groups advocating for the rights of those in mental distress (Hervey, 1986). The 20th century saw the rise of similar groups that provided essential support outside of traditional mental health services (Basset et al., 2015, Watson and Meddings, 2019).

The service user movement of the 1970s was pivotal in expanding PS in the UK. Influenced by broader social movements like those advocating for women, disability rights, and LGBTQ+ rights, service users began to critique the over-

medicalisation of mental health systems. They sought alternatives through PS (Watson and Meddings, 2019). Groups like the Mental Patient Union and the Scottish Union of Mental Patients emerged to challenge compulsory treatment and advocate for civil rights, highlighting PS's dual role in personal and political empowerment.

In the 20th century, PS took on various forms, including crisis houses, self-help groups, and survivor networks (Chamberlin, 1978). The Hearing Voices Network, established in 1988, offered an alternative understanding of mental health by encouraging open discussions about hearing voices, emphasising empathy and mutual respect. Other groups, like the UK Advocacy Network and Survivors Speak Out, sought independence from traditional mental health care, while organisations like Mind aligned with the survivor movement, advocating for service-user rights and public awareness (Crossley and Crossley, 2001).

The diversity of emerging peer groups has been viewed as vital for mental health recovery (Deegan, 1988). This variety has enriched the peer landscape and raised its profile. Three key themes emerge from the evolution of PS:

1. It was created by and for those unmet by traditional mental health services.
2. It provided service users a voice in decisions affecting their lives and mental health care.

3. Personal narratives were central to all peer relationships.

These shared experiences transformed into a form of service-user capital, a concept referring to the collective resources, networks, and support systems built through shared lived experiences that hold significant influence and power (Watson and Meddings, 2019). This service-user capital was pivotal in driving an increased focus on formal PSW roles and peer interventions, which aim to support recovery-oriented transformation within mental health systems.

Recovery and peer support

PS is closely aligned with the widely-cited CHIME framework, which identifies five key processes of recovery (Leamy et al., 2011). The CHIME framework has been particularly useful in highlighting stages in which peers progress through recovery and work roles (Zeng and Chung, 2020). These five processes, as they relate to PS, are conceptualised as follows:

1. **Connectedness**: PS facilitates direct contact with others who share similar experiences, helping individuals build and nurture a sense of community of their choosing.
2. **Hope**: PS fosters a belief in personal recovery by providing role models who have navigated their recovery journeys.
3. **Identity**: PS can reduce stigma and contribute to developing a positive sense of self.

4. **Meaning**: PS can enhance individuals' sense of purpose by encouraging participation in activities, relationships, and pursuits that matter to them.
5. **Empowerment**: PS emphasises an individual's strengths and helps identify unique qualities, promoting self-agency and confidence.

Together, these aspects of PS encapsulate the conceptual frameworks of personal recovery, which underlie the development of recovery-focused services and transformation (Shepherd, 2014). While implementing PSWs is increasingly regarded as an important indicator of recovery-focused change - positioning PSWs as visible representations of the recovery process - it is crucial to acknowledge that their presence alone does not ensure that a service is fully recovery-oriented. For example, as discussed in Section 2.4, organisational commitment can affect the effectiveness of PSWs, as they may be formally endorsed, but, in practice, they might be assimilated, reassigned or absorbed into other roles within mental health teams (Elswick et al., 2024).

Spread of peer support

PSWs are implemented across a wide range of settings and services. These include primary care (Lawn et al., 2024), inpatient services (Kuek et al., 2021), outpatient services (Ojeda et al., 2021), community-group settings (Poulsen et al., 2022), assertive outreach services (Craig et al., 2004), and crisis resolution teams (Lawn et al., 2008). PSWs also support various populations, such as individuals experiencing homelessness (Schel et al., 2022), those involved in the criminal justice system (Adams and Lincoln, 2021), people with dual

diagnosis (Milani et al., 2020), and perinatal populations (McLeish et al., 2023). PSWs also support young people (Simmons et al., 2023b), parents (Grennan et al., 2022), the LGBTQ+ community (Willging et al., 2018), and veterans (Stefanovics et al., 2017).

PSWs have also become a vital component of global mental health strategies (Stratford et al., 2019). For instance, addressing long-term mental health problems through diverse, person-centred, and recovery-oriented approaches, such as PS, is now a priority within the global mental health agenda (Barbui and Albanese, 2020, Bemme and Kirmayer, 2020). PSWs are well-established in high-income countries such as the United States (Gates and Akabas, 2007), the UK (Moore and Zeeman, 2021), Israel (Hornik-Lurie et al., 2018), and Germany (Otte et al., 2020). Efforts to formalise and implement PSWs are also expanding to countries like China (Fan et al., 2018) and Singapore (Lee et al., 2019b), as well as low- and middle-income countries such as Uganda (Ryan et al., 2019) and India (Pathare et al., 2018b).

PS offers a promising approach to closing the mental health care gap (Pathare et al., 2018a). It has also been investigated in international multicentre trials such as the Using Peer Support in Developing Empowerment Mental Health Services study, which aims to scale-up PS interventions for people with severe mental illness (SMI), generating evidence of sustainable best practice in high-, middle- and low-resource settings (Puschner et al., 2019, Moran et al., 2020). Reflecting this growing global recognition, international mental health policies increasingly recommend embedding lived experience support within formal

mental health services (Farkas and Boevink, 2018). For example, through its QualityRights initiative, WHO highlights the growing importance of PS by providing guidance and two modules on PS, both by and for individuals with lived experience (World Health Organization, 2023b).

The growth of peer support and UK policy

In the UK, the recognition of lived experience in mental health roles began in 1995. The Pathfinder User Employment Service established the first role requiring lived experience of mental health problems as a key criterion for employment (Perkins et al., 2000). In 2002, the Department of Health launched the Expert Patient Programme, designed to develop a PS model and empower individuals with long-term conditions to take a central role in their healthcare (Department of Health, 2001a).

Formal PSWs emerged later. In 2006, the Scottish Recovery Network developed the first PS role in Scottish mental health services, piloting them in five NHS Trusts to complement, rather than replace, existing mental health roles (McLean and McLean, 2009). By 2008-2009, PSWs were first employed and trained in Nottingham, Cambridge, Peterborough, and Sussex. By 2010, three trusts - Nottinghamshire Healthcare, Cambridge and Peterborough, and Central and Northwest London NHS Foundation Trust - had expanded the workforce to include sixty eight PSWs (Watson and Meddings, 2019).

The PSW workforce has grown steadily within NHS Trusts and outside traditional services (Crepaz-Keay, 2017). The 2023 *Peer Support Workers*

Census, commissioned by NHS England Workforce, Training, and Education Directorate (formerly Health Education England), assessed the PSW workforce (paid and unpaid) in NHS-commissioned mental health services (The NHS Benchmarking Networking, 2023). The census aims to establish a comprehensive profile of the PSW workforce in England, which can be used to monitor progress in expanding and evolving the peer workforce. The key census findings include:

- 738.7 whole-time equivalent (WTE) PSWs, equating to a headcount of 1,018, 95% of whom were in paid roles, with 5% unpaid.
- Most PSWs (88%) were directly employed by NHS Trusts, with the remaining 12% in Voluntary, Community and Social Enterprise (VCSE) settings.
- The workforce included PSWs (72%), coordinators/managers (7%), trainees (2%), specialised PSWs (4%), senior PSWs (11%), and others (4%).
- Most PSWs (50%) were employed at Band 3 on the Agenda for Change pay scale (NHS Employers, 2024), with specialised and senior roles predominantly at Bands 4 (80%) and 5 (89%) on the Agenda for Change Pay Scale (NHS Employers, 2024).

The data shows a largely paid and NHS-based PSW workforce, with most in entry-level Band 3 roles. While the data provides a clearer picture of the peer workforce, it has two significant limitations. First, there is incomplete data, as eight NHS Trusts did not provide information, and an additional forty-five WTE

PSWs were identified through a separate benchmarking exercise. Second, the census excludes PSWs working in primary care settings and VCSE roles outside NHS Trust commissioning. The census underscores the need for further work to capture the full scope of the PSW workforce, including contributions from the VCSE sector.

A 2020 report by the Association of Mental Health Providers, Mind, and NSUN (Faulkner, 2020), highlights the significant role of the VCSE sector in PS. While the report does not provide a comprehensive estimate of workforce numbers within the sector, it references earlier evidence indicating that PS takes a wide variety of forms and is broadly defined in the VCSE Sector (Mind, 2013), and 79% of eight hundred and ninety six service user groups across England were engaged in self-help and mutual support (Wallcraft et al., 2003). These workforce findings highlight the importance of developing more comprehensive data collection methods to fully capture and understand the diverse and growing presence of PSWs in mental health services and the VCSE sector, where PS plays a significant but often under-documented role.

PSW roles are now integral to mental health policy and recognised as a vital facilitator of recovery across various health and social care policy agendas (HM Government, 2011a, NHS England, 2016, Health Foundation, 2011, Department of Health, 2007a); reflecting an increased understanding of the value of embedding lived experience support in formal mental health services (NHS England, 2019a, NHS England, 2017). For instance, the *Stepping Forward to 2020/21* mental health workforce plan prioritised developing non-

traditional roles, including PSWs (Health Education England, 2017). This commitment is reinforced *in The Mental Health Implementation Plan*, emphasising the expansion of PSW roles across multiple areas of mental health services (NHS England, 2019b). To achieve these goals, *The NHS Long Term Workforce Plan* sets ambitious targets to grow the peer workforce by 4,730 by 2023/24, with a target of 6,500 by 2036/37 (NHS England, 2023a). Supporting this expansion, Health Education England commissioned the development of a PSW competency framework as part of their national program to introduce and expand roles within mental health services (Health Education England, 2020).

2.6 What roles do PSWs perform

PSWs are employed in various capacities within mental health services. They may work in dedicated PS teams or alongside mental health clinicians in established teams. Literature on PSW's various role components and content has been synthesised in Table 2-4 to provide further insights into their role and work content.

Table 2-4 - Peer support worker roles in mental health services

PSW role	Role content
Team-specific role content	
Supporting service users across service transitions	Supporting service users with transitioning from Children and Adolescent MH Services (CAHMS) to Adult MH Services (AMHS) (Lambert et al., 2014)
Supporting with referrals	Supporting service users with transitioning from inpatient hospital care to community-based support or Community MH Teams (CMHTs) (Kidd et al., 2016, Lawn et al., 2008, Scanlan et al., 2017)
Providing advice	Responding to referrals from other MH teams for PSWs (Repper and Watson, 2012)
Providing service wide functions	Providing specialist consultancy advice regarding recovery-focused practices, e.g., Wellness Recovery Action Plan (Starnino et al., 2010)
Generic role content for PSWs employed in existing community or inpatient teams	
Supporting learning in Recovery Colleges	Working with MH workers to deliver and co-produce courses and facilitate engagement (Perkins et al., 2012)
Facilitating earlier discharge from mental health inpatient wards	Supporting the discharge from inpatient MH wards to the community (Scanlan et al., 2017, Lawn et al., 2008, Simpson et al., 2014)
Leading on social inclusion in the community	Supporting independent living (Salzer et al., 2016, Klein et al., 1998)
	Supporting opportunities for employment or retaining employment (Kaehne and Beyer, 2013, Ochocka et al., 2006)
	Supporting social opportunities and activities (Mowbray et al., 1996, Rivera et al., 2007, Kane and Blank, 2004)
	Supporting social prescribing (Stickley and Hui, 2012)
Providing role-specific support	Case management role, which involves assessing, monitoring and linking service users with support services (Solomon and Draine, 1995, Sells et al., 2006, Chinman et al., 2013, Clarke et al., 2000, Rivera et al., 2007)
	Mentoring role (Sledge et al., 2011)
	Coaching role (Simon et al., 2011, Young et al., 2017, Proudfoot et al., 2012a).
	Healthcare assistant role (Craig et al., 2004).
Delivering interventions	Supporting self-management (Hunkeler et al., 2000, Wrobleski et al., 2015, Johnson et al., 2018)
	Supporting shared decision-making (Yamaguchi et al., 2017)
	Delivering cognitive behavioural intervention (Seeley et al., 2017)
	Delivering trauma treatment (Crisanti et al., 2019)

2.7 Empirical evidence for PSW roles

While the evidence base for PSWs is rapidly expanding, findings in relation to their effectiveness remain mixed. The most consistent positive impacts are aligned with recovery-oriented outcomes such as empowerment and self-efficacy. However, research also highlights the range of benefits PSWs bring to service users, the PSWs themselves, mental health teams, and the wider services in which they work (Shalaby and Agyapong, 2020).

Mechanisms underpinning the PSW role

The mechanisms and processes underlying the effectiveness of PS in mental health remain an area of active exploration, with various theories and mechanisms proposed to explain its impact. While there is no consensus on the specific therapeutic processes that differentiate one-to-one and group-based PS, several key mechanisms have been identified.

Reviews, such as those by Solomon (2004) and Watson (2019), emphasise how PSWs leverage their lived experience to provide support (Watson, 2019), acting as recovery role models who foster recovery through personal identification and modelling positive behaviours (Bandura, 1977, Solomon, 2004). The concept of “upward” social comparison (Festinger, 1954), in which individuals draw hope and motivation by comparing themselves to PSWs in recovery, has also been identified as a key mechanism. Additionally, the exchange of experiential knowledge enables PSWs to share insights rooted in the realities of recovery (Solomon, 2004), offering a distinct and valuable knowledge base for mental health management (Faulkner, 2017).

The unique liminal position of PSWs, situated between the identity of a service user and clinician, has been identified as important in peer relationships (Watson, 2019). Social support within these relationships is significant (Proudfoot et al., 2012b), involving the exchange of emotional and practical resources (Shumaker and Brownell, 1984), and emphasising strengths-based support (Watson, 2019). Watson (2019) also identifies mechanisms such as love labour, where PSWs ensure the emotional safety and well-being of others, and the helper role, which supports the PSWs own recovery by transforming negative experiences into valuable assets.

Emerging theories provide additional insights into potential PS mechanisms. Fortuna et al. (2019) propose self-determination theory, which posits that meeting psychological needs for autonomy, competency, and connectedness fosters the pursuit of growth in well-being and recovery (Deci, 1999). For example, PSWs prioritise fostering autonomy as a central goal, working collaboratively with individuals to achieve their self-determined objectives (Fortuna et al., 2019). Similarly, empowerment theory highlights strategies PSWs use to support peers (Fortuna et al., 2022), such as providing information, enhancing awareness, and, in turn, enabling individuals to participate effectively in decisions about their mental health. Kotera et al. (2022) propose common humanity as a key mechanism of effectiveness, emphasising that recognising shared experience of challenges or distress (Kotera et al., 2022) can aid in emotional regulation (Kim et al., 2020), a process encouraged within peer relationships (Stratford et al., 2019).

A notable qualitative study by Gillard et al. (2015) identified three key mechanisms for PS interventions in mental health services. These include (1) building trusting

relationships based on shared lived experiences, (2) role-modelling individual recovery and living well with mental health conditions, and (3) engaging service users with mental health services and their broader communities (Gillard et al., 2015a). New studies, such as theory of change models for one-to-one PS with young people continue to emerge (Walker et al., 2024), further contributing to this evolving area.

Greater clarity around the mechanisms underpinning PS is essential for tailoring research to explore these processes more effectively. However, as noted by several researchers (Bellamy et al., 2017, King and Simmons, 2018, Gillard et al., 2015a, Watson, 2019), the theory and mechanisms around PS remain in its early stages, warranting further investigation. However, research shows promising benefits that PSWs bring.

What PSWs bring

PSWs gain significant benefits from their roles. For instance, the role can be healing, as it enables PSWs to view their lived experience as a strength rather than a problem, fostering a positive sense of identity (Gates and Akabas, 2007). This shift has been characterised as moving from a service user identity to an “expert by experience” (Moran et al., 2012), allowing some PSWs to find a role in the community beyond the service user identity (Walker and Bryant, 2013).

Working as a PSW has also been associated with improved wellness and recovery. For instance, PSWs report increased self-esteem, personal growth, and social networks (Du Plessis et al., 2020, Bailie and Tickle, 2015, Lewis and Foye, 2022). The

role can also enhance empowerment in recovery, bolster self-confidence, increase self-acceptance of mental health problems, and equip PSWs with new skills (Repper, 2013, Bailie and Tickle, 2015). Other benefits include improved social functioning, social inclusion, and learning more about their own mental health (Du Plessis et al., 2020).

For paid PSWs, the role can also provide a safe path back into the workforce, offering the opportunity to regain a key social role with financial compensation (Moran et al., 2014). PSWs emphasise the importance of being role models for service users, demonstrating that recovery is possible (Bailie and Tickle, 2015). Therefore, the role is often reported as mutually beneficial, bringing value not only to PSW themselves but to service users too (Lewis and Foye, 2022). However, the role has been associated with challenges that may negatively impact the well-being and recovery of PSWs. For instance, the role can serve as a reminder of their own mental health problems (Du Plessis et al., 2020), and concerns about gaps in knowledge that extend beyond their own personal lived experience (Viking et al., 2022).

The integration of PSWs into mental health services can also bring significant benefits to mental health staff, services, and systems. In mental health teams, PSWs can help shift perceptions of lived experience, improving team relationships, fostering a greater appreciation of service user perspectives, and highlighting the value of lived experience (Scholz, 2017, Davidson et al., 2012, McLean and McLean, 2009, Parker et al., 2023). They can also challenge negative attitudes that contribute to a “them” versus “us” dynamic, promoting greater collaboration (Basset et al., 2012), bridging gaps in understanding (Repper and Watson, 2012), and strengthening trust-based

pathways between those providing the service and those accessing it (Viking et al., 2022). Working alongside PSWs has been shown to increase empathy, reduce stigma, and strengthen staff belief in recovery (Walker and Bryant, 2013). However, concerns have been raised about how PSWs manage triggers, distressing situations, and their own mental health, which may result in absences and increased caseloads for other staff (Pitt et al., 2013). Boundary issues and complexities in information sharing have also been highlighted (Korsbek et al., 2021), and team hierarchies have been identified as limiting the ability of PSWs to challenge clinically dominant ways of working (Viking et al., 2022).

PSWs can also bring numerous benefits to service users. For instance, PSWs can be role models, offering and demonstrating hope for recovery (Åkerblom and Ness, 2023). PSWs contribute significantly to promoting a more normalised and less medicalised understanding of experiences (Lewis and Foye, 2022), and destigmatising mental health experiences, such as psychosis (Nguyen et al., 2022). Service users report feeling empowered by the relatable insights and lived experiences of PSWs, which fosters a sense of trust and approachability, as PSWs are often perceived as more empathetic than non-peer staff (Ong et al., 2023). Qualitative studies, such as Walker and Bryant (2013), show that service users view peer workers positively, reporting increased hope and motivation. However, concerns have been raised about the lack of formal training for PSWs (Walker and Bryant, 2013), with some service users questioning their professional status and the impact of their personal mental health histories (Ong et al., 2023).

PSW outcomes

Although PSWs bring a range of benefits, the evidence supporting the effectiveness of PS interventions remains mixed. In a recent umbrella review, Cooper et al. (2024) examined twenty-three reviews, including meta-analyses and systematic and scoping reviews, on the effectiveness and cost-effectiveness of PS across clinical, recovery, and psychosocial domains. While many reviews reported no significant effects on various outcomes, meta-analyses identified benefits in areas such as perinatal depression, reduced hospitalisation risk for adults with SMI, recovery outcomes, self-efficacy, and stigma reduction. However, findings for outcomes like overall psychiatric symptoms, hospital stays, hope, empowerment, and quality of life were mixed. Low-quality methodologies, heterogeneous populations, and poorly defined PS roles were noted as potentially contributing to these inconsistencies (Cooper et al., 2024).

Similarly, an umbrella review by Yim et al (2023) found that PS is generally effective, particularly in enhancing recovery-related outcomes like empowerment, self-efficacy, and hope, with eight of thirteen reviews reporting positive effects. (Yim et al., 2023). A meta-synthesis by White et al. (2020) noted modest improvements in recovery and empowerment for one-to-one PS but no significant impact on clinical symptoms or service use (White et al., 2020). Likewise, another meta-analysis found group-based PS also demonstrated benefits for personal recovery, though effects on symptoms and service use were limited (Lyons et al., 2021). These findings are echoed by other meta-analyses reporting modest improvements in recovery and self-efficacy but minimal effects on clinical outcomes such as symptoms or functioning (Høgh Egmose et al., 2023, Burke et al., 2019, Smit et al., 2023).

For individuals with SMI, such as schizophrenia, systematic reviews (Lloyd-Evans et al., 2014, Chien et al., 2019) have noted limited effects on hospitalisation and symptom severity but some improvements in hope and empowerment. Several reviews have investigated effectiveness of PS for other mental health problems, such as anxiety and depression (Simmons et al., 2023a, Shorey and Chua, 2023, Pfeiffer et al., 2011). For depression, PS interventions have shown potential, with some studies suggesting they are as effective as traditional therapies like cognitive behavioural therapy, although the evidence remains limited (Pfeiffer et al., 2011, Shorey and Chua, 2023).

Other systematic reviews, such as a Cochrane review by Pitt et al. (2013), found that PSWs achieved outcomes comparable to those of mental health workers in similar roles (Pitt et al., 2013). Similarly, another review found that peers were better able to reduce inpatient use and improve a range of recovery outcomes compared to professional staff (Chinman, 2014). While a range of study designs identify specific benefits, including improved social relationships (Arbour and Rose, 2018, Lucchi et al., 2018) self-efficacy (Mahlke et al., 2017), patient activation (Cook et al., 2020), reductions in mental health symptoms (Rivera et al., 2007), and their potential to foster generativity - the contributions individuals make to others that support their recovery (Jordan et al., 2022). Evidence from RCTs of PS for hospital-to-community transitions is mixed. Some studies report no superior outcomes compared to treatment as usual (Gillard et al., 2022, Kidd et al., 2021), while others found peer-delivered self-management reduced readmissions to acute care (Johnson et al., 2018).

However, economic evaluations of PS are limited but promising. Initial studies highlight cost-saving potential (Le Novere et al., 2023, Iemmi et al., 2015), with one report

showing a cost-benefit ratio of 1:4.76, indicating significant savings in inpatient bed usage for every £1 spent (Trachtenberg, 2013). Cooper et al. (2024) also identified PS interventions as low-cost and potentially cost saving based on three systematic reviews (Gaiser et al., 2021, Triece et al., 2022, Huang et al., 2020).

Overall, while PS interventions show promise in enhancing personal recovery, reducing admissions, and improving self-efficacy, the evidence remains inconsistent. To address this, indexes (Gillard et al., 2021) and guidelines (King and Simmons, 2018) have been developed to better measure and capture the unique value of PS. However, further high-quality research is required to fully understand their impact across different mental health services and optimise their implementation.

2.8 Impact of organisational culture on PSW implementation

PSWs embody the integration of a new type of mental health worker into the organisational milieu. They bring experiential knowledge, skills, and perspectives that can challenge or disrupt the traditional approaches to treating, supporting, and interacting with service users. However, PSWs are often low-paid (Adams, 2020) and face limited career progression opportunities (Chapman et al., 2018). While growth in PSW roles has created jobs for individuals with lived experience in mental health services, these positive developments have also highlighted existing and new challenges (Perkins and Repper, 2019). For instance, as the number of PSWs increase, rigid, established, and standardised organisational systems including traditional mental health services can pose challenges for PSWs, which may restrict their ability to impact mental health systems meaningfully (Gillard et al., 2014).

OC is recognised as a strong influence on the implementation of PSW roles (Ibrahim et al., 2019, Mancini, 2018, Mutschler et al., 2022).

A proportionate review informed by scoping review methodology was conducted to explore the influence of OC on the implementation of PSWs in mental health services. The aim was to identify papers that identify OC as a key influence on PSW implementation rather than provide an exhaustive account of the literature. A proportionate approach allowed for a structured yet flexible mapping of relevant studies within the constraints of thesis scope and time. The search strategy combined electronic database searches across PsycINFO, PubMed, Scopus, CINAHL, and Web of Science, using combinations of keywords and subject headings related to “peer support,” “organisational culture,” “mental health services,” and “implementation.” To enhance coverage, hand-searching of key journals, reference lists, and backward citation searching was conducted. Knowledge of foundational and high-impact papers in the field was also applied. Inclusion criteria comprised peer-reviewed articles published in English between 2010 and 2024 that explicitly identified OC as a factor influencing the development, integration, or sustainability of PSW roles. Both empirical studies and reviews were considered, provided OC was discussed as an influence, e.g., barrier and/or facilitator. While this review approach ensured a snapshot overview of the literature, it is acknowledged that not all eligible studies may have been captured. Table 2-5 below presents studies that identified OC as a key factor in implementing PSW roles.

Table 2-5 - Studies identifying organisational culture as a key influence (n=19)

#	Paper	Study design	Core finding about OC	Verbatim finding relating to OC
1	A systematic review of influences on implementation of peer support work for adults with mental health problems (Ibrahim et al., 2019)	Systematic review	OC was reported by 53% of the papers as the largest influence on PSW implementation	Facilitators of OC: The service has clear goals and a recovery orientation, with a culture of reflexive practice and an openness to change. PSWs occupy a central position within the service network. There is adequate communication with them, efforts are made to make cultural modifications for them, and they are seen by other staff as 'fitting in'. PSWs may be independent/autonomous from mental health service (i.e. not managed within the organisation). Disability and work performance assessment are separated [p.289] Barriers of OC: There is a risk-averse culture focussed on traditional clinical risk and peer-patient risk, with a lack of recovery orientation and coproduction. Treatment protocols are inflexible and conflict with person-centred principles. Traditional workplace hierarchies exist, and there is a lack of organisational commitment to PSWs. PSWs perceive that stigma exists about the PSW role, and PSWs are seen as outsiders. Co-optation occurs by incorporating PSWs into medical ways of working, leading to identity conflict between being a patient and being a worker [p.289]
2	A systematic review of modifications to peer support work for adults with mental health problems (Charles et al., 2020)	Systematic review	OC is a key consideration in informing what types of modifications are to be made in relation to the PS role	Differing OCs lead to issues of professionalism, role expectations, and issues with practice boundaries are common [p.305].

3	Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review (Vandewalle et al., 2016)	Literature review	PSWs identified workplace culture including lack of a recovery-oriented culture as a barrier to implementation on a social context level	Shared values of peer support and recovery is important for integration [p.246] Lack of recovery-oriented culture: some peer workers in traditional organizations perceive their work context has a lack of 'recovery-orientation' [p.246] Mental health nurses should take the leadership in creating recovery-oriented cultures and in facilitating the implementation of peer worker roles [p.248] Peer workers are becoming 'socialized' in OCs whereby stakeholders uphold specific standards of practice and professional norms [p.247] Where peer worker roles are implemented within a culture of shared values of recovery and peer support, peer workers were given the opportunity to develop a distinctive contribution based on lived experience [p.247]. Establishing recovery oriented cultures is essential in facilitating implementation and effectiveness of peer worker roles [p.247]
4	Challenges Experienced by Paid Peer Providers in Mental Health Recovery: A Qualitative Study (Moran et al., 2013)	Qualitative study	Identified how leadership should focus on creating a recovery-oriented culture through flexible and accommodating workplace	
5	Introducing New Peer Worker Roles into MH Services in England: Comparative	Comparative case study design	Differences in PSW role in different OCs	Introducing this new way of working into large organisations that were highly structured and had well-developed cultures of practice resulted in tensions observable in a relative lack of shared expectations of the peer work role in the statutory sector compared to other contexts [p.687-8]

	Case Study Research Across a Range of Organisational Contexts (Gillard et al., 2015b)			Strong, shared understanding of the peer worker role across participants in our voluntary sector cases, frequently attributed to a well-established culture of peer support that spread through the organisation [p.689] Senior managers were keen to address this issue of OC clash in order to ensure that the distinctiveness of the peer worker role was not lost [p.690] Where innovation is project-based it benefits from some freedom from the constraints that characterise large OC [p.691] In our statutory sector cases the distinctiveness of the role was, in comparison to our voluntary sector cases, at times constrained by expectations within a rigidly structured and hierarchical NHS culture, and the potential for the new role to bring meaningfully different practice to the team could be inhibited [p.691] There is a risk of peer workers becoming 'socialised' into the working culture around them [p.691] The voluntary sector employer imported its flexible, peer-led culture of practice into the statutory environment [p.691]
6	New ways of working in mental health services: a qualitative, comparative case study assessing and informing the emergence of new peer worker roles in MH services in England (Gillard et al., 2014)	Comparative case study design	Organisational change is needed to support the adoption of PSW roles at a team and organisational level	Supportive culture: shared expectations (across team); mutuality; supportive management [p.32] Strong agreement that work needed to be done to develop a supportive OC before a new peer worker role was introduced [p.32] Structural and Identity issues impact on OC in two ways: (1) the way in which boundaries are challenged and, (2) the way in which MH is talked about in teams [p.65] The introduction of new peer worker roles had an impact on OC, and that culture needed to change to support the adoption of peer worker roles [p.88] Dominant culture within the NHS and partnership cases was underpinned by a medical approach [p.95] Alternative OC found in voluntary sector cases [p.96]

				If the peer worker role is required to adapt to fit prevailing culture (often referred to in both our statutory and voluntary sector cases as the professionalisation of the role), rather than the culture evolving to support the role, then there is a real risk that the 'essence' of the peer worker role will be somehow lost [p.97] The peer worker role is most empowered where there is a culture of reflective practice within the organisation or team, and where there is a pervasive culture of valuing and using lived experience throughout the organisation [p.107]
7	An Exploration of Factors that Effect the Implementation of Peer Support Services in Community MH Settings (Mancini, 2018)	Qualitative interviews	OC and support identified as impacting on PSW role integration in mental health settings	Under the theme of OC and support, teamwork, blurred professional boundaries and expectations, accommodations, and strategic implementation were sub-themes [p.133-134] OC and support, which refers to the need for implementation strategies that include leadership support, team-building, quality supervision and ongoing training in the use of peer services [p.132]
8	Addressing Challenges to Providing Peer-Based Recovery Support (Alberta et al., 2012)	Literature review	The effective use of peer-based recovery support faces challenges, particularly those stemming from the structure and culture of traditional mental health services	Emphasizing organizational values and culture as the basis for staff training, and implementing measures designed to encourage accountability among peer support staff p.481] One identified set of challenges, referred to here as environmental, is associated with integrating peer support staff (PSS) into organizations or systems of care built around professionally credentialed staff members and the professional culture they generally embrace [p.482] Another set of challenges identified in the literature referred to here as individual, is associated with peer staff members entering employment settings characterized by expectations inherent in this same professional culture as well as unfamiliar working conditions grounded in this culture [p.482]

				a result of their training and experience, be highly invested in maintaining traditional professional cultures and roles in behavioral health organizations [p.482] The centers exists as a freestanding entity enhances the ability of the PSS and friends to act autonomously as they participate in the development of communities and cultures that provide opportunities [p.485]
9	Peer Worker Roles and Risk in Mental Health Services: A Qualitative Comparative Case Study (Holley et al., 2015)	Qualitative comparative case study	A cultural shift is needed because many mental health services operate within a risk-averse environment	Many services are still currently embedded in a risk-averse culture of practice and suggested that, to enable peer workers to use their lived experience to work in a more positive way with risk, there needs to be a shift in culture [p.486] There is evidence that a risk adverse culture in responding to these challenges can inhibit the peer specific qualities of the role [p.487] Research has cautioned against the 'socialisation' of peer workers into the working culture around them [p.488] Importing the culture of the peer-led service provider into a statutory sector context—-in the partnership cases we considered—-was at least provoking those different conversations about risk [p.489]
10	Organizational Climate and Support Among Peer Specialists Working in Peer-Run, Hybrid and Conventional MH Settings (Jones et al., 2019)	Online survey	Peer-run organisations had a larger share of groups with high scores in support and organisational climate. They outperformed all other groups in areas such as service quality, career development support, and overall organisational climate	The OC sub-scale comprises six Likert-scaled items designed to operationalize staff perceptions of their agency's respect and support for clients. Example items include "service users feel welcome and valued" [p.153] Greater attention needs to be paid to organizational values, climate and culture and effective change strategies [p.163] The relationship between OC as it pertains to peer staff (versus clients), remains largely unexplored [p.163] Climate and support for peer specialists may lead to improved services and improved client outcomes—a possibility deserving careful empirical investigation [p.163]
11	Cooptation of Peer Support Staff:	Survey	Peer staff in treatment organisations undergo acculturation into	Peer staff members working in treatment organizations are subject to processes of acculturation into professional cultures that peer staff working in peer organizations are not [p.25]

	Quantitative Evidence (Alberta and Ploski, 2014)		professional cultures, a process that peer staff in peer-run organisations do not experience	The culture of treatment organizations includes an understanding of supervision in treatment matters as explicitly incorporating efforts to guide the professional development of the supervisees p.28]
12	Lived experience practitioners and the medical model: world's colliding? (Byrne et al., 2016)	Grounded theory study interviews	The medical model significantly limited the effectiveness, implementation, and development of roles for individuals with lived experience. This culture was seen as a major obstacle to advancing recovery-oriented approaches	The medical model as a prevailing culture within mental health services from their personal and professional experiences. This culture imposed a major limitation on the implementation, effectiveness and development of lived experience roles and themselves as individuals. It was also seen as a major limitation to the progress of Recovery oriented reform [p.217] Medical model concepts were identified as; an overemphasis on labelling/diagnosis, a culture of mistrusting consumers, consumers developing patient identity as a result of authoritarian or paternalistic systems, and ideas and beliefs that contradict Recovery or positive attitudes [p.219] It is within this culture of marked unequal relationships between health professionals and consumers that lived experience practitioners (LEP) currently exist [p.219] The medical model culture prevailing throughout mental health services presents a major barrier to LEP being able to realise the potential of the roles and contribute effectively to Recovery-based reform [p.221] Achieving policy expectations for Recovery-oriented services and enhanced consumer participation requires a willingness to reflect on the prevailing culture of mental health services [p.221]
13	What Does Recovery Mean in Practice? A Qualitative Analysis of International Recovery-	Qualitative analysis	Organisations that support a recovery- orientation demonstrate a commitment in their service structures and work environments which are beneficial to	Organisational commitment identified as a key practice domain. The OC gives primacy to recovery and focuses on and adapts to the needs of people rather than those of services [p.1474]

	Oriented Practice Guidance (Le Boutillier et al., 2011)		promoting recovery-oriented practice	
14	A Narrative Review of Factors Influencing Peer Support Role Implementation in Mental Health Systems: Implications for Research, Policy and Practice (Mirbahaeddin and Chreim, 2022)	Narrative review	Influencing factors at the meso level include OC	The medical model culture that prevails in mental health services is a major barrier to recovery-focused approaches and to PSW role implementation. This culture privileges a hierarchical structure whereby power lies in having a medical or clinical background [p.600] Peer support services are offered within organizations that have different OC [p.604] Implementing the PSW role often requires that the mental health organization demonstrate openness to change, especially when the culture and dominant views at the organization are not supportive of recovery practices or incorporating lived experience as part of mental health care services [p.604] The following facilitate the implementation and the sustainability of the PSW role: a supportive OC [p.606]
15	Societal and organisational influences on implementation of mental health peer support work in low-income and high-income settings: a qualitative focus group study (Ramesh et al., 2023)	Focus group study	OC identified as a key implementation influence	At the organisational level, the interlinked themes of resource allocation and OC were identified, as well as staff attitudes and the challenge of ensuring role clarity [p.8] More attention needs to be paid to societal attitudes and OC in developing and implementing PSW programmes [p.8] In terms of OC, the findings reinforce existing evidence that OC impacts on recovery support, so organisational transformation may be needed [P.8] Approaches to supporting culture change within mental health services include the introduction of prorecovery interventions [p.8]

16	Organisational Actions for Improving Recognition, Integration and Acceptance of Peer Support as Identified by a Current Peer Workforce (Reeves et al., 2024a)	Qualitative interviews	OC is a main theme within the data	Generating recovery-oriented workplace culture, compliment organisational change and development and support the sustainability of peer support roles [p.170] Workplace culture has been noted through literature as a common barrier for the effective implementation and integration of peer worker [p.175] The influence leadership has on facilitating a positive and productive OC [p.176] The importance of effective change across multiple levels within an organisation including worker mindsets and culture, structures and practices, resource flows, relationships and policy to support overall systems change [p.176] Consideration: taking consistent action to generate a culture that values lived experience expertise through training and education, consistent of use of recovery language, commitment and inclusion at all levels of the organisation [p.176]
17	A multi-national peer support intervention: the UPSIDES pilot phase (Nixdorf et al., 2022)	Mixed methods	Implementing an OC open to learning	OC: The services goals, orientation, principles, and culture. The communication within the team, workplace hierarchies. Attitudes towards recovery and co-production, stigma [p.6]
18	Facilitators and Challenges of Integrating Experts by Experience Activity in Mental Health Services: Experiences from Finland (Kivistö et al., 2023)	Focus groups	Facilitating a culture that values lived experience	It is recognised that the implementation and integration of peer support work require an OC that supports the activities, the willingness of the organisation and management, and equal treatment of peer support workers [p.541] Based on the results, the starting point for integration is an OC in which expertise by experience is understood and Experts by Experience activity is valued by the management and staff throughout the organisation as comprehensively as possible [p.548]

19	Implementation of Peer Support in Mental Health Services: A Systematic Review of the Literature (Mutschler et al., 2022)	Systematic review	OC was a factor that affected successful implementation	Best practices within the inner setting include an OC accepting of peer support, available resources, leadership engagement, and an engaged implementation climate. In order to implement successfully, it is necessary that recovery-oriented values and ethics are implemented so that PSWs do not feel coopted to perform duties outside of the PSW role [p.13] In order to combat tensions, it is important that health professionals are educated on the role, scope, and ideology of other professionals [p.13] Strong organizational leadership and commitment was found to be the most important factor in successful implementation [p.13] The implementation climate, including the priority of the intervention, needs to be understood by the organization in order to provide PSWs with adequate pay rates and recognition [p.13]

In Table 2-5, no paper defines OC or provides a theoretical framework for conceptualising OC. While all papers acknowledge OC as a key influence on PSW role implementation and highlight a nexus of relevant influences, the concept of OC remains vague and inconsistent.

Differing organisational constructs

As highlighted in Table 2-5, various constructs of OC have been used to describe the culture in traditional mental health services and non-traditional services, such as peer-run services. In statutory mental health services, OCs have been characterised as risk-averse (Holley et al., 2015, Ibrahim et al., 2019), highly structured and well-developed (Gillard et al., 2015b), professional (Alberta and Ploski, 2014), workplace (Vandewalle et al., 2016), supportive (Gillard et al., 2014) and centred on the medical model (Gillard et al., 2015b, Byrne et al., 2016). In non-traditional and voluntary sector services, the culture is described as accepting and welcoming (Mutschler et al., 2022), where PS is well-established, and there is a shared understanding of the PSW role (Gillard et al., 2015b). These variations highlight the complexity and multifaceted nature of OC across different mental health settings, as well as the lack of consensus on describing or characterising OC.

Different OCs have been linked to issues around role integrity, professionalism, and practice boundaries (Charles et al., 2020). Four examples of how OC impacts formal PSW role implementation in mental health services are synthesised and outlined below. This comprises challenges relating to (1) maintaining role integrity, (2) team integration, (3) maintaining boundaries, and (4) risk of professionalisation.

OC challenge one: maintaining role integrity

Role integrity refers to **the clarity and distinctiveness of a job role, ensuring that the responsibilities, expectations, and tasks of a position are well-defined, consistent and preserved over time** (Elswick et al., 2024). For PSWs, maintaining role integrity can be difficult due to identity conflicts and role confusion (Moll et al., 2009), particularly when transitioning from being a service user to a provider (Walker and Bryant, 2013, Mancini, 2018). Unclear or vague job descriptions, duties, and tasks can create role uncertainty (Carlson et al., 2001, Viking et al., 2022, Asad and Chreim, 2016), which may prevent PSWs from fully utilising their lived experience or make them hesitant to do so (Mancini, 2018, Moran et al., 2013). Similarly, this lack of role clarity can result in PSWs feeling that they need extra time to adjust to their role (Gillard et al., 2015b), and role uncertainty can lead to a lack of support from non-peer staff (Miyamoto and Sono, 2012).

Additionally, risk-averse OCs can restrict the unique contributions of PSWs (Holley et al., 2015). For example, sharing lived experiences is sometimes discouraged by some mental health workers to protect PSWs well-being (Van Erp et al., 2010). However, when PSWs feel constrained, they may feel undervalued, less credible, and disconnected from the core purpose of PS (Kent, 2019). A lack of managerial understanding or support for PSW roles can further impact their job satisfaction and lead to underutilisation of their skills (Kuhn et al., 2015). To address these challenges, Imroc recommends the prioritisation of well-defined and clear roles when implementing PSWs (Repper et al., 2013). Clearly outlining the roles, responsibilities, and expectations of PSWs is crucial, along with providing the necessary support (Gates and Akabas, 2007, Charles et al., 2020).

OC challenge two: team integration

Effective team integration is crucial for PSWs working within mental health teams. Research shows that teams which embrace shared recovery values and recognise the importance of the PSW role are more successful in integrating PSWs (Vandewalle et al., 2016). This integration can lead to greater team consultation with the PSW, increased referrals, and better role utilisation (Davis and Pilgrim, 2015). Supportive workplaces and flexible employers also foster greater team cohesion, respect between team members, increased communication, and leadership that promotes a recovery-oriented culture (Mancini and Lawson, 2009, Ibrahim et al., 2019, Moran et al., 2013, Mutschler et al., 2022).

However, integration challenges persist. Some mental health workers view PSWs as equals, while others may not (Gillard et al., 2013). This can result in power imbalances and communication difficulties, such as PSW challenges around clinical terminology and discomfort with public speaking in team settings (Ahmed et al., 2015). PSWs can often feel caught between two identities - neither fully mental health professionals nor service users - which can affect their sense of belonging within the team (Ahmed et al., 2015, Burr et al., 2020, Kemp and Henderson, 2012). Additionally, some PSWs fear failure in this new role, which can hinder their ability to integrate into MDTs - defined as **a mix of health and care professionals come together to plan and coordinate services for patients**. The pressure to succeed as pioneers (Otte et al., 2020) and not meeting these expectations could lead to fears around a reduction in future PSWs (Viking et al., 2022).

Moreover, mental health workers may harbour negative attitudes or uncertainties about the PSW role. For some, feeling threatened by the potential for PSWs to replace their role (Viking et al., 2022, Stratford et al., 2019) due to being paid less than their mental health colleagues (Otte et al., 2020) or feeling uneasy about working with people they've previously supported (Mutschler et al., 2022). Additional concerns around the effectiveness of PS and expectations that supporting PSWs would increase their workload have been highlighted (Pitt et al., 2013). These challenges can generate additional discontent for PSWs and lead to feeling undervalued, isolated and stressed, hindering effective team integration (Kent, 2019).

To support team integration, adequate workplace support is essential for PSWs. Limited access to resources such as computers and service user records can hinder their ability to perform their duties effectively, reinforcing perceptions of PSWs lower status within the organisation (Van Erp et al., 2010, Asad and Chreim, 2016). Additionally, the lack of clear pathways for career progression and development opportunities can further demotivate PSWs, signalling that their skills and contributions are not fully valued (Moran et al., 2013, Asad and Chreim, 2016). Insecure employment due to short-term contracts, coupled with inadequate remuneration and resources, exacerbates this issue (Chinman et al., 2008, Garrison et al., 2010). To support successful implementation, organisations must provide the necessary resources, clear job structures, and supportive environments that reflect the value of their lived experience (Stirrup et al., 2022).

OC challenge three: maintaining boundaries

Maintaining boundaries is also crucial for PSWs. Their lived experience is essential to the role, and positive self-disclosure can be vital in offering support. However, this process can sometimes lead to challenges around setting boundaries (Moran et al., 2013). Many PSWs identify that establishing and maintaining effective boundaries is a significant issue (Repper and Carter, 2011, Ibrahim et al., 2019). Unclear boundaries between PSWs and other mental health workers can lead to role confusion. PSWs may also face dilemmas when sharing personal contact information or engaging in relationships outside of designated support programs (Knopes and D'égale-Flanagan, 2023).

In addition, PSWs may hesitate to share confidential service user information with colleagues out of concern it might breach trust (Gates and Akabas, 2007). This issue relates to the ongoing friend versus service user dilemma, where PSWs must carefully navigate decisions about how to manage their relationships with service users and how to maintain professional distance despite their lived experiences (Otte et al., 2019, Gates and Akabas, 2007, Asad and Chreim, 2016). These challenges underscore the complexity of boundary-setting and the importance of supervision in managing and navigating these challenges.

Supervision is crucial for PSWs. A recent study by Stefancic et al. (2021) identified several supervision strategies and lessons to support PSWs, including access to multiple supervisors, both formal and informal support, acknowledgement of lack of role clarity, ongoing role negotiation, a collaborative approach to troubleshooting challenges, explicit recognition of the value PSWs bring, connecting PSWs to mutual

support, and ongoing development opportunities (Stefancic et al., 2021). Other studies also show that supervision can help PSWs clarify expectations, address differing opinions (Aretz and Jungbauer, 2019), and support with job satisfaction (Edwards and Solomon, 2023). However, inadequate supervision - focused on tasks rather than boundary issues and emotional concerns - can harm PSWs well-being and impede their effective integration (Simpson et al., 2013; Ahmed et al., 2015). Developing clear boundaries is an ethical issue that should be guided by thorough assessment and defined policies (Gillard et al., 2015b, Williams et al., 2006).

OC challenge four: risk of professionalisation

Professionalisation is an essential consideration for the PSW role. As defined by Levine (2011), professionalisation is **the development of skills, norms, and identities associated with being part of a professional group** (Levine, 2001). A critical question arises about whether PSWs should be more professionalised or remain less professionalised to preserve their unique approach. Professionalisation risks diluting the distinctive nature of their work, while not being professionalised may lead to confusion and unclear boundaries. For instance, role practice boundaries may arise when PSWs are integrated as traditional mental health workers rather than a defined PSW role (Alberta and Ploski, 2014). This ambiguity may impact the extent to which the PSWs offer a unique service or replicate existing roles within the team (Gillard et al., 2015b).

Training has been identified as critical for PSW development (Asad and Chreim, 2016). This includes initial PSW training and ongoing opportunities for skill development (Charles et al., 2021). However, training can sometimes lead to

unintended assimilation into the existing professional culture, which may shift PSWs away from the distinctiveness of their role (Alberta and Ploski, 2014). Many PSWs feel that role-specific training - focused on self-disclosure, managing emotions, and workplace policies - is needed (Hamilton et al., 2015, Moran et al., 2013).

PS is often seen as political, supporting individuals' rights to self-determination (Beresford et al., 2002). However, PSWs can face dilemmas when they are faced with upholding the principles and values of PS whilst complying with job descriptions that may require them to perform tasks like administering medication or using restraint (Mead and Filson, 2017). This highlights a tension between the mental health system co-opting the role of medical ways of working (Alberta and Ploski, 2014), and using PSWs as healthcare assistants versus the intention that PSWs act as carriers and agents of recovery culture within a system marked by significant in-system stigma (Adams, 2020). The ways in which these tensions are managed can shape the effectiveness and integrity of the PSW role in mental health services.

Introducing PSWs into mental health services can disrupt power dynamics (McNeil et al., 2013). The intentions of PSWs to foster mutuality are complicated by the systemic power imbalance between service users and mental health workers, particularly if PSWs are seen as being part of the system. For example, if PSWs adopt professional practices or behaviours, their entrenchment into the mental health system deepens, which can inadvertently increase the social distance between the PSW and the service user, making occupying a liminal space more difficult (Byrne et al., 2016). Such dynamics can impede or obstruct the development and practice of the PSW role. Critics argue that “institutionalisation” and “over-professionalisation” risk limiting the

distinctive contributions that PSWs bring to services (Simpson et al., 2018, Voronka, 2019, Adams, 2020).

This power imbalance is further reinforced by the dominance of the traditional clinical recovery model in mental health services (Gillard et al., 2015b). While recovery-oriented organisations are critical to successful PSW role implementation (Le Boutillier et al., 2011, Moran et al., 2013, Ibrahim et al., 2019), the focus on clinical risk in the medical model often impedes recovery (Byrne et al., 2016). The introduction of PSW roles in mental health services with traditional hierarchies has been described as a clash of cultures (Gillard et al., 2015b). PSWs report that the medical model can create a culture of mistrust toward service users and produce attitudes and beliefs that limit recovery principles and progress (Byrne et al., 2016).

On the one hand, some argue that PSWs need professional development opportunities to support role satisfaction, including clearer role definitions, better pay, and increased autonomy (Ahmed et al., 2015, Myrick and Del Vecchio, 2016). On the other hand, others caution that professionalisation risks undermining PSWs distinctiveness and core values, potentially reducing effectiveness and a barrier to PSW worker entry and retention (Alberta and Ploski, 2014, Adams, 2020).

Knowledge gap

Evidence indicates that OC significantly influences the implementation of PSW roles with a range of challenges highlighted. However, OC can be viewed as a polyvalent construct, defined as something that superficially commands stakeholder

endorsement while concealing conflicting assumptions and expectations (Slade, 2017). As shown in Table 2-5, OC is widely recognised as influential in shaping the implementation of PSW roles, but its meaning remains unclear and subject to varied interpretations and conflicting assumptions. This ambiguity raises two critical questions: What do we mean by OC, and how does it influence the implementation of PSW roles?

These questions point to a significant knowledge gap in understanding the relationship between OC and PSW implementation, which is important for several reasons. First, the connection between OC and PSW role implementation is under-researched (Jones et al., 2019). Second, PSW roles are becoming integral to mental health policy and the future mental health workforce (NHS England, 2019a, NHS England, 2019b). Third, PSW roles have demonstrated effectiveness in improving service user recovery outcomes and positively impacting mental health systems. Understanding how OC impacts their implementation is essential for maximising these benefits. Addressing this knowledge gap can lead to better-informed policies, more effective PSW integration, and a stronger theoretical foundation for PSW roles. This knowledge is also relevant for a wide range of stakeholders, including PSWs, clinicians working with and alongside PSWs, policymakers, commissioners, and organisations currently implementing or planning to integrate PSWs into their workforce.

Summary

This chapter reviewed mental health recovery as a central framework, focusing on its integration into policies and practice. It highlighted key evidence supporting recovery while exploring the roles of PSWs and the growing body of empirical evidence

surrounding their contributions. OC was identified as a significant factor shaping the implementation of PSW roles, with specific challenges noted. The chapter concluded by identifying a critical gap in understanding the relationship between PSW role implementation and OC, laying the groundwork for deeper theoretical review and exploration in Chapter 3.

Chapter 3: Theoretical review of institutional logics

This chapter builds on the knowledge gap identified in Chapter 2 by providing a theoretical review of institutional logics. The chapter begins with reflections on the review methodology and justifying the selection of institutional logics as the theoretical approach for examining PSW role implementation and aspects of OC. A detailed exploration of institutional logics - including its definitions, evolution, and the recognition of multiple, often conflicting logics within OCs - sheds light on how this theory can deepen our understanding of PSW roles in mental health settings. By reviewing its application in healthcare research, the chapter highlights how institutional logics can offer new insights into the challenges and opportunities in implementing PSWs and aspects of OC. The chapter concludes by positioning institutional logics as the theoretical lens to address the knowledge gap identified, with a detailed discussion of methodology and methods to follow in Chapter 4.

Reflections on theoretical review methodology

Initially, Chapter 3 was intended to be a systematic review. The aim was to investigate the organisational barriers and facilitators to implementing PSW roles in different mental health settings. However, two main challenges arose when applying systematic review methodology to the concept of OC:

1. Framing the review question to capture OC and related terms proved difficult. The review required precise search terms, but it was unclear which terms should be included to accurately reflect OC.

2. During the pilot review search, studies used the term "organisational culture" either alongside or interchangeably with other terms like "organisational components," "features," "aspects," "climate," and "factors." This raised concerns about whether these terms referred to OC or had different meanings altogether.

The pilot search also revealed that authors did not clearly distinguish between these various terms, making it hard to determine what they meant by OC. Additionally, PS studies identified in Table 2-5 did not clearly define OC. As a result, it became impossible to create a systematic review question or inclusion criteria that was sufficiently sensitive and specific to yield credible findings. Attempting to review the vast literature, with its inconsistent terminology and unclear definitions, would not have answered the intended review question.

As highlighted in Section 2.8, OC is a broad, amorphous, and often vague concept that is difficult to operationalise. While OC is not well-defined or fully understood about PSWs or even healthcare in general, it has been studied and defined in various ways in other contexts. The lack of a clear, theoretically informed understanding of OC impedes an effective understanding of the implementation of PSW roles. Without this understanding, it becomes challenging to modify or change OC in ways that could support PSW implementation. Therefore, developing a theoretical understanding of OC about PSW implementation is essential for facilitating the successful adoption and implementation of evidence-based PSW roles in mental health organisations.

Given the complexity of OC, a theoretical review was deemed the most appropriate approach for exploring these PSW roles and implementation dynamics. Theoretical reviews can serve several purposes, such as (1) examining influential and overlooked theories, (2) mapping a wide range of theories, (3) integrating complementary theories, or (4) conducting in-depth analyses of key theoretical works (Campbell et al., 2014). Unlike systematic reviews, which aim to minimise bias in analysing empirical data, theoretical reviews allow for a broader exploration of ideas, making them suitable for addressing complex or multifaceted concepts like OC (Campbell et al., 2014). By drawing on diverse literature and interdisciplinary perspectives, theoretical reviews can generate new questions and insights. They also offer more flexibility and nuance, allowing subjective and inductive processes to navigate complex theoretical landscapes.

This theoretical review purposefully spotlighted the theory of institutional logics to explore how it might offer novel insights into aspects of OC and PSW implementation. Instead of attempting a comprehensive review of all relevant theories of OC, this review focused on the potential of institutional logics to illuminate new insights and understandings. Campbell et al (2014) was drawn upon to support the understanding and structure of theoretical reviews; however, it was used solely for informational purposes and did not serve as a guiding methodological structure for this review.

3.1 Rationale for choosing institutional logics

Numerous sociological theories exist that can be used to understand organisations, institutions, and OC through a sociological lens. Among these, the theory of

Institutional logics has been selected to address the identified knowledge gap. Institutional logics offers a useful theoretical lens for exploring aspects of OC and the implementation of PSW by adopting a cross-level perspective, it considers how salient aspects of macro level institutions (e.g., mental health policy) exert their influence and shape micro level actions (e.g., PSWs interactions with service users) while mediated by meso level organisational realities (e.g., team structure) (Thornton and Ocasio, 2008). The theory recognises the complexity and varying influences across different levels that may impact the implementation of roles within organisations, such as PSWs.

As discussed in Section 2.8, PSWs work within a specific set of principles and values (Repper, 2013), which can conflict with traditional clinical recovery cultures, such as the medical model. These tensions raise concerns about how PSWs can operationalise their support within these environments. The literature highlights systemic pressures from healthcare organisations (e.g., NHS) influencing both the role and its implementation, suggesting a clash between recovery-focused versus medical approaches within mental health organisations. This indicates the presence of competing influences or institutional logics within and across different levels of mental health organisations that employ PSWs.

Institutional logics provide a theoretical approach to understanding how differing influences or logics at various levels of a mental health organisation enable or constrain PSW role implementation (Greenwood et al., 2011). By focusing on cross-level processes and multi-level mechanisms, the theory can offer insights into how

institutional logics - at the macro, meso, and micro levels - shape the implementation of PSW roles and aspects of OC. These different levels of analysis are defined below:

- **Micro level:** refers to the level of individual actors and their behaviours, actions, interactions, and carriers of rules within the systems in which they organise, such as how individuals make decisions or interact with others.

- **Meso level: r**efers to the organisational level, including workplace policies, rules, and norms that govern behaviour within an organisation.

- **Macro level:** refers to the broader societal level, including institutions, structures, and systems that shape society, such as political and policy influences.

Applying institutional logics has the potential to illuminate how the relationship between these different levels constrains or enables PSWs. It may also uncover various, potentially conflicting, institutional logics within mental health organisations, offering deeper insights into key aspects of OC. Given its ability to link different levels of influence, institutional logics were chosen as the preferred theoretical lens to explore the relationship between OC and PSW role implementation in a mental health organisation. The following theoretical review explores how institutional logics can offer new interpretations and insights into PSW role implementation while revealing aspects of OC.

Institutional logics concepts

In this chapter, the key concepts, their definitions and examples to help clarify and enhance the reader's understanding of these terms are presented in Table 3-1.

Table 3-1 - Key concepts

Concept	Definition	Examples
Actor	An actor is a name used by sociologists to describe humans who act in their environment, thereby shaping that environment (Harries, 2011)	PSWs, clinicians (e.g., nurses, psychiatrists, advanced nurse practitioners), healthcare assistants, carer peer support workers, team managers
Structure	Structure and structures refer to the organisational policies and cultures that surround, shape, and influence actors, just as actors shape and influence these structures.	Capitalism in its current neo-liberal form, National health service, organisational policies, team hierarchies
Agency	Agency refers to the capacity of actors to act independently, make decisions, and sometimes resist or recast existing structures while still being influenced by them	PSWs advocating for changes to the way service users are seen and cared for by psychiatrists or nurses accepting or resisting PSW interpretations
Organisation	An organisation is a group of individuals with a shared united purpose, forming a social structure to pursue the collaborative attainment of specific goals (Scott and Davis, 2015). It has a relatively fixed structure of roles, responsibilities, and authority that exist independently of those occupying roles (Handel, 2003)	NHS trust, Universities
Institution	An institution refers to a set of distinct and coherent ideas, norms, or practices that shape and give meaning to how actors frame, theorise, and narrate their	Hospitals as a way to care for acutely unwell people, and RCs as a way to support those

	experiences. Institutions are often embedded within wider social structures	with mental health distress
Organisation and Institution	The key difference between an institution and an organisation is that an organisation is the social structure where actors are employed, and an institution refers to the ideas that shape and influence how these actors perform their day-to-day tasks. Institutions may or may not have their ideas become a form of professional practice (e.g., nurses become professionals, families do not)	The organisation of an NHS trust with physical buildings, NHS organisations employ professionals whose practices are institutionalised professional role duties

This thesis defines institutional logics **as historically contingent and socially constructed patterns of assumptions, expectations, material practices, values, rules, and beliefs held by actors, often unconsciously, which shape their reasoning frameworks** (Suddaby and Greenwood, 2005, Thornton and Ocasio, 2008).

3.2 Institutional logics theory

Institutional logics was first introduced by Friedland and Alford, who defined them as sets of "*material practices and symbolic constructions*" that are "*organisationally structured, politically defended, and technically and materially constrained*" (1991, p.248). Later, Rao, Monin, and Durand expanded this definition, describing institutional logics as "*distinctive categories, beliefs, expectations and motives [which] constitute the social identity of actors*" (Rao et al., 2003) (p.797). Thornton and Oscacio provided a more detailed definition, calling institutional logics "*the socially constructed, historical pattern of material practices, values, rules, and beliefs by which individuals, groups,*

and organisations produce and reproduce their material subsistence, organise space and time, and provide meaning to their social reality" (Thornton et al., 2008) (p.804).

A common theme unites these definitions. Institutional logics arise from institutions and are shaped by them. In essence, they serve as constraints and guidelines tied to institutions, providing a frame of reference that influences actors' beliefs and actions by defining which goals and aims make sense and what is considered legitimate or appropriate in a specific circumstance or situation. By providing a framework for organisational orders, practices, and boundaries of legitimacy, institutional logics offer actors choices for sense-making, the vocabulary to motivate action, and a sense of identity and self (Haveman and Gualtieri, 2017).

Critically, institutional logics define the limits of rationality by determining both means and ends and what is valued and how it is valued. Institutional logics help actors understand what constitutes appropriate behaviour, sometimes limiting their consideration of alternative actions. Friedland (2013) emphasises that institutional ideas transform into logics only when theories, frames, and narratives are integrated into embodied practices. Institutions such as religion, family, state, and profession strongly influence actors. For example, at the macro level, the institutional logic of religion shapes the behaviours and identities of actors within organisations such as convents, including nuns. A nun, for instance, is unlikely to disobey the norms of the convent because she has internalised the logic of the religious order. This logic creates a shared sense of purpose, common identity, and a framework for interpreting situations, constraining her actions (Reay and Hinings, 2009).

An example of how institutional logics operate across different levels can be seen in the role of a nurse, psychiatrist, and PSW. Each role draws on distinct training, values, and institutional logics to guide how their practices are interpreted and enacted.

At the micro level, individual interactions with service users may reflect different institutional logics. A nurse responding to a distressed service user might focus on assessing risk, drawing on professional nursing logic and using clinical judgment to detect subtle cues that indicate potential harm. This reflects internalised values of nursing care, as well as constraints, such as the use of touch (e.g., limited) or the type of relationship the nurse can offer (e.g., professional rather than personal). A psychiatrist, on the other hand, might approach the same situation with a professional logic that prioritises diagnosing symptoms and determining treatment options, such as medication adjustments. This reflects their medical training, which prioritises clinical expertise and structured evidence-based approaches to care. While a PSW grounded in a recovery-oriented logic might approach the same situation differently. Rather than focusing on diagnosis or risk, the PSW might seek to normalise the service user's feelings and share lived experiences to instil hope.

At the meso level, the NHS Trust and specific healthcare settings provide frameworks of guidelines, responsibilities, and constraints that shape actions. A nurse within an NHS Trust might follow specific policies, such as addressing risks and completing care plans within a defined timeframe. While these guidelines may influence their actions, the nurse still has agency in deciding how best to apply these tasks based on the situation and their professional judgment. Psychiatrists, similarly, might encounter meso level requirements such as conducting regular medication reviews and

documenting detailed risk assessments. While these frameworks define key professional responsibilities, psychiatrists may interpret their roles differently. Some might adhere strictly to the medical model, while others might collaborate with nurses and PSWs to align treatment plans with recovery-oriented care. For PSWs, meso level structures could involve participating in team meetings, providing opportunities to advocate for recovery-oriented approaches. However, these meetings can be hierarchical, with clinical expertise typically holding greater authority. As a result, PSWs may need to assert the value of their lived experience to influence care decisions, depending on the team dynamics.

At the macro level, broader healthcare policies, such as recovery-oriented care, shape how different roles deliver care. However, each role may interpret these policies differently based on their institutional logics. For nurses, this might involve balancing medical and pharmaceutical values with an emphasis on recovery-oriented values. While some nurses may lean toward a medically focused interpretation of their role, others might embrace a more holistic approach, without the experiential element, that centres on service user empowerment. For psychiatrists, broader policies might influence how they interpret their responsibilities. Some psychiatrists may focus predominantly on symptom reduction and functional improvement, consistent with the medical model, and others might actively integrate recovery principles by seeking the input of PSWs and nurses to align care with the goals and values of service users. While PSWs align more closely with the ethos of recovery-oriented care, they may face challenges in systems dominated by medical logics, where their recovery-oriented values can conflict with medical priorities. In practice, each role relies on institutional logics to navigate these broader guidelines and implement care daily.

The relationship between professional or role identity and institutional logics is recursive. For example, the nurse's experiences and professional training reinforce their shared professional nursing logic, which, in turn, then shapes their sense-making and influences their responses to various situations. The link between professional identity and institutional logics is integral across these levels. It links macro level ideas or orders, meso level structures, and micro level actions, helping the nurse, psychiatrist, and PSW to interpret, make sense of, and respond to the complexity within healthcare settings.

In summary, each institution establishes unique organising principles, practices, and symbols that shape how reasoning and rationality are understood and experienced by actors. Actors' sense-making and actions are influenced by different aspects of their identity, rooted in institutional logics. Ultimately, institutional logics manifest as macro level institutional ideas that actors interpret and transform into micro level realities through their reflexive and self-aware actions (Shaw et al., 2017).

3.3 Institutional logics use and evolution

Institutional logics have become a key concept in organisational and management studies (Greenwood et al., 2017). The early foundations were laid in the 1960s by scholars like Selznick and Stinchcombe (Selznick, 1957, Stinchcombe, 1965). Meyer, Rowan, and Zucker contributed significantly to early work in the 1970s. Zucker highlighted the role of cognition and culture in institutional analysis, emphasising how cultural understandings are preserved and perpetuated over time. This ongoing reinforcement of shared meanings and practices can signal institutionalisation (Zucker, 1977). Meyer and Rowan (1977) describe institutionalisation as the process

through which socially accepted conventions become widely recognised and integrated into social thought and actions. Zucker (1977) further notes that institutionalisation is also a property of acts and actors that have become a "*more or less taken for granted part of social reality*" (p.728).

Meyer and Rowan proposed that organisations operate within rule systems that are often taken for granted and communicated as rationalised myths, which are accepted regardless of their actual suitability or accuracy (Meyer and Rowan, 1977). Together, these early scholars laid the groundwork for understanding the cultural and cognitive dimensions of institutions and logics, showing how shared, taken for granted rules and understandings define and shape organisational realities.

Emphasis on structure over agency

Friedland and Alford's 1991 work was a highly influential analysis of institutional logics. They focused on macro societal phenomena, proposing that key institutions in Western societies, such as the family, markets, states, and democracies, each operate according to their own central institutional logic (Friedland and Alford, 1991). These logics explain connections across three levels of analysis: individual, organisational, and societal. In their view, institutional logics are societal-level constructs that organisations and actors draw upon to guide and assign meaning to institutions. They saw these logics as more influential than the institutions themselves, providing overarching frameworks that shape institutions, organisations, and actors.

Initially, institutional logics emphasised structure over agency (Haveman and Gualtieri, 2017). The levels of analysis - societal (macro), organisational (meso), and individual

(micro) - were seen as nested, with each level structuring the level below. For instance, societal structures shape organisational actions by creating opportunities and constraints, while organisational structures do the same for individual actions. Although actors can sometimes reinterpret or manipulate institutional symbols and logics to serve their interests, the agency was viewed as limited. Institutional logics, when internalised, are widely accepted, embedded, and go unquestioned, leaving little room for resistance. On the other hand, externalised logics, which are less entrenched, offer more flexibility and room for agency, as actors have the space to apply their own rules or manipulate logics to meet their needs. However, achieving desired ends depends on who controls the allocation of resources and rules.

Increasing emphasis on agency

Over time, the theory of institutional logics has been reformulated to place greater emphasis on agency, particularly through the concept of "embedded agency" (Thornton and Ocasio, 2008, Thornton et al., 2012a). Embedded agency refers to the idea that while actors are embedded within institutional logics, they also retain a degree of independence from them. This assumption recognises that institutional logics, though they shape behaviour and decision-making, offer actors opportunities to reinterpret and reconstruct logics in ways that align with their own interests.

In the context of mental health, an embedded agency might involve clinicians working within the institutional logic of the medical model while also drawing from recovery-oriented principles to advocate for more holistic approaches. For example, a psychiatrist might operate within a professional logic that focuses on diagnosis and medication but also incorporates recovery-oriented practices and a recovery logic that

prioritises service user empowerment and self-determination. Here, the actor navigates and sometimes challenges the tension between the traditional clinical recovery approach and recovery-oriented approaches.

Embedded agency also suggests that actors can leverage contradictions between the logics of different institutions. For example, a mental health organisation working within both the public healthcare system and the nonprofit sector might leverage the efficiency-driven logic of the public system alongside the social welfare logic of the nonprofit sector. This could allow the organisation to advocate for policy changes that increase access to mental health services while simultaneously emphasising the importance of community support and long-term recovery outcomes. By navigating these tensions, the organisation can strategically select and combine logics to achieve its goals of improving mental health care delivery.

The newer formulation of institutional logics acknowledges that while institutional environments can constrain actors, those actors can also exert agency within those environments. Institutional logics are no longer seen as solely societal-level constructs but can also operate at multiple levels, including within and between organisations. For example, an organisation might embody the logic of professions, the state, and advocacy groups (Kraatz and Block, 2008). When logics are nested hierarchically, they frame actions and are, in turn, shaped by those actions. For example, a clinician working within traditional mental health services may attempt to incorporate recovery principles in their practice, advocating for strengths-based, trauma-informed treatment plans. However, the dominance of the medical model, which prioritises symptom-focused interventions, may limit the integration of recovery approaches. This illustrates

how dominant logics can suppress other logics, even when they aim to reshape practices and challenge established norms.

Shift toward multiple and competing logics

Institutional logics distinguishes between being an institution and being a consequence of one (Greenwood et al., 2011). This distinction provides the core strength of the theory, offering a lens to understand and analyse how institutions influence actors and organisations and how institutional logics constrain and enable action. Rather than focusing solely on institutions themselves, the theory examines the institutional logics that emerge from them. Two key assumptions arise from this:

1. Institutional logics are not mutually exclusive; multiple logics can coexist and overlap within the same environment.
2. These institutional logics can conflict, providing incompatible prescriptions for action, which creates tension for actors (Greenwood et al., 2011, Friedland and Alford, 1991).

A key reformulation of the theory is decoupling institutional logics from institutional orders. This allows for the conceptualisation of multiple logics within a single field, where a single logic, like professional logic, can be influenced by or derived from various institutional orders, such as government bodies and professional associations. This shift has led to a growing focus on hybrid or plural logics, where multiple, often competing or complementary logics coexist within organisations or fields. Scholars have explored how organisations respond to these logics, noting that they can be incompatible and contested, coexist peacefully, or result in one logic dominating while

others play peripheral roles (Pache and Santos, 2010, Besharov and Smith, 2014). For example, a mental health organisation might simultaneously adopt a professional, medical model, recovery-oriented, and risk logic, each emphasising different goals.

Conflicting logics

Institutional logics operate across multiple levels - societal (macro), organisational (meso), and individual (micro). Each level shapes the opportunities and constraints for the level below it (Friedland and Alford, 1991). As Friedland and Alford (1991) note, "*individuals competing and negotiating, organisations in conflict and negotiation, and institutions in contradiction and interdependency*" (1991) (p. 240). Conflict between institutional logics can occur in two ways:

1. **Cross-level conflict**: tensions arise when logics at different levels influence one another, such as meso level organisational expectations clashing with micro level individual goals.

2. **Intra-level conflict**: multiple logics within the same level (e.g., within an organisation or field) compete for dominance, leading to tension.

In a mental health setting, these conflicts may manifest in a variety of ways, especially with a range of actors involved at different levels. Examples of how these cross-level and intra-level conflicts might manifest are outlined in Table 3-2.

Table 3-2 - Examples of cross and intra-level conflicts

Actor	Cross-level conflict	Intra-level conflict
PSW	A PSW supports a service user's recovery and self-determination (micro) while needing to comply with organisational safety and accountability policies (meso)	PSWs may face tension with nurses or psychiatrists whose professional logics focus on risk management, and clinical interventions might clash with the recovery logic of the PSW
Nurse	A nurse aims to provide person-centred care by asking questions that explore their interests, which can be time-consuming (micro) while adhering to organisational efficiency targets (meso)	Nurses aligned with a nursing professional logic but with different specialisations (e.g., mental health vs. adult) may have competing priorities
Manager	A manager balances the team's morale and well-being (micro) while meeting the organisation's key performance indicators and budgetary constraints (meso)	Conflicts may arise between managers aligned with managerial logic and prioritising competing resources within the same organisation
Chief executive	A chief executive may aim to innovate and drive systemic change based on government policies (macro) while facing resistance from meso level stakeholders who prefer established routines and protocols	Tension may occur between executives with differing visions for organisational strategy or long-term goals

Reay and Hinings (2009) propose that these conflicts may lead to the coexistence or competition of multiple logics within an organisation or field and the dominance of one

logic, where certain groups or organisations prioritise specific practices over others (Reay and Hinings, 2009).

Institutional logics evolved from an initial focus on singular, societal-level logics towards recognising the existence of multiple, overlapping, and competing logics at different levels. This theoretical lens provides insight into how actors and organisations are shaped by institutional logics and how conflicts between logics - across or within levels - can influence which practices and institutional logics dominate in a given context.

3.4 Studies using institutional logics

The theory of institutional logics has been applied across various fields and disciplines. Some examples include accounting (Lander et al., 2013), publishing (Thornton, 2004), banking (Lounsbury, 2007), higher education (Kunkle, 2023), media (Van Dijck and Poell, 2013), and social movements (Lee and Lounsbury, 2015). Additionally, it has been utilised in a range of contexts, such as non-profit (Mullins, 2006), private (Smets et al., 2015), and public sector (Berg and Pinheiro, 2016), including within healthcare organisations and systems (Kjekshus and Bygstad, 2024, Van den Broek et al., 2014).

Healthcare organisations have been characterised by institutional complexity (Greenwood et al., 2011). They are multifaceted and complex and may embody multiple, simultaneous institutional logics. Each institutional logic provides different interpretations of reality, embodying the organising principles that guide how healthcare workers perform their work (Scott, 2000). A review of the literature identified four studies applying institutional logics to healthcare organisations. Two studies

highlighted unexpected cooperation and the fusing of logics, while the other two, focused on mental health, demonstrated how the theory illuminated polarising perspectives and the impact of restructuring reforms on care delivery.

Study one: Unexpected co-operation

Study one examined the implementation of integrated transitional care at a hospital in London, England (Shaw et al., 2017). The researchers used an ethnographic case study design, utilising non-participant observation, in-depth interviews, and document analysis. They aimed to understand how macro level policy ideas, meso level organisational factors, and micro level clinical practices interacted to enable or constrain integrated care.

Using institutional logics theory, the researchers analysed how broader institutional ideas embedded in The Community Care (Delayed Discharges) Act (Department of Health, 2003) influenced organisational and clinical practices. At the macro level, the Community Care (Delayed Discharges) Act included policy ideas, such as promoting fines for delayed discharges and partnerships between health and social care. At the meso level, leaders within the organisation acted as “institutional entrepreneurs”, promoting a “partnership logic” over the conflict-oriented logic reflected in policy. They achieved this by creating agreements and processes to foster collaboration between health and social organisations. At the micro level, a key staff member acted as an entrepreneur, bringing the partnership logic to life by leading a new “hub” model of integrated care planning and engaging in “relationship work” to build partnerships.

The institutional logics theory helped the researchers identify and trace how the policy idea of partnerships became the dominant guiding logic for organisational and clinical practices in this area, enabling more integrated transitional care. They emphasised that institutional entrepreneurship by leaders at multiple levels was key to translating policy ideas into an integrated care logic applied in daily practices. In summary, institutional logics provided an explanation of how macro level policy directives shape meso level organisational and micro level clinical actions through the sense-making and agency of institutional entrepreneurs, highlighting the role of human actors in mediating and enacting policy ideas in practice.

Study two: Fusing of logics

Study two explored how care workers in the United States attempted to navigate multiple institutional logics in hospice care (Cain, 2019). The researcher employed longitudinal ethnographic qualitative methods, including participant observation and semi-structured interviews with care workers, to understand the impact of Medicare policy change on their organisation.

The researcher conceptualised three institutional logics informing hospice care: medical, holistic, and managerial. Before the policy change, the interdisciplinary team was viewed as the main innovation of the hospice, allowing workers to resist the prevailing logics from the larger medical institution. However, following the policy change, increased organisational pressures led both workers and managers to adapt in ways that reinforced medical logics.

While many workers recognised the importance of providing high-quality care, under pressure they organised logics in their environment in ways which aligned more closely with conventional medical settings. Although they subtly adjusted their team behaviours, they maintained a commitment to the interdisciplinary team in their discourse, resulting in a disconnect between their stated beliefs and actual practices. For instance, some workers often reverted to their medical training, which emphasised siloed working and acute care practices. Overall, the findings revealed that several processes at different levels, including administrative, team meetings, and individual practices, allowed the fusion of managerial and medical logics while marginalising holistic logics and granting more authority to medical professionals.

In summary, institutional logics provided a theoretical lens to explain how the three logics (managerial, holistic, medical) interacted, sometimes contradicting and cooperating, making some actions appear more reasonable. The theory enabled the identification of these contradictions, particularly the tension between the rhetoric of interdisciplinary teams and the actual behaviours of workers. Furthermore, it revealed how macro level policy changes and pressures can impact work practices, such as shifts in the division of labour, leading workers to make minor adjustments to meet job demands and find meaning in their work.

Study three: Illuminating polarising views

Study three examined the development and implementation of clinical pathways in mental health services in Norway (Tørseth, 2021). Researchers employed a qualitative single case study design, text/document analysis and in-depth interviews. These methods helped identify the key actors and their respective institutional logics

regarding clinical pathways. The analysis revealed two main groups of actors: mental health professionals and politicians. Mental health professionals prioritised values of discretion and autonomy in patient treatment, viewing clinical pathways as potential interference with providing individualised care. In contrast, politicians emphasised efficiency, quality, and control values, believing that clinical pathways would enhance services through standardisation.

The conflicting institutional logics between groups sparked debates and negotiations during the development of the pathway, with each group striving to retain their core values. The outcome of this process was a pathway that retained some degree of professional discretion while also increasing bureaucratic coding and monitoring. Overall, examining how the different institutional logics influenced sense-making and debates provided valuable insights into how actors' values shaped the construction of the new clinical pathway policy. The application of institutional logics also highlighted how these conflicting logics resulted in polarised debates about the clinical pathway and a negotiation process between maintaining professional discretion and implementing greater control and standardisation. The theory illustrated how institutional logics influence actors' interpretations, and the challenges faced when groups with conflicting logics collaborate to develop new policies.

Study four: Re-structuring influences care

Study four explored how institutional logics shaped organisational change in a community mental health clubhouse in the United States (Spitzmueller, 2020). The ethnographic study focused on a “Community Club” club-house programme, utilising observations, staff interviews, and document analysis over 12 months.

The research examined two primary logics: the community logic that guided the club-house model and the managerial logic introduced by new Medicaid reforms. The community logic of the club-house emphasised member empowerment, flexibility, and social connection, while the managerial logic of Medicaid prioritised accountability, efficiency, and standardised practices. Quality assurance (QA) staff acted as institutional entrepreneurs, promoting the managerial logic by monitoring documentation and staff productivity. This approach clashed with the community logic held by frontline staff, leading to distress and resistance as QA practices imposed oversight on daily work. The theory of institutional logics revealed how the managerial logic disrupted the community logic, resulting in ongoing conflicts over issues such as documentation requirements and the therapeutic environment. This conflict ultimately led to a transformation of the club-house approach.

The theory highlighted the different values and assumptions guiding the clubhouse model's community logic versus the Medicaid reforms' managerial logic. It clarified why frontline staff resisted changes that threatened their community-oriented values and autonomy. Additionally, it explained the ongoing tensions and conflicts that arose as both logics competed for legitimacy. Ultimately, it showed how the managerial logic gained dominance, reshaping aspects of the clubhouse approach through the power of QA staff. Institutional logics enabled the researcher to trace how macro level reforms altered organisational roles and priorities at the micro level. It provided insights into the complex struggles that emerged as external reforms collided with internal professional identities and practices rooted in different belief systems, enhancing the understanding of organisational change through the lens of institutional logics.

Key insights from the four empirical studies

The four empirical examples that have applied institutional logics as a theoretical lens share many similarities, summarised in Table 3-3.

Table 3-3 - Key insights from studies utilising institutional logics

Common themes	Key insights	Details
1. Methodological choices	Ethnographic approach	Studies #1, #2, and #4 employed ethnographic methods to explore institutional logics, while study #3 utilised multiple methods for diverse and rich data collection
	Data richness	Studies #1, #2, and #4 combined observations and interviews allowing the researchers to uncover contradictions between actions and beliefs, providing deeper insights
2. Participant-centric analysis	Grounded perspectives	All studies focused on participants' experiences and perspectives, drawing on in-depth qualitative examples to enhance analysis
3. Application of institutional logics theory	Identifying logics	All studies used institutional logics to identify specific logics emerging from institutional ideas or examine diverse logics within complex healthcare contexts
	Understanding agency	Studies #1, #2, and #4 illustrated how the theory helped reveal actors' agency in responding to institutional changes and reforms
	Highlight values and beliefs	Studies #3 and #4 demonstrated how it helped identify and categorise values, assumptions, and beliefs of the main actors’
4. Tensions and conflicts	Highlighting tensions	All studies used theory to illuminate the tensions between competing logics (e.g., top-down reforms vs. front-line priorities), showcasing how resistance and change arise from these conflicts and power dynamics
	Contradictions in practice:	All studies identified contradictions stemming from competing logics, employing the institutional logics lens to clarify these complexities

5.	**Strategies for navigation**	Creative management	Studies #1, #2, #4 highlighted individuals' strategies to navigate and manage multiple logics and institutional complexities effectively
		Sense-making	All studies provided explanations for how actors make sense of and/or interpret logics and negotiate changes
6.	**Key explanatory framework**	Inductive and iterative	All studies used a consistent inductive and iterative approach allowing institutional logics theory to emerge as a key explanatory framework, enhancing the understanding of healthcare organisational dynamics

Critiques of institutional logics

There are several criticisms directed towards the theory of institutional logics. First, institutional logics are defined as both material and cultural, which can be problematic. Logics are cognitive constructs, including socially constructed rationalisations, shared understandings, and schemas, rather than material constructs (e.g., practices, policies, or structures). Material phenomena are consequences of human action that manifest from these logics (Haveman and Gualtieri, 2017). This distinction can be difficult to untangle in empirical work.

For this thesis, it is crucial to avoid assuming that material documents, such as PSW role descriptions, fully reflect the social reality of their work. To address this, multiple material sources will be employed alongside participant observation to interpret the PSW's work. This will help ensure that material documents are not taken at face value but are contextualised through direct observations of how PSWs carry out their roles in practice.

Second, previous research has approached logics as purely rational "cold" constructs. There has been criticism of how this may limit their scope by overlooking the emotional and affective components of logics (Haveman and Gualtieri, 2017). To address this limitation, the thesis will incorporate the emotional tone observed during interactions, as recorded in the observation data, and reflective field notes will capture the researcher's emotional responses and interpretations of emotions displayed in those interactions. Considering both rational and emotional dimensions of institutional logics, a more holistic understanding of how they shape behaviours may be developed.

Third, recognising multiple logics has led to under-specified or unspecified field-level logics about broader societal-level logic. This can create confusion about how logics emerged and how they operate across different levels of social order (Purdy et al., 2019). To address this, observational data will focus on instances where societal values are explicitly expressed or implicitly shape choices and behaviours. Additionally, the researcher's positionality will play a key role in analysis, acknowledging how personal assumptions, social background, and identity may influence data collection and interpretation. Reflexive practices will help highlight moments where the data challenges or shifts the perspective of the researcher, ensuring that positionality is critically examined throughout the study.

3.5 Applying institutional logics to PSW role implementation

In the context of this thesis, mental health organisations are seen as embodying multiple institutional logics. Institutional logics are hierarchically structured and non-exclusive. They can coexist within, across, or within organisational settings, potentially competing or conflicting. This means that actors within a mental health organisation may be exposed to multiple, sometimes contradictory, institutional logics simultaneously. These organisations are conceptualised as complex settings where various mental health workers, care philosophies, managerial processes, policies, protocols, and structures interact. Introducing PSWs into this already complex environment could create tension or lead to competing or conflicting institutional logics.

Within traditional mental health services, the PSW role can be seen as positioned within a space governed by multiple logics that exert significant influence and power

over all actors in the organisation (Light, 1995). Table 3-4 outlines examples of institutional logics that are likely to be present, each shaping the policies and practices within the organisation. These preliminary insights are formed based on my professional experience as a mental health nurse and an informal PSW, providing an initial understanding of how institutional logics might operate within mental health settings.

Table 3-4 - Preliminary typology of institutional logics

Potential type of Institutional logic	Description
Professional logic	Conflicting priorities among different healthcare clinicians (e.g., nurses, psychiatrists), mental health workers (e.g., support workers), and PSWs, each operating under a role-specific logic (e.g., nurses adhering to the Nursing and Midwifery Council's code of conduct)
Managerial logic	Mental health services include hierarchical structures, managerial duties, and administrative obligations
Policy logic	Variations in how different professional groups interpret and implement healthcare policies
Recovery logic	The framework and practices focused on recovery, such as the implementation of recovery-oriented roles and the use of recovery-based interventions
Medical model logic	The traditional medical framework focused on assessment, diagnosis, treatment, and medication adherence
Risk logic	The prioritisation and management of risk, including actions related to risk assessment, enactment of policies, and use of procedures such as the Mental Health Act in care delivery

The PSW role aligns closely with a recovery logic but may be less aligned to the other logics outlined in Table 3-4. These distinctions include:

1. **PSWs as carriers of recovery**: PSWs play a key role in promoting a recovery-oriented transformation within mental health organisations. They embody and advocate for the recovery culture as a visible part of this shift.

2. **Unique principles and values**: The PSW role is grounded in principles such as mutuality, reciprocity, non-hierarchical relationships, safety, and trust - values that set it apart from other mental health workers. In contrast, mental health clinicians, such as nurses or psychiatrists, often emphasise evidence-based interventions, hierarchal decision-making, and clinical boundaries to ensure structured care delivery and risk management.

3. **Sociopolitical roots: t**he PSW role is rooted in the historical and socio-political context of PS, which focuses on political change. This change agenda is unique to PSWs and reinforces the integrity of their role in a way that is not present in other mental health professions.

Examples of how the PSW role might conflict with or compete against other logics include:

- **Disclosure of personal recovery**: PSWs may choose to share their own experiences of recovery to model hope, which may be devalued or negatively valorised within a professional logic but highly valued by a PSW who is upholding a recovery logic.

- **Conflicting role expectations**: PSWs may be asked to engage in clinical practices, such as the control and restraint of service users, which could conflict with their core values and PS principles around trust and safety. This request could create tension between the PSW role and the risk-driven logic that guides traditional mental health workers' roles.

- **Task misalignment**: PSWs may be asked to perform duties outside their role, such as delivering medication, reflecting a misunderstanding of the PSW role. This can result in conflict between clinicians and PSWs, which could lead to the dominance of the medical model logic, overshadowing the PSW, who is strongly connected to a recovery logic.

The theory of institutional logics offers significant potential for revealing insights into the relationship between macro, meso, and micro level practices related to PSW role implementation. Key phenomena anticipated being in scope within the theory of institutional logics may include:

1. **Macro level**: how policy directives and institutional ideas embedded in policies (such as PSW workforce role expansion) affect PSW implementation.
2. **Meso level**: how mental health organisations operationalise these policies, such as implementing PSW roles and integrating them into services.
3. **Micro level**: how PSWs carry out their roles in practice, including their interactions with mental health workers and service users.

Institutional logics has not yet been applied to explore the role of mental health PSWs. The knowledge gap identified in Chapter 2 emphasised the lack of understanding of what the term OC means, and this theoretical approach offers a way to deconstruct and clarify the complex and multifaceted nature of this construct. The findings are likely to address macro level constructs such as recovery-oriented policy imperatives for PSW implementation, meso level constructs such as PSW job role descriptions, organisational procedures, and managerial practices, and micro level constructs such as PSW everyday interactions with other team members and service users. Ultimately, this thesis seeks to operationalise, characterise, and illuminate aspects of OC in relation to PSW implementation, as outlined in the Objectives in Section 1.2.

Summary

Chapter 3 introduced institutional logics as a valuable theoretical lens for understanding aspects of OC and PSW role implementation. By reviewing the theory's application in healthcare research, the chapter highlighted how institutional logics can offer rich insights into the complexities of implementing PSW roles and OC. It concluded by proposing potential institutional logics in relation to the PSW role. Chapter 4 builds on this by outlining the epistemology, methodology, and methods chosen to address the research question.

Chapter 4: Epistemology, Methodology and Methods

This chapter will present an overview of the epistemology, methodology, and methods of this thesis. By making explicit the methodological approach, the reader is better equipped to appraise the study findings. The chapter begins with my epistemological stance underpinning the research. This is followed by the philosophical and methodological assumptions of the research and the implications of using ethnography as the appropriate methodological approach to address the research questions defined and developed within the previous chapter. A critical examination of the chosen methodology follows, highlighting its strengths and limitations. The chapter also discusses the rationale behind the research design, ethical considerations, and the empirical methods employed in data collection and analysis. Finally, it details the data analysis strategy and how the subsequent findings in Chapters 5 and 6 will be presented.

4.1 Underpinning epistemology

This thesis considered a range of epistemological stances. The three main candidate epistemologies were standpoint theory, interpretivism, and critical realism.

Standpoint theory examines how an individual's social and political experiences shape their understanding of the world. It highlights the epistemic position of the PSW and focuses on how power, authority, and dominant forces shape and influence their knowledge. However, the research question seeks to explore broader institutional logics and aspects of OC on multiple levels, rather than from a singular standpoint. As such, standpoint theory was considered unsuitable for this thesis.

Alternatively, an interpretive approach focuses on understanding subjective, situated knowledge and localised meanings. While valuable for exploring context-specific experiences, interpretivism is limited in its ability to move beyond interpretation-based explanations of the social world. This limitation restricts the transferability of findings to other contexts. Consequently, interpretivism was also deemed an unsuitable approach for addressing the research question.

The third candidate, critical realism, moves beyond interpretations or individual perspectives. This epistemology can provide deeper insights into the underlying structures shaping phenomena. This stance seeks to offer insights and knowledge into "how" and "why" things occur by exposing hidden mechanisms, ideologies, politics, and power relations embedded within mental health settings. This stance allows for a more comprehensive understanding of the potential forces shaping behaviour - mechanisms that might remain hidden in other epistemologies, like interpretivism. On balance, critical realism was selected as the most suitable epistemology for this research due to its ability to provide nuanced insights into the potential structural and systemic factors at play.

Critical realism distinguishes between ontology (what we say exists or is 'real') - the 'observable' world, and epistemology (what we can understand or know about the 'real' world). This position states that the 'real' world exists independently of human perspectives and constructions, though it may not always be directly observable. Instead, the 'real' becomes evident through its effects on actions and events. Therefore, the world, as we understand and know it, is constructed from our experiences and perspectives through what is observable. Unobservable structures,

events, mechanisms, and contextual conditions interact to generate a given set of observable events. Therefore, the social world can only be understood if people understand the powers, structures, and relations that produce such events.

Table 4-1 outlines Bhasker's (1975) differentiated model of the ‘real’, distinguishing between the empirical, the ‘real’, and the actual (Bhaskar, 1975).

Table 4-1 - Differentiated model of the 'real'

Concept	Definition	Examples
The empirical	Refers to experiences, both direct and indirect, including empirically observable behaviours, thoughts, or feelings related to specific interactions or events	A PSWs observable behaviour, thoughts, or feelings during an interaction with a nurse
The real	Refers to the mechanisms that produce or inhibit an action, which may or may not be observable. These mechanisms have the potential to be activated by other powerful causal forces (Sayer, 1999, Vandenberghe, 2009)	Structures, relations, and powers (Parlour and McCormack, 2012) that influence whether a PSW engages with a psychiatrist. Institutional logics are an example of ‘real’ forces’ that may or may not be causal and impact an interaction
The actual	Represents the discernible outcomes or events, understood retrospectively, that indicate whether mechanisms within the real domain were activated	Evidence of mechanisms (e.g., institutional logics) influencing a specific interaction between a PSW and a nurse

The critical realist worldview adopted in this thesis acknowledges an empirical reality - a world that exists independently and speaks back to our constructions of it. However, it also recognises that not all constructions are equal since some fit better than others.

Individual meanings and experiences shape behaviour, which is ‘real’ in that they exist and may be potential causal mechanisms for human actions. Critical realism also acknowledges that humans all construct and receive constructions of our understanding of what is out there through our own cultural, geographical and social lenses and that no one has an entirely objective view. For example, scientists all come with their own cultural and geographical lenses. Although we can count and measure things as empirical reality, we must remain mindful that these measurements and the theories we use to interpret them and what may be casual are also socially constructed. In this thesis, I will be using the institutional logics theory as an element of the ‘real’ and exploring with participants how these logics may play out empirically.

Although critical realism forms the epistemological foundation of this thesis, an ethnographic qualitative methodology will be adopted. Using institutional logics as a theoretical framework, I intend to explore the factors that may or may not contribute to aspects of OC in relation to PSW role implementation. A full critical realist methodology would require a multiple-methods study design, which is beyond the scope of this PhD.

4.2 Methodology

Qualitative research paradigm

A qualitative methodology was chosen to explore how and in what ways institutional logics influence the implementation of PSW roles in mental health organisations. This methodology is underpinned by particular assumptions regarding ontology (the nature of reality) and epistemology (the nature and forms of knowledge) and the appropriate methods for acquiring that ‘knowledge’ (Avis, 2003).

Ontologically, qualitative research challenges the notion of a single, fixed social reality. Instead, it acknowledges the presence of multiple coexisting social realities (Lincoln, 1985). Epistemologically, it posits that both ‘knowledge’ and meaningful reality are socially constructed through social interactions between individuals and their social world, developed and conducted in specific social contexts (Bryman, 1984). Methodologically, qualitative research emphasises the subjective, insider perspective - the ‘emic’ view of an individual’s interactions, discourses, perceptions, understandings, and knowledge (Cresswell and Plano Clark, 2011).

Qualitative inquiry aims to understand, interpret, and describe how actors make experiential and explanatory sense of their social world (Grix, 2018). Ethnography involves open-ended questions about the phenomena of interest, grounded in the social, cultural and contextual setting of participants (Carter and Little, 2007). This is further enriched by observations of participants' actions and behaviours within these settings. By immersing the researcher in the participant’s world, qualitative research can generate rich data from the ‘emic’ and ‘insider’ viewpoint (Bradley, 1993).

Through reflexive practice and analysis, the researcher develops an ‘etic’ perspective, offering their interpretation of the phenomena (Mortari, 2015). Employing a qualitative approach was particularly suitable for exploring institutional logics within a mental health setting and how a PSW identity is shaped within an OC. The ethnographic methodology allowed for an in-depth exploration of the PSW and mental health workers' perceptions and experiences of different institutional logics. It also included observations, interpreted through my perspective, to shed light on how these logics influence the implementation of the PSW role.

Ethnography

An ethnographic approach was chosen to explore PSW role implementation and aspects of OC. Ethnography aims to uncover the cultural meanings and beliefs that individuals within particular cultures use to interpret their experiences and realities (Denzin, 1997, Lofland, 1995). Given the dynamic and complex nature of mental health organisations, ethnography enables the researcher to embed themselves in the environment, offering a more holistic perspective (Patton, 2005).

Observation is a central component of ethnographic research and involves my own interpretations. By observing participants and engaging in conversations, the researcher gains insights into their interpretations and actions. This approach provides a deeper understanding of how individuals navigate their social worlds and the meanings they attach to their behaviours within these contexts. Through this methodology, I observed and engaged in formal and informal discussions with team members and the PSW as they interacted with one another. These meaningful interactions provided valuable insights into their behaviours, practices, and the emerging institutional logics shaping their roles.

By capturing these moments in the everyday context of their work, I could examine how different logics manifest in ‘real’ world situations and influence the implementation of the PSW role. This immersive approach not only highlighted the complexities of institutional logics within a mental health setting but also allowed for a richer understanding of the lived experiences of PSWs and mental health workers. By documenting these interactions, I aimed to illuminate the subtleties of how OC shapes and is shaped by the dynamics between different actors in the field.

An ethnography can be understood as comprising three essential components: (1) guiding principles for data production and construction, (2) specific empirical methods employed during research, and (3) the final written thesis that presents the findings. Together, these elements shed light on the often un-noticed or taken-for-granted aspects of social behaviours, practices, and understandings, transforming the peculiar into the familiar (Savage, 2006).

Ethnography has gained increasing recognition in healthcare research as it provides valuable insights into the complexity and diversity of healthcare organisations (Jones and Smith, 2017). In mental health, it has provided nuanced insights into various practices and interventions. For instance, Forchuk et al. (2020) used an ethnographic approach to explore a community intervention from the perspective of PSWs, highlighting their experiences and revealing potential benefits for clients, such as enhancing hope and autonomy (Forchuk et al., 2020). Similarly, Aughterson et al. (2024) examined the mechanisms of action through which social prescribing community groups promote psychosocial well-being, offering a deeper understanding of how these groups operate (Aughterson et al., 2024). Norton et al. (2023) utilised an autoethnographic approach to reflect on PS supervision, providing a personal lens on this practice (Norton et al., 2023).

Ethnography is particularly valuable in capturing both the overt aspects of culture that are recognised and acknowledged and the covert dimensions that may remain unexpressed but are nonetheless shared among individuals. Such comparison can reveal discrepancies between what people say and what they do (Fetterman, 2010).

Ethnography originates from the field of interpretive anthropology. It emphasises the idea that culture consists of intricate “webs” of meanings (Denzin, 1997). As a result, the analysis of culture is an endeavour focused on understanding meaning rather than a scientific quest for universal laws or theories. Ethnography aims to document the intimate, inter-subjective, and nuanced understandings of particular groups, cultures, or social contexts (Reeves et al., 2008). Epistemologically, the phenomena under investigation are viewed as reflections of our beliefs and thoughts about the world. What actors perceive to be ‘true’ is both individually and socially constructed through their interactions over time within specific cultural and social contexts (Grix, 2018). Consequently, this position views the social world as a realm of ideas that can have a ‘real’ impact, and the researcher becomes interwoven into the very fabric of these social worlds. The researcher is unable to refrain from influencing the ‘knowledge’ produced and the field of study, thus making it impossible to maintain an entirely objective perspective (Hammersley and Atkinson, 2019).

The emergence of diverse perspectives regarding the phenomena of interest leads to an array of diverse interpretations, with each actor constructing their own personal and valid viewpoints (Gadamer, 1976). This thesis presents the interpretations of participants’ behaviours, constructs, and understandings, which have the potential to reveal identifiable patterns influencing behaviour. Thus, the resulting ‘knowledge’ is contextually grounded, pointing to potential underlying mechanisms that drive behaviour. It is important to note that this position acknowledges the inherent values within ‘knowledge’, suggesting that no aspect of the research can be considered value-free, objective, or fixed (Cresswell and Plano Clark, 2011).

Principles of ethnographic research

Several key anthropological principles are foundational to ethnographic research (Prentice, 2010). First and foremost, fieldwork is essential for developing theory and requires being embedded in the environments and contexts of the participants. This immersion allows researchers to engage with participants, gaining an in-depth understanding of their social practices, behaviours, and activities as they unfold in real-time within their natural context (Hallberg, 2013). The objective is to actively learn from participants and engage in the process of discovering and learning about their world with the purposeful intention of grasping their perspective, often referred to as the 'native' or 'insider' viewpoint (Roper and Shapira, 2000).

To achieve this, the researcher assumes the role of a data-gathering instrument, responsible for both collecting and analysing data (Pezalla et al., 2012). This unique position enables the researcher to observe firsthand the social particularities, nuances, empirical generalities, structures, rules, and norms that characterise a particular culture (Wolf, 2012). This thesis includes the PSW and mental health workers in their everyday context. Immersion in the setting allows the researcher to gain in-depth insights relevant to the research question, enriching the findings (Brink and Edgecombe, 2003). In addition to observation data, formal and informal conversations with the PSW and mental health workers were used to clarify and further understand their experiences, interpretations, and actions in their daily activities. The fieldwork focused on illuminating the institutional logics within the mental health setting and understanding how PSWs and team members interpret these through inductive conceptualisations.

Second, the research process is iterative (Karen, 2008). The researcher must observe, interpret, and reflect throughout the research process. This means that ‘knowledge’ is not a pre-existing entity awaiting discovery; instead, it emerges gradually over time (Jeffrey and Troman, 2004). This flexible approach gives the researcher time to ‘grasp’ the participant’s point of view and attempt to understand their versions of the world (Geertz, 1973).

Finally, social context is crucial to understanding complex socio-cultural phenomena like OC (Hammersley and Atkinson, 2019). Individual’s beliefs and behaviours are influenced and shaped by various factors, including organisational dynamics, structures, power, institutional rules, and expectations. Therefore, to capture the ideas, beliefs, and practices of participants, the researcher must study them in their “natural” social contexts (Wolf, 2012).

Ethnographic research is shaped by the relationship between those being researched and the researcher (Hammersley and Atkinson, 2019). This takes into consideration both the etic (outsider) and emic (insider) points of view and acknowledgement of multiple realities (Whitehead, 2005). These etic and emic perspectives played a significant role in exploring the implementation of the PSW roles within a mental health community team. As a researcher, I viewed these perspectives as two different ways of viewing and learning about the world instead of attempting to find a balance between the two. The types of etic and emic data included:

- Etic data: field observations, interviews, and artefacts/documents within the setting, offering an ‘outsider’ viewpoint to explore PSW role implementation and aspects of OC.

- Emic data: my ‘insider’ perspective and interpretations of the cultural meanings, practices, and/or behaviours of the team members who engage and participate in that culture.

The etic and emic perspectives were synthesised iteratively throughout, and this approach enabled a rich analysis in order to explore PSW role implementation, explain institutional logics and illuminate aspects of OC.

Ethnography critique

Ethnographic research faces several criticisms, particularly concerning the role of the ethnographer and knowledge production. One significant critique highlights the insufficient recognition of the broader processes that influence the ‘knowledge’ produced and the subsequent findings (Brewer, 1994). To address these concerns, researchers must practice reflexivity, allowing them to understand and contextualise their findings (Hammersley and Atkinson, 2019). Ethnographers are part of the environment they study, so their findings emerge from the interactions and relationships within that field. This necessitates a commitment to ongoing self-reflexivity.

Reflexivity is a practice that acknowledges the limitations of the ethnographer’s account, which claims to represent an “authentic” reality (Finlay, 2002). Researchers

must recognise and articulate their assumptions, beliefs, feelings, and actions about their role through critical-self-analysis. This methodological self-consciousness requires an acute awareness of the various relations within the field, including those between the researcher, the research topic itself, and the participants (Van Maanen, 2011). Notably, reflexivity should be grounded by empirically authenticated and theoretically informed transparent accounts of the researcher's activities (Guillemin and Gillam, 2004). As the creator of the final ethnographic text, the researcher must ensure that their accounts are transparent and explicit, enhancing the validity of both the methodology and findings. The goal is to provide authentic insights into how that knowledge is constructed and to bolster the trustworthiness of that knowledge (Connelly, 2016).

Moreover, researchers must acknowledge their positionality in knowledge production. This involves understanding that the phenomenon is filtered through a particular lens shaped by personal history, professional identity, gender, class, and education. This lens inevitably influences the researcher's neutrality and impartiality in generating knowledge (England, 1994). In this thesis, I address these challenges by documenting my field observations, engaging in reflective discussions through reflexive memos, and thoroughly examining my positionality. In Section 8.4, I provide a detailed reflection on my 'insider-outsider' positionality, exploring how I navigated my multiple identities, made key methodological decisions, managed fieldwork challenges, and dealt with ethical dilemmas and role conflicts. I also reflect on how these factors influenced my analysis and presentation of the findings.

I acknowledge that no methodological or epistemological position will be unlimited in this thesis. However, by adopting a critical realist position and utilising an ethnographic approach, I believe this approach offers a transferable, credible, and trustworthy framework in the pursuit of knowledge relating to institutional logics and aspects of OC within the social and cultural context of a mental health setting.

4.3 Design rationale

Setting

In this thesis, the ethnographic research study is titled: The Peer Support Observational Ethnography -Theory in Context (POETIC) study. The POETIC study is a single-site case study. MacDonald and Walker (1975) describe a case study as "*the study of the instance in action,"* aiming to produce detailed reports of experiences that offer rich details about a particular phenomenon in its social context (MacDonald and Walker, 1975, Suryani, 2008). The POETIC study was conducted in one community mental health team within a large NHS Trust.

The selected Trust and setting were purposefully chosen to align with the research question. It was essential to identify a setting with experience in implementing PSW roles. The Trust met this criterion with over 13 years of experience in PS, an established PSW development team, and a clear commitment to developing PSW roles. At the time of this thesis, PSW roles had been implemented in various service areas within the Trust, including Adult Mental Health, Child and Adolescent Mental Health Services, and Perinatal Services, with plans for further expansion.

Pragmatic factors also influenced the choice of Trust. The geographical location and my prior experience as a final-year nursing student completing a three-month management placement in 2016 provided familiarity with the setting and pre-existing relationships. During this placement, I worked closely with many team members involved in the POETIC study. These connections facilitated access and deepened my understanding of the unique challenges in this dynamic environment. While many original team members remained, new additions, including the team manager, PSW and carer peer support worker (CPSW) had joined the team.

The setting, the Home Treatment Team (HTT), a community mental health team identified early in the POETIC study design, offered both practical experience of PSW role implementation and a PSW employed in the team. This made it well suited to uncover the broader ecological, societal, and organisational challenges associated with implementing PSWs into mental health teams. The HTT included a diverse range of MDT members: the team manager, nurses, psychiatrists, clinical psychologists, healthcare assistants (HCAs), support workers, a CPSW, and PSW. This diversity provided a variety of perspectives and insights on team dynamics, particularly working with and alongside a PSW. These varying insights offered meaningful interpretations of different team member's roles within the organisational context. This richness in perspectives made the setting ideal for identifying, characterising, and understanding institutional logics and exploring how OC shapes the implementation of the PSW role - reflecting the objectives outlined in Section 1.1.

Access

Accessing the HTT setting followed a process conducted alongside obtaining ethical approval, as outlined below:

1. A key gatekeeper connected to all mental health teams employing PSWs within the Trust was crucial in facilitating access. Following service changes, a former nurse mentor helped secure direct contact with the HTT manager, who expressed an interest in supporting the POETIC study.

2. Once ethical approval was obtained. I emailed the HTT manager to introduce the POETIC study, attaching the participant information sheet (PIS) and consent forms (shown in Appendix 1). After several exchanges, a face-to-face meeting was arranged with the team manager, PSW, and me. Preparing for this interaction, I discussed with my supervisors how my identities as a researcher, nurse, and informal PSW might influence the discussion, ensuring I presented the study effectively and acknowledged my previous experience with the team. During the meeting, I introduced myself and decided to be fully transparent about my identities in an effort to create a comfortable atmosphere for discussion. I then provided a detailed explanation of the POETIC study, addressing any questions or concerns raised by the manager and PSW. I provided hard copies of the PIS and consent form, highlighting the voluntary nature of participation.

3. After this meeting, I met with the PSW one-on-one in the cafeteria, allowing them to raise specific concerns in a more relaxed environment. I assured them

of my flexibility, commitment to respecting their work practices, and adherence to Trust protocols. With support from the PSW to participate in the POETIC study, I informed the manager, who also provided their support. Once team consent to participate was established, I then initiated the recruitment and consent processes.

4.4 Ethics

As the PSW and mental health workers were recruited from an NHS Trust, the relevant ethical approval was sought from the NHS Health Research Authority (HRA) Research Ethics Committee (REC), the Confidentiality Advisory Group (CAG), and the local NHS Trust Research and Development (R&D) department. Public liability insurance and sponsorship was obtained from the University of Nottingham (UoN) before obtaining these approvals. For the POETIC study, the UoN Research Governance Framework, the UK Policy Framework for Health and Social Care Research (2020), and the National Institute for Health Research (NIHR) principles for Good Clinical Practice (GCP) were adhered to.

The POETIC study involved several ethical considerations throughout its design, conduct, data collection, analysis, interpretation, and dissemination. The ethical issues addressed in research implementing an ethnographic approach include informed consent, minimising potential harm and disruption, and confidentiality. Below is the outline of obtaining ethical approval via the UoN sponsor, NHS REC, CAG, and the Trust's R&D department. Table 4-2 summarises the ethical approval process.

Table 4-2 - Ethical approval process

Stage	Approvals	Description
1	University of Nottingham	Drafted ethics paperwork after the confirmation review on 20.07.21 and submitted for review on 15.10.21. Following feedback, amendments were made. The sponsor advised a separate ethics application for the CAG due to potential incidental exposure to patient data during observations (e.g., MDTs). Final documents were sent to both NHS REC and CAG on 08.11.21
2	NHS Research Ethics Committee	Sixteen documents were submitted via the Integrated Research Application System (IRAS) on 08.11.21. Attended the REC meeting on 30.11.21 to discuss the application. Received a favourable opinion on 13.12.21 with the condition of obtaining CAG approval
3	Confidentiality Advisory Group	Fourteen documents were sent to CAG via email. CAG then requested the completion of an advice form addressing specific issues regarding research scope, patient notification, and security assurances. Engaged in further consultation with service users on 11.12.21 and 13.12.21. CAG approval obtained on 07.01.22
4	Research and Development	All approved ethics paperwork was sent to the local Trust R&D on 12.01.22 for review and localisation. Approval was received on 01.03.22, allowing the study to commence. The first participant was recruited on 03.03.22

Throughout the process, specific ethical issues, such as the need for informed consent strategies to minimise potential harm and disruption, were addressed. The CAG required additional consultations with patients and the public, which informed various aspects of the research approach, including transparency about the purpose of the

study and notification of the POETIC study. The ethics process highlighted my position as a nurse researcher, emphasising the importance of adhering to professional nursing standards. This designation by the ethics panel underscored the necessity of clear and transparent communication about the research activities and ensuring participant understanding in alignment with the ethical expectations of nursing practice. The HRA approval letter can be found in Appendix 2.

Sampling strategy

A purposeful sampling approach was employed to conduct observations and interviews. This non-random strategy guaranteed the selection of information-rich cases for both the study site and the participants (Merriam and Grenier, 2019). The participants recruited for this study were both knowledgeable and experienced in PSW implementation because they were already part of the Trust, setting, and culture where the PSW roles were embedded.

This purposive strategy ensured representation from a diverse range of mental health workers, increasing the likelihood of capturing different perspectives and deepening the understanding of institutional logics and OC (Gertner et al., 2021). Although qualitative research is sometimes criticised for producing non-generalisable accounts (Sarfo et al., 2021), its goal is to provide a nuanced understanding of the uniqueness of specific social situations through participants' accounts rather than to achieve generalisability (Fischer and Guzel, 2023). Moreover, the concept of generalisability is incongruent with critical realism. While the perspective adopted in this study was one that focuses on generating thick, detailed descriptions of institutional logics and OC (Priya, 2021), the critical realist position means there may be underlying causal

mechanisms that could make the findings transferable to other settings (Bonell et al., 2022).

Participants

Participants in the POETIC study were recruited from one community mental health team, the HTT. The HTT operates within a defined caseload and serves as the primary unit of interest since it includes the setting in which the PSW role is implemented. Participating in the POETIC study involved contributing to the research by allowing me to observe their interactions and team processes in relation to the PSW role and/or by sharing their insights and experiences of PSWs during interviews.

For the observations, all team members working in the HTT were invited to participate. For the interviews, 13 participants were recruited. These individuals represented a range of roles within the team and were chosen based on their direct engagement with the setting and the PSW, making them knowledgeable about the PSW role and its implementation. For instance, the team manager's inclusion was essential, as they bridged the gap between the meso level (executive leadership, organisational policies, etc.) and micro level (front-line staff, clinical interactions, etc.), offering insights into different aspects of OC and institutional logics in relation to PSW implementation. Initially, the aim was to recruit 20 participants for interviews to ensure a wide range of data. However, as the study progressed, this number was reduced to 13 to manage the volume of data effectively and allocate sufficient time for thorough analysis. This adjustment reflects the iterative and adaptive nature of qualitative research.

Service users were excluded from the POETIC study, as the focus was on PSW implementation within the Trust which pertains to employed staff roles rather than those receiving services. However, it is acknowledged that service users, family members, and carers may influence OC through the rise of the 'informed consumer' Additionally, their collective choice to engage or not engage with PSWs may impact how PSWs are perceived within the team, which could potentially influence future resource allocation and the implementation of PSW roles.

Recruitment

Three methods were used for recruitment:

1. **Team meeting**: the manager introduced the study and distributed PISs and consent forms (shown in Appendix 1) to all team members.
2. **Email**: The manager sent PIS and consent forms to all team members via NHS email, providing details about the study and offering the opportunity for face-to-face discussion. My email was included for questions, queries, and clarifications.
3. **In-person introductions**: when I first visited the team in person, I introduced myself to each staff member, explained the study, and distributed PIS and consent forms. Copies of these forms were also left in the office for workers to review.

For the first two weeks, I introduced myself to team members individually and explained who I was and the purpose of my presence. Given the large team and varying shifts, I repeated this process whenever encountering new staff members. At

team and MDT meetings, I reiterated my purpose and directed workers to the PIS and consent forms available on the main table. I continued these introductions until all team members were familiar with the POETIC study and had the opportunity to consent to participate or decline. Once the consent forms were signed, I retained one copy, and the other was given to the participant. The PIS outlined that participants could withdraw from the study at any time, though no one chose to do so.

During MDT meetings, I proceeded with observations even when individuals who had not consented to participate were present. However, I excluded their presence and any contributions they made from the recorded observations of the meeting. This ensured that only data involving consenting participants were included in the study. Three mental health workers declined to participate in the interviews but consented to observation. One worker opted out of the study entirely, and no observations involving this individual were recorded.

In alignment with the research question outlined in Section 1.1, the fieldwork primarily focused on the role of PSWs. After discussions with the PSW, it was agreed that accompanying them on community visits to service users would provide valuable insights into their role. Before each visit, the PSW contacted the service user to request permission for me to observe the meeting. Upon arrival, the PSW sought verbal permission again before I joined the visit. I also introduced myself as a researcher, explained my purpose of observing to understand the PSW role, and assured the service user that I would leave immediately if they felt uncomfortable at any point. Verbal consent was obtained from the PSW before each visit, both in the office and prior to the community visit. On two occasions, I did not accompany the PSW due to

the service user's preference. To maintain confidentiality, no service user data was recorded. My observational notes were documented only after returning to the team office.

4.5 Methods

Multiple methods were used to collect detailed, contextually rich data, in line with the ethnographic tradition. Some data collection methods were considered, for example, focus groups were not used for several reasons. First, scheduling a time for all mental health workers to participate together in a focus group would have been challenging due to their clinical duties and schedules. Second, having participants from different seniority levels in the same group could influence responses, as less senior workers might feel inhibited during the discussions (Acocella, 2012). Lastly, focus groups do not allow for more in-depth exploration of a specific phenomenon, which limits the detail and nuance they can provide in a short timeframe.

The methods outlined in the following sections were considered the most suitable for generating detailed and comprehensive data.

Non-participant observation and informal conversations

Non-participant observation was employed in the POETIC study. This type of observation involves observing interactions, practices, and activities of those being studied without any involvement, interaction, or interference with participants or the field environment. By using this 'fly on the wall' observational approach, I was able to observe the daily routines of the PSW and mental health workers, mainly within the team office and occasionally in community settings. This method allowed me to

minimise disruption in the busy clinical setting (Bluff, 1997, Parahoo, 2014). Observations are essential for capturing insights into the social world that may not be fully revealed through interviews, as specific behaviours, dynamics, and practices are challenging to construct, articulate, or explain verbally. Therefore, observations contribute to a more nuanced understanding of the study context. A non-participant observational approach was chosen, for three main reasons:

1. **Research focus**: the research question explores institutional logics and OC rather than understanding the PSW role. I was interested in observing the relationships, interactions, dynamics, and activities of PSWs and mental health workers, rather than pursuing an experiential understanding of what it is like to be a PSW.

2. **Minimal disruption**: non-participant observation is less intrusive and is less likely to interfere with clinical practices in the field.

3. **Researcher position**: as an 'outsider', this method suited the overt observer-as-participant role rather than an overt participant-as-observer role, which would have required full integration into the group being studied (Denscombe, 2003). This outsider stance allowed me to capture institutional logics and aspects of OC that emerge on a meso level rather than purely micro level.

The initial plan was to conduct observations over six months, in line with typical ethnographic research (Williams, 2008). However, after meeting with my supervisors,

the observation period was reduced to five months due to the extensive data already collected. This adjustment ensured adequate time for thorough analysis. The frequency and length of observations were negotiated with the team manager and my supervisors, considering the intensity of fieldwork and my well-being. In total, I completed four hundred and thirty-two hours of observations over five-months in the HTT service setting.

Observations occurred one to four days a week, varying in day and time to capture various team interactions and processes. Each observation lasted up to seven hours. The total observation hours for each month fluctuated due to personal well-being, COVID-related illness, attending conferences, or annual leave. I primarily observed during core working hours (9-5pm), but I occasionally observed outside these hours, such as after 5pm. Table 4-3 outlines the observation details, listing specific days, weeks of the month, hours observed, total weekly observations, and monthly totals.

Table 4-3 - Non-participant observation hours

Month (2022)	Days observed	Hours per day	Total hours each week	Total hours overall
March	Monday, Tuesday, Friday	6, 4, 6	16	56
	Monday, Thursday, Friday	1, 6, 6	13	
	Monday, Thursday, Friday	6, 3, 4.5	13.5	
	Monday, Thursday	7, 6.5	13.5	
April	Monday, Thursday	3, 4.5	7.5	33.3
	Tuesday, Wednesday	3, 2.5	5.5	
	Tuesday, Wednesday, Thursday, Friday	7, 5, 6, 2.5	20.5	
May	Tuesday, Thursday, Friday	6, 3, 5	14	52
	Tuesday, Friday	5, 6	11	
	Wednesday, Thursday, Friday	3, 4.5, 4.5	12	
	Tuesday, Wednesday, Friday	4, 4.5, 3.5	12	
	Tuesday	3	3	
June	Thursday	2	2	7.5
	Thursday	2.5	2.5	
July	Monday, Tuesday, Thursday	3, 3, 5.5	11.5	14
	Wednesday	1	1	
	Thursday, Monday	2.5, (no observation)	2.5	

Observations in the POETIC study involved directly observing the PSW in their interactions with other mental health workers and service users. I shadowed the PSW throughout their daily routines, including attending planned MDT and team meetings, engaging with other mental health workers, and supporting service users. My primary focus was on PSWs interactions during meetings, their exchanges with other staff, and discussions in the team office where the PSW role was mentioned. Consent for these observations was obtained in writing from the PSW and other mental health workers beforehand, with verbal consent being renegotiated before each observation

session. This ongoing process of negotiating and renegotiating verbal consent over time, as the ethnographer-host relationship and trust develops, is a validated practice in ethnographic research (Denscombe, 2014).

The research question guided the observations, initially focusing on the preliminary typology of institutional logics outlined in Table 3-4. However, I remained open to new logics emerging and to the absence of preliminary logics during fieldwork. This approach allowed me to explore which institutional logics were present and how they manifested in various interactions and behaviours. When I did not fully understand what I observed, I asked questions to clarify the context or behaviour (Price and Johnson, 2006).

I created detailed field notes from my observations (Emerson et al., 2001), to ensure dependability in the research process. These notes included reflections on specific issues and points of interest related to institutional logics or OC. In certain situations, such as clinical settings or sensitive interactions, contemporaneous notetaking was not appropriate. In these instances, I made notes outside the immediate field as soon as possible (e.g., during short breaks) to capture critical details (Hammersley and Atkinson, 2019). Whilst there was a risk of forgetting some key details, I prioritised minimising any disruption, distraction, or discomfort that note-taking might cause for participants (Emerson et al., 2001).

The timing and appropriateness of notetaking were carefully adjusted based on the specific observation context or situation. To guide my observations, I created a

structured template (shown in Appendix 3) that included headings such as "Description of field observation," "Behaviour (what, by whom, and with whom)," and "Emerging key insights and concepts."

I also kept a reflective journal throughout my fieldwork, where I handwrote my thoughts and feelings. These diaries allowed me to process my emotional responses to specific situations, such as when staff asked challenging questions or invited me to participate in clinical activities. They helped me reflect deeply on my positionality, documenting how my identity and perspectives as a researcher influenced my experiences in the field. The reflective writing provided emotional relief and enabled me to explore how these factors shaped my role as a researcher. These journals served as an essential complementary data source to my observations and other methods employed during the study.

Semi-structured interviews

Semi-structured interviews were the second mode of data collection. Qualitative interviews are valuable for understanding participants' interpretations of complex phenomena, such as culture and institutional practices, which may reveal prevailing institutional logics (Warren, 2002). In addition to observations, interviews allow researchers to compare what is seen and heard in the field with what participants articulate in a more structured form of interaction (Corbin and Strauss, 2014).

Interviews give participants time and space to reflect on, reconstruct, and interpret their actions and perspectives using their frameworks of meaning. Compared to observation, interviews offer greater depth and coverage (Denzin and Lincoln, 2008).

When combined, observations and interviews can illuminate their situation more fully, and the use of multiple methods can provide a comprehensive reflection of the research question (Bell et al., 2018).

Semi-structured interviews were selected for two reasons. First, they allow the researcher to use an interview guide to steer discussions toward topics relevant to institutional logics and OC through a focused question (DiCicco-Bloom and Crabtree, 2006). Second, they use open-ended questions, enabling participants to reflect on their practices and roles, particularly about implementation (Kvale and Brinkmann, 2009). This flexible approach allows the researcher to follow up on unanticipated points or explore new areas of discussion that reveal new dimensions of thought (Galletta, 2013). The ultimate goal of using interviews was to gather data that provided authentic, rich accounts of institutional logics and thoughts relating to various components of OC.

An initial interview guide was developed based on the research question. It was piloted, modified, and adapted after testing it with a colleague before being used in the field (Creswell and Poth, 2016). After conducting several interviews, I discussed challenges with specific questions designed to uncover aspects of OC with my supervisors. After reviewing the responses of participants and reflecting on my interview technique, I adjusted the wording of several questions and added new ones to better guide discussions toward topics related to emerging institutional logics and OC (DiCicco-Bloom and Crabtree, 2006). The post pilot version can be found in Appendix 4. Some of the added questions were:

- Do PSWs work in the same model as the rest of the team?
- Do PSWs bring a different language? How?
- Are PSWs a colleague, an intervention or both?
- What does professional mean for the PSW, and what does un-professional look like?
- Do the PSWs challenge the team?
- How much does the team/Trust support peer support workers?
- From your perspective, what is the difference between a support worker or health care assistant and a peer support worker?

A total of thirteen interviews were conducted with various mental health workers in the team, including the PSW, CPSW, HCA, nurses, psychiatrist, clinical psychologist, advanced nurse practitioner, and team manager.

The interview locations were arranged through discussions with the team manager to ensure the spaces were private, accessible, and convenient for participants. Interviews took place in two private spaces outside the team office, lasting 30 to 60 minutes, depending on participant availability. Given the time pressures on mental health workers due to their duties, interview timing was flexible to accommodate their schedules and minimise disruption to the depth and breadth of the data collected. To create a relaxed and conversational atmosphere, interviews were recorded using two digital devices, minimising the need for notetaking. Participants provided informed, written consent to be recorded. Although I initially aimed to conduct repeat interviews with some participants as institutional logics emerged, time constraints prevented this.

Document collection

Document collection was the third data collection method. This approach involves gathering documentary evidence related to the research question, which is then used alongside other methods as part of the ethnographic study (Bloor and Wood, 2006). Documents and artefacts are social products created according to specific discourses or conventions, shaped by collective consumptions and production (Prior, 2003). As such, they add valuable contextual depth to the phenomena being studied.

The narrative review in Chapter 3 highlighted that PS policy is generally linked to broader recovery policies rather than specific national policies on PS. Additionally, the identified knowledge gap concerns OC. To understand aspects of OC and the institutional logics at play, evidence gathered at the meso level (organisational level), such as Trust documents and policies, was more relevant to the research question than evidence from the macro level (societal level), such as national policies.

During the POETIC study, documents related to the PSW role were collected and analysed to inform the interpretation of the findings from interviews and observations. Documents were gathered through photographs, e-mailed resources, or photocopies provided by workers in the field. In total, 68 documents and artefacts were collected within the Trust. These included local documents that were either readily available to the PSW, such as those in their online PS resources folder or easily accessible within the team office, such as medication leaflets. The documents collected included:

- PSW tool kits and training manuals

- PSW resources, e.g., supervision template, PSW principles, PSW code of conduct, drop-in sessions flyer, PS referral form, newsletters, and well-being plans
- Team recovery folders, documents, and implementation plans
- PSW job description
- Team best practice poster
- Team documentation guidelines
- Medication leaflets

These documents were used to corroborate, clarify, challenge, or expand upon the findings from the interviews and observations through the triangulation process - an iterative process combining multiple data sources - to ensure rigour and provide a holistic and in-depth understanding of the phenomena (Patton, 1999, Noble and Heale, 2019).

4.6 Recording and managing data

With participant consent, all 13 interviews were digitally recorded and transcribed verbatim to ensure accuracy and complete data capture. To maintain anonymity, participant names and identifiers were removed during transcription and replaced with participant numbers and titles to uphold anonymity. Member checking of the transcripts was not conducted. While some argue this process can increase the trustworthiness of qualitative research, others caution that it may lead to corrections or self-censorship and overlook the fact that participants' opinions or perspectives can change depending on the context, time, and perceived audience (McKim, 2023). For

instance, in the POETIC study, this decision was partly influenced by the recognition - or lack thereof - of the PSW role, which may affect how participants articulate their perspectives.

The digital recordings were handled, managed, stored, and archived in compliance with the General Data Protection Regulation (GDPR) and the University of Nottingham's Code of Research Conduct and Research Ethics. The data was uploaded to a secure password-protected web server, to which I only had access. Hard copies were stored in a locked storage with restricted access. Observations and informal conversations were recorded on digital observation templates, and any handwritten notes were typed into templates after the hard copies were shredded and disposed of as confidential waste at UoN. All data, including documents and artefacts, were managed, stored, and password-protected per GDPR regulations and the University of Nottingham Code of Research Conduct and Ethics.

4.7 Data analysis

Ethnographic research produces large volumes of unstructured data from various sources (Abramson and Dohan, 2015). This POETIC study data included my observation field notes, reflexive accounts, documentary evidence, and interview transcripts. The challenge was to manage and make sense of this extensive data. In qualitative research, data analysis is a recursive, dynamic, and iterative process involving a non-linear and dialectical relationship with the data (Gibbs, 2002). My own ontological and epistemological position informed this process.

This ethnographic analysis focused on creating a rich and detailed record of the field of study and participants' interpretations of their social world. The aim was to apply theory to uncover and understand different institutional logics and aspects of OC. To achieve this, an abductive research strategy was employed (Blaikie, 2010). This approach was selected because it helps answer the research questions and allows for identifying patterns that may reveal possible causal mechanisms. An abductive approach enabled me to use institutional logics to explain the data while also remaining open to exploring beyond the theory, either by elaborating on or rejecting it as needed (Thornberg, 2012).

A reflexive thematic analysis was used to analyse the data. This method involved identifying, analysing, organising, describing, and reporting pertinent themes within the data set, as well as highlighting my active role in the production of knowledge (Braun et al., 2023, Braun and Clarke, 2019). Other analytical approaches, such as qualitative content analysis and discourse analysis, were also considered but not chosen. Content analysis, focusing on systematically reducing data to concepts and numerical data (Mayring, 2004), was too prescriptive for the needs of this study. Similarly, discourse analysis, focusing on language use in social contexts, was not aligned with the research question.

Thematic analysis was preferred for its flexibility and ability to produce detailed, complex accounts of ethnographic data (Cassell and Symon, 2004, Braun and Clarke, 2021), as well as its capacity to summarise key components of large data sets (King, 2004). Although a discourse analysis was not used, themes generated from the thematic analysis spanned content and interactional variables to include some focus

on language, such as professional roles and the use of clinical terminology. While thematic analysis has potential drawbacks, such as flexibility leading to a lack of coherence in developing themes (Holloway and Todres, 2003), these were addressed by explicitly stating the study's epistemological stance in order to help maintain cohesion and consistency.

Data analysis process

Analysis was undertaken using the six-phase method by Braun and Clarke (2023). A summary of the six-phase process is outlined in Table 4-4 followed by a description of this process in the POETIC study, and a section on integrating reflexivity into thematic analysis.

Table 4-4 - Six-phase process of thematic analysis

Phase	Purpose of phase	Analysis process
1	Description and triangulation	Engaging in periods of deep immersion with all the data, including familiarising themselves with the breadth and depth of data and documenting their theoretical and reflective thoughts, emerging insights, perspectives, thoughts, and beliefs (Lincoln, 1985, Sandelowski, 1995)
2	Initial production of codes	Revisiting, interacting with, and thinking about the data, allowing ideas to develop regarding what is going on and the initial indexing of preliminary codes (Richards and Morse, 2013, Savage, 2000)
3	Searching for themes	Collating and sorting through all relevant coded data and bringing together components or experiences into superordinate themes
4	Reviewing and refining themes	Identifying a coherent pattern that accurately reflects individual themes and considering whether the themes reflect the broader data set as a whole

5	Naming and defining each theme	Labelling the themes along with writing a detailed description of what the theme captures, including the story it tells
6	Producing the final report	Presenting the fully established list of themes coherently, logically, and concisely for the reader to ensure that the claims made are both believable and credible (Thorne, 2000)

Familiarisation

I spent months immersed in the data, which included interview transcripts, field notes, and documents. First, I transcribed all of the interviews myself. Then, I began reading and reading all the material multiple times to fully grasp the depth and breadth of the data. It was a challenging process, as the contradictions and nuances often felt both familiar and elusive. I aimed to approach the data openly, not considering the theoretical framework at this stage. I used triangulation to cross-check findings across different data types and between participants, enhancing the credibility and depth of analysis. Additionally, it enabled me to document broad initial thoughts and reflections (Lincoln, 1985, Sandelowski, 1995) laying the groundwork for a more focused analysis in phase two.

Initial production of codes

Next, I began identifying initial codes across all data sets. This involved continually revisiting, interacting, and thinking about the data, allowing for the development of ideas about what is going on and highlighting points of interest, potential institutional logics, and emerging codes (Richards and Morse, 2013, Savage, 2000).

Searching for themes

I then started grouping related codes and searching for themes (Braun et al., 2023). Initially, I grouped related codes and began identifying broader themes by collating, sorting, and integrating relevant coded data. These were combined into an initial 50-page coding table organised by overarching logic, sub-logics, and relevant extracts (e.g., interview quotes and observations). This table was instrumental in identifying patterns and contradictions, particularly between what mental health workers said and did. To distinguish and identify the dominant institutional logics within the mental health setting, I employed a three-pronged approach:

(1) I used existing research on institutional logics within well-documented societal fields, often referred to as grand institutional regimes (Meyer et al., 2014). For example, I examined predefined logics outlined in works such as Scott et al. (2000) and Reay and Hinings (2009), which offered foundational insights for contextualising, defining societal fields (Dunn and Jones, 2010) and identifying the prevailing logics in the mental health setting.

(2) Given the relatively under-researched nature of mental health contexts in relation to institutional logics, I utilised the ethnographic data to retrospectively identify emerging logics (McPherson and Sauder, 2013). This approach allowed the nuances of the setting to emerge organically, capturing potentially new logics that may not be evident or align with predefined or established institutional logics in the literature.

(3) I reflexively incorporated my experiences as a mental health nurse to bridge theoretical constructs with practical aspects of the field (Dwyer and Buckle, 2009). This reflexive engagement to some extent enabled a deeper understanding of how institutional logics interact with broader institutional forces, specific demands of the field, and my own professional background. This critical reflexivity involved reflecting on what the data has taught me as but also how my perspective shaped the interpretation. This allowed me to remain sensitive to potential new emerging logics.

To guide the identification of logics, I began by searching for similarities in the expressions of participants and aligning these with established elements of institutional logics, such as values (e.g., shared beliefs), material practices (e.g., system structures, clinical practices, and objects), rules, and assumptions (Thornton et al., 2012a). Examples from the literature, such as Tine Nesbø (Tørseth, 2021), Scott and colleagues (Scott et al., 2000), and Reay and Hinings (Reay and Hinings, 2009) provided frameworks to identify these components. For example, clinicians with a professional logic shared beliefs around managing risk, which were reflected in their material practices, such as prioritising risk assessments. Particular attention was given to how these characteristics (e.g., beliefs about risk) unfolded within the setting, particularly concerning the PSW role (e.g., not referring particular service users to PSW who were deemed “high-risk”). While multiple logics were identified within the setting, the analysis focused on the most dominant and relevant ones to ensure feasibility and alignment with the research question. This comprehensive approach highlighted how institutional logics manifested, offering nuanced insights into their interaction and influence in relation to the PSW role.

In addition, discussions with my supervisors during this phase were essential. These conversations helped refine my analytical approach, guiding me to identify and develop significant themes and sub-themes and identify institutional logics most relevant to addressing the research question.

Reviewing and refining themes

I continued reviewing and refining the themes to ensure they coherently aligned with institutional logics. This iterative process, which spanned several months, involved revisiting and reorganising extracts and quotes as new insights emerged. I also carried out multiple iterations of mapping and refining the consolidated data table to ensure the themes accurately represented both individual data points and the broader dataset. Throughout this process, regular supervision played a critical role. Discussions with my supervisor provided valuable feedback, challenged my interpretations, and helped refine the thematic framework, ensuring a robust and collaborative approach to the interpretive process.

Naming/defining themes and final report

In this phase, I defined and named each theme, writing detailed descriptions of what each captured and the story it told (Braun et al., 2023). The final phase resulted in the production of fully developed themes, which I aim to present clearly and coherently to ensure that the claims are both credible and believable (Thorne, 2000). This process culminated in the findings that form the basis of the thesis conclusions.

Integrating reflexivity into thematic analysis

After completing the initial analysis of data sources, I turned to my journal reflections. These journal entries provided valuable context, helping cross-check situations and offering detailed insights into the environment. However, I intentionally kept the long extracts and reflections separate from the primary analysis due to their different style, length, and positionality. I used selected extracts from my journal to enrich the findings, showing my perspectives, feelings, and emotions as they related to the emerging themes.

Re-reading my diary revealed a range of conflicting emotions I experienced during fieldwork, which were often challenging. These reflections uncovered my assumptions and tapped into uncomfortable personal life experiences, raising several questions about my identity. Although revisiting these entries during the data analysis did not evoke the same intensity of emotion, I recognised their importance in shaping my interpretation of the data. I did not omit any reflections intentionally but chose those that ensured transparency regarding my role as a researcher.

Throughout the fieldwork, I was deeply affected by the kindness and openness of the PSW and HTT members. Their honesty and willingness to share their experiences left me feeling privileged and, at times, uneasy with the possibility of censoring my reflections or their data. Despite my struggle with reflexive practice, I made a concerted effort to disentangle my assumptions, beliefs, and thoughts. I aimed to present my journal reflections in a way that balanced my voice with those of the participants, offering greater context and transparency to the findings without overshadowing their experiences.

Incorporating journal reflections added a layer of depth to the analysis process, particularly in Phase five of the analysis. These reflections helped inform how I defined and described the emerging themes, providing additional nuance to the identified institutional logics. The process of reflexivity complemented the thematic analysis by ensuring my positions were transparent while enriching the broader interpretation of the data. For example, I recognised how my beliefs and values as a nurse, shaped my understanding of an emerging professional logic, which was reflected in the data. Through this integration, I strived to reflect the voices of participants authentically and provide a clear account of how my personal experiences and emotions shaped the interpretation of the research findings.

4.8 Presentation of findings

The themes and subthemes in the POETIC study were developed inductively, directly reflecting the data while engaging with institutional logics theory and existing literature. The theme development process was iterative, evolving through a continuous dialogue between the data, theoretical approach, and literature. I aimed to reflexively integrate various observations, documents, and the voices of participants to accurately represent their experiences and perspectives. This included the perspectives of the PSW, mental health workers, and my own reflections as a researcher. The broad themes structuring my findings and subsequent chapters include:

1. The contextual setting
2. Time’s unifying urgency and cross-cutting constraint
3. Illuminating multi-dimensional aspects of risk

The empirical data presented in the following chapters stem from several ethnographic sources:

- **Interview quotes**: these are taken directly from interview transcripts with mental health workers, sharing their experiences working within the team and experience of working alongside the PSW.

- **Observation**: these include my written observations in the field, focusing on interactions involving the PSW. Each observation will indicate the date and context, such as whether it occurred during a multidisciplinary team (MDT) meeting or team meeting (TMG).

- **Informal conversation**: these are drawn from my observational field notes and consist of dialogues between myself and other mental health workers about various aspects of the field and the PSW role.

- **Documentary evidence** includes field documents about the PSW role. They are presented as paraphrased or direct quotes or as photographs. taken *in situ.*

- **My journal**: selected extracts from my reflexive journal, including the date of entry and its title, are included to enrich the analysis.

In ethnographic writing, the line between description and data is often blurred, creating an overlap that enriches the narrative. The portrayal of the setting as a social organisation is crucial in this study, as it emphasises the environment and various

factors that impact PSW work. Thus, the data chapters will adopt an inclusive approach, combining contextual descriptions from observation field notes with more traditional data forms, such as interview quotes. Some extracts are longer to clarify context, offering a nuanced portrayal of the PSW role within the setting. Italics will be used to emphasise the analytical focus, while bold text will highlight my voice as an interviewer. Each data extract includes the source, type, participant role, and relevant details while ensuring participant anonymity. The data source labels are structured in Table 4-5.

Table 4-5 - Data source labels

Labels	Label information	Example
Interview quotes	[Int, #participant number, role]	[Int #13, Nurse]
Observation	[Ob, date, (optional) specific activity if meeting-related] For example, team meeting [TMG] and [MDT]	[Ob, 27.04.22, TMG]
Informal conversation	[IC, date]	[IC, 27.04.22]
Documentary evidence	[DE, type of evidence].	[DE, Poster]
My journal	[Diary entry, date, journal title]	[Diary entry, 27.04.22, My first impression]

Summary

This chapter identified the epistemology, the rationale for the ethnographic case study methodology design, and described the methods. The findings are now presented, with those relating to the context in Chapter 5 and the emergent themes of time and risk in Chapters 6 and 7 respectively.

Chapter 5: Findings: the contextual setting

Chapter 5 offers a detailed overview of the contextual setting in which the PSW and the wider MDT work. It is structured into four parts. Section 5.1 details the composition of the MDT, outlining the various roles and corresponding salaries of team members who work alongside the PSW. Section 5.2 provides an in-depth examination of the PSW role, including the working conditions, expectations articulated in the job description and those established within the team dynamics. Section 5.3 provides a walkthrough of the team base, drawing attention to the office environment. It highlights key features that emerge from relevant documentary, visual, and environmental aspects, illuminating risk and time within the environment. Section 5.4 identifies and describes the three primary institutional logics that emerged as the most influential within the community mental health team setting.

In presenting the findings, any specific cases or identifiable names mentioned by participants are modified to protect their identities, especially in sensitive situations.

5.1 The team

The mental health community team had a diverse, multi-disciplinary composition consisting of the following workers and roles:

- 23 Mental Health Nurses
- 2 Senior Mental Health Nurses
- 1 Advanced Nurse Practitioner (ANP)

- 1 Clinical Psychologist
- 4 Training-grade psychiatrists
- 5 Consultant Psychiatrists
- 6 Health Care Assistants (HCAs) and Support Workers (SWs)
- 1 Peer Support Worker (PSW)
- 1 Carer Peer Support Worker (CPSW)
- 1 Team Manager (manages the HTT)
- 1 Service Manager (manages HTT and other teams)
- 1 Team Administrator
- 4 Administrative Assistants

The team comprises 51 mental health workers, encompassing various roles, including qualified and non-qualified roles. Qualified workers have completed clinical training, hold professional accreditation, and are registered with a regulatory body, such as the Nursing & Midwifery Council (Nursing & Midwifery Council, 2018a). These aspects are key components of professional logics, as discussed in Section 5.4. Non-qualified workers have received role-specific training but do not have professional accreditation or registration with a regulatory body. In the HTT, the terms HCAs and SWs are used interchangeably, as both perform similar duties. The term HCA will be used throughout for consistency in the findings, as it was the most frequently mentioned by team members. Additionally, to organise the findings effectively, roles providing direct

mental health support with service users are categorised into two groups as shown in Table 5-1:

Table 5-1 - Roles providing direct mental health support

Role category	Role examples	Direct work with service users	Requires professional accreditation
Direct support roles	HCAs, SWs, CPSWs, and PSWs	Yes	No
Clinician roles	Nurses, Clinical Psychologists, Team Manager, Training-grade Psychiatrists, Consultant Psychiatrists	Yes	Yes

The HTT supports individuals aged 18 to 65 who are experiencing significant mental health distress. Their primary objectives include *minimising a person's risk of being admitted to the hospital, providing support to achieve recovery at home, supporting those discharged from the hospital*, and *making referrals to appropriate services following discharge* [DE, Team information leaflet]. Due to the large size of the team and the presence of part-time workers, not all team members were observed or interviewed; thus, the ethnographic data pertains to a subset of the team.

PSW roles were first introduced in the Trust in 2012 and integrated into the team being studied in 2019. Over time, the team gained experience working with various PSWs, including those directly employed by the team and those from external organisations. One PSW had been with the team since 2019 and brought over ten years of experience across different teams and service settings. This individual was the sole PSW employed within the team during this study. Additionally, while there was a

CPSW within the team, their role was not the primary focus of the study. However, the CPSW provided valuable insights into the PSW role and context.

5.2 The PSW role in context

The PSW works alongside the wider clinical team. Roles within the HTT correspond with NHS banding levels, which dictate pay scales and responsibilities. PSWs are banded at an Agenda for Change Band 3, with starting salaries of £22,816 per year, increasing to £24,336 after seven years' experience. Nurses hold Band 5 or Band 6 positions, earning starting salaries of £28,407 and £35,392, respectively. Their salaries increase with experience to £34,581 and £42,612. Senior nurses, the team manager, and ANPs are typically banded at Band 7, with salaries starting at £43,742 and rising to £50,056.

Some roles, including service manager managers, fall under Band 8, starting at £50,952. Support workers, administrative staff, and CPSWs are all paid at Band 3, while some HCAs and administrative staff may be paid at Band 2, starting at £22,383. Psychiatrists follow a separate pay scale, training-grade psychiatrists earning £43,923 to £63,152, and consultant psychiatrists making between £93,666 to £126,281. In addition, consultant psychiatrists may qualify for a Clinical Excellence Award - a financial incentive provided to NHS consultants in recognition of their contributions to clinical practice, innovation, and leadership.

There are some overlaps between the responsibilities of HCAs and the PSWs in the team. Both are the only non-qualified roles providing direct mental health support.

Additionally, both groups are paid at either Band 2 or 3. They are also expected to visit service users in the community, document case notes, and share information with the team. However, there are clear distinctions in their core skills and duties. HCAs are expected to implement nursing care plans, attend urgent assessments when senior nurses request, and perform clinical tasks such as delivering and administering medication. In contrast, PSWs are generally not expected to perform these tasks.

The *Best Practice Guidance for PSWs*, which is a Trust document, outlines role elements, expectations, tasks, duties and responsibilities for all PSWs in the Trust [DE, Peer Toolkit]. These include:

- *Are able to lone work or offer one to one support. In the community, peer workers hold a caseload of their own. Peer workers should plan their own time with the support of supervision and manage it appropriately.*
- *Should support people to work toward the goals that they have defined for themselves in their own recovery.*
- *Should maintain up-to-date clinical records using the same reporting systems as the rest of the team.*
- *Be conscious of issues surrounding risk and know who to go to if they have concerns.*
- *Follow the peer worker and bands 2-4 code of conduct.*
- *Should have access to the information technology systems used by the team, including a mobile phone and laptop when needed.*

The *Best Practice Guidance for PSWs* also highlights key skills PSWs develop during their initial training. These include *active listening, understanding the importance of language and the role of stigma, supporting personal well-being, building, and maintaining and ending relationships with people who use services, codes of conduct, boundaries, and personal safety, using lived experience in a way that is helpful* [DE, Peer Toolkit]. Their work is centred on utilising lived experience to support personal recovery. The job description outlines that the PSW:

> *Will work alongside people in the community…will use active listening skills and the core principles of peer support to build supportive connections with staff members and people being supported by services…will also contribute to daily team processes such as contributing to care plans, offering practical care and support with everyday living. It is expected that the peer support worker will undertake every interaction with a recovery focused positive approach* [DE, Job description].

The core principles of PS are fundamental to the PSW role and are highlighted in the job description, providing a logic for working with PSWs. These principles, as outlined in Table 2-5, are also highlighted in various peer role-related resources, including the Peer Toolkit, the Preparation Training Handbook, Practice Opportunity Training Document, and peer well-being resources. Collectively, these documents emphasise the importance of peer principles.

Distinct features of PSW role

Four distinct role-specific features set the PSW apart from the rest of the team. First, the PSW has unique working arrangements. They manage their individual caseload, which includes arranging community visits and completing specific tasks over multiple visits. In contrast, other team members, such as nurses and HCAs, have their schedules arranged by a shift lead at the beginning of each shift. While the entire team shares responsibility for all service users, this collective approach makes it challenging for other team members to track the progress of specific service users, unlike the PSW, who maintains ongoing relationships with their caseload.

Second, the PSW maintains specific role boundaries not kept by other team members. There is an expectation that community visits arranged by the PSW cannot be cancelled, unlike visits from other team members, which may be rearranged for urgent assessments or other clinical needs. Additionally, the PSW is not included in staff ratio counts and is therefore not expected to assist with urgent assessments or serve as a second person on visits requiring two staff members. The visit duration of the PSW is also more flexible, often lasting over an hour, while other team members typically conduct no more than one-hour visits. These role boundaries were established in discussions with the previous manager to facilitate their integration into the team, and the current manager reinforces these boundaries through communication, such as team emails and meetings.

Third, the PSW receives a range of supervision and support. This includes monthly clinical and managerial supervision sessions with the manager and a senior nurse and weekly informal supervision with the CPSW. Additionally, the PSW participates in

formal peer group supervision provided by the Trust and can request individual supervision with PSW colleagues [DE, Peer Toolkit]. The PSW also has access to an online forum for PSWs within the same Trust and attends a PS development day every three to six months.

Fourth, the PSW is uniquely required to embed recovery values in their work, a requirement explicitly stated in the job description. PSWs are expected to act as "*recovery champions*," using recovery-oriented language among staff and "*modelling strengths-based, positive, non-jargon, non-medicalised, and non-discriminatory language*" [DE, Job description]. When the PSW first completed their initial training, tutors described them as "*pioneers of change*" and a bridge between the individuals they support and qualified staff [IC, 20.07.22]. This illustrates that the PSW role encompasses responsibilities beyond direct care, as they are also tasked with influencing the OC and promoting recovery values. In contrast, the nurse role has a specific remit focused on providing direct care, clinical expertise, and service user advocacy, with clear responsibilities defined by professional standards and the NMC. Despite being one of the lowest paid roles in the team, the PSW expected to drive broader cultural and systemic shifts, whereas the nurse's role is centred on maintaining established care standards and practices.

5.3 Walking through the hospital

The data presented in this walkthrough section was gathered during the POETIC study, offering valuable context for the three main objectives of the thesis. The detailed description reflects how all team members enter and exit the office, providing insights

into the daily dynamics within the team office. It also highlights key environmental features of the office space, particularly those related to time and risk, which are discussed in more detail in Chapters 6 and 7, further supporting the objectives of this thesis.

The community team office is nested within the mental health hospital. The hospital itself is an indistinct environment. From the outside, it resembles a long, low building stretching across a large, enclosed land space. Its function as a hospital is subtle, revealed only by the presence of the Trust's signage. Inside, the hospital is divided into sections designed for specific purposes and priorities, with distinct environment constraints. The community team office occupies one of these spaces.

Outside space and hospital corridors

The outside space of the hospital presents a stark contrast to the interior environment. An expansive car park stretches in front of the building, filled with orderly rows of parked cars, punctuated only by the occasional vehicle entering or leaving. Lush trees and shrubbery line the parking areas, while a small garden with a wooden fence stands out. High fences encircle the hospital grounds, obstructing any view beyond. Aside from the distant hum of traffic from a busy main road, the area is surprisingly quiet, with only a few individuals moving through the car park - either heading to their cars, making their way to the busy street, or approaching the hospital entrance.

Sometimes, a person can be seen standing or sitting outside one of the service entrance areas. An ambulance or police car may occasionally park in the designated area near the hospital entrance. These vehicles and uniformed staff walking through

the area are the only obvious signs of the building's purpose. Despite the ordinary appearance of the car park, an unexpected calm permeates the space. This tranquillity is in stark contrast to the urgent energy experienced indoors. My memories of working on the wards flood back: loud noises, crowded spaces, a sense of urgency, and stress. Outside, the unease felt within the hospital walls begins to dissipate, replaced by open space, fresh air, and a chance to unwind.

While there is room to breathe and regain composure, this separation feels fragile - the calm merely an interlude between acts. An undercurrent of unease lingers, reminding me that this car park has not always been peaceful. Although the outside space offers the illusion of serenity, it serves as a fleeting refuge from the intensity and pace of the interior - almost liminal.

> *Walking to my car today, I was abruptly pulled from quiet observation mode into urgent action. Approached by a stranger in emotional distress asking for help, my researcher role evaporated, and my instincts kicked in as a mental health nurse. At that moment, my perspective shifted. I felt the familiar weight of obligation settle upon my shoulders, my focus narrowing to this individual before me. During our conversation, my words turned deliberate and purposeful; my body language careful and tense - no longer relaxed but alert. I automatically reverted to my clinical training, moving through familiar de-escalation patterns, problem-solving, assessing risk, and active listening. In an instant, my nursing identity re-emerged - that ingrained hypervigilance snapping to the fore. With compassion overriding discomfort, I tuned myself to*

their frequency of distress. I felt the weight of anticipating every possibility, accounting for whatever may unfold.

The constant tension returned, that unrelenting responsibility and accountability wired into my nerves. My senses heightened, tuned for signs, ready to react. Ten minutes of earnest connection tapped reserves stored for my research. Yet this person needed me present, fully there - so I sank into caregiving, identity blending again with purpose. As we parted, I breathed deeply, processing the unexpected, tangible, and natural interaction. Yet alongside intention, less comfortable notes sounded. That familiar background hum of anxiety, fatigue bred from chronic stress, the feeling of never doing enough as a nurse. In this car park, so utilitarian to me before, humanity and my mental health nurse identity had intruded, demanding acknowledgement.

This jarring interaction expanded my notion of identity and the research field itself. With distance, I see how readily my multiple identities shift to meet circumstances and how the presentation of self (e.g., nurse, researcher) impacts both the field and my findings. With my mind opened back up to the broader context, remembering myself as a researcher, my initial observation focus now seems so narrow and limited. Within those confined four walls of the team office, whilst rich, only reveals part of the institution. The car park, once just a transitional space in my mind, became suddenly significant - the car park is not separate or a space in between, but is the institution too [Diary entry, 07.03.22, Walking to my car].

The main entrance to the hospital features two large automatic doors that lead into a spacious area filled with natural light - sunlight streams through tall windows, supplemented by rows of bright ceiling lights. To the left, a reception desk stands, with a receptionist positioned behind a large glass window with a small opening at head height for communication. This barrier creates a sense of distance between service users and staff, suggesting a need for staff protection from potential risks posed by service users in the environment.

To the immediate right of the entrance is a hand sanitising and glove station, accompanied by a small seating area and a vending machine that seems out of place. The sparse furniture and muted colour palette make the space feel vast, giving it a distinctly clinical atmosphere. Long hallways are lined with bulletin boards and doors, occasionally adorned with artwork, notices, and announcements. The most prominent features are numerous posters outlining COVID-19 policies, codes of conduct, and other rules, providing constant reminders about risk precautions for service users, families, and carers. The feeling is unwelcoming, with very few sounds except for the occasional footsteps and muffled conversations. Brief bursts of noise occur when staff use keycards to access restricted areas, but these sounds quickly fade as the industrial doors close.

As I observe the reception area, it becomes clear that its emptiness is a regular sight. Very few people pass through, and those who do are in Trust uniforms or casual attire (mostly ward staff, community workers, or service users). They always stop at the sanitising station before promptly heading outside or moving down one of the vast,

tentacle-like corridors. Their movements are quick and purposeful, and it is notable that they do not linger or engage in conversation. The atmosphere feels like an underground footpath - used out of necessity and avoided if possible. A palpable tension hangs in the air, with the potential for an emergency alarm to sound or an incident to arise at any moment.

Occasionally, the alarm does blare, startlingly loud and abrupt. Staff rush out of the corridors and sprint through the reception area toward the source of the emergency, their movements conveying urgency and risk. When the alarm finally stops, people slowly return through the reception area, fading back into the distant corridors, and the space resumes its subdued, tense demeanour.

The community team office is near the hospital's centre, down one of the sparse corridors. It is discreetly situated to the right, behind a set of secure double doors requiring keycard entry, limiting access to HTT members only. A poster titled "*No Excuse for Abuse*" is displayed on one of the doors. It states:

> *We will not tolerate any form of abuse, harassment or violence against staff, visitors, carers, and those who use our services, whether verbal, threatening or physical* [DE, Poster].

This poster indicates that the area may harbour potential risks, suggesting a hostile and aggressive environment. For the team members who frequently enter and exit

through this door, the message is a constant reminder of the unpredictable and potentially far-reaching impacts of their work. Reflecting on this poster, I recall multiple instances of witnessing risks to service users during physical restraint procedures in the hospital. While the poster offers context regarding the risks staff face, it also highlights the potential dangers for those receiving care, indicating that risk flows both ways in these seemingly benign corridors.

The team office

Reaching the community team requires walking down a long, narrow corridor devoid of natural light, illuminated instead by harsh clinical lighting. To the left, a deceptively spacious administrator office houses four to five administrative staff diligently typing on their computers. On the right, a small kitchenette accommodates one or two employees making drinks or using the microwave. Further down the hall on the left is a dimly lit service managerial office, while directly across is a meeting room that senior nurses, e.g., Band 6 or 7, always occupy. In contrast to the sterile hospital corridors, the corridor to the HTT office buzzes with productivity sounds, with people engaged in various activities.

At the end of the corridor, the door on the left opens into the heart of the team workspace, a modest rectangular room. At the centre, a large table is cluttered with the HTT planner, diaries, and various paper resources. Flanking this table are two long workstations equipped with four shared computer stations, forming the primary hot-desking area for the team. Other surfaces are filled with work laptops, uniform-grey

telephones, and a single bright red emergency phone, used by the team in emergencies, which stands out against the monochrome surroundings.

There are ten to fifteen wheeled office chairs scattered throughout the room, constantly in motion as workers shuttle between tasks. In the back corner is a small managerial office, with its door propped open, allowing various staff to come and go. Two large windows flood the room with natural light, reflecting off countless COVID health protocol posters as visual reminders of the importance of reducing contagion risks. Packed bookshelves line the walls, overflowing with binders, extra personal protective equipment, and well-worn clinical textbooks, their spines faded from years of use. Despite the clutter, the office has an undeniable collaborative, functional feel, reflecting the team's long history of working together in the community.

While the office may lack explicit signs of the purpose of the HTT, two large whiteboards stand prominently between two filing cabinets, intentionally positioned in the centre of the room. Covered with lists of names and coloured squares, these boards detail the current caseload and guide their daily work. The information helps organise various visits - such as assessments, monitoring, and discharges - and prioritise community visits and tri-weekly multidisciplinary meetings. The whiteboards serve as a crucial framework for team organisation, employing a traffic light system to categorise community visits based on risk levels. Each name is accompanied by a coloured square - red, amber, or green (RAG) - indicating risk status: red for high-risk individuals needing intensive support, yellow for medium-risk cases requiring less intensive intervention, and green for low-risk nearing discharge.

These RAG ratings are linked to perceptions about the risk of hospitalisation. The colours carry collective meaning and guide the actions of the team: those rated red must be seen in person daily until their status changes to amber. The vivid colours draw attention, ensuring the team focuses on where attention is most critically needed. The whiteboards sit crammed with names, others added daily, a living representation of the current and increasing workload of the HTT. Their central position is a reminder that service users are at the centre of their work, with care and safety as top priorities.

The daily routines of the team are carried out with precise organisation. During the two daytime shifts, a Band 6 staff member (typically a nurse) is designated as the shift lead and usually occupies the hot-desking space closest to the whiteboard. The shift lead is the most vocal team member, effectively managing daily activities by updating the team planner, triaging urgent issues and assessments, delegating tasks, and ensuring everyone is clear about their responsibilities. Given the team often operates short-staffed, the shift lead frequently oversees discussions about strategies to cover shifts and address staffing gaps - topics that regularly appear on team meeting agendas and are commonly discussed informally [Ob, 06.05.22, TMG]:

> *There are staffing shortages, not enough people doing the work, not enough bodies on the floor, chronic lack of funding impacting on the entire system* [IC, 18.3.22].

The team constantly faces the challenge of short staffing along with competing demands. As highlighted in a poster, they must be available 24/7 to receive referrals

from various agencies, complete initial assessments within four hours, take calls from service users and their families, and document every interaction, such as community visits, to meet HTT contact targets [Ob, 24.03.22, TMG]. As a result, interactions between the shift lead and other team members are often brief and focused on tasks.

Opposite the shift lead sits the administrator, who assists with essential tasks to support the collective care team efforts. The manager is present from 9 AM to 5 PM, moving between desks to monitor the whiteboard, join conversations, answer calls, and attend meetings. The rest of the shift typically consists of an MDT primarily comprised of nurses. Team members have varied working hours based on their roles and preferences. For instance, the PSW works four weekly daytime shifts, while other team members may be assigned long days, weekends, or night shifts. Most staff wear smart casual clothing, which obscures any obvious hierarchy, except for psychiatrists, who typically wear suits or scrubs, highlighting their status and position.

Team routines

The daily routines of the team unfold in an orderly routine. Upon arriving, each member including the PSW follows a familiar sequence: they glance at the whiteboards, check in with the shift lead, and review the day's schedule around the central table before settling into a hot desk. For the PSW, this involves checking emails, reviewing their diary, noting service user addresses for visits, and preparing by reading the case notes. As the hours pass, team members engage in a flurry of community visits; all workers, except administrative staff, are involved in this work. Before leaving the office for their visits, they meticulously repeat their routines - packing up, reviewing the

whiteboards, and gathering around the planner to confirm details with the shift lead. This shared planner outlines the who, when, where, and type of visits (e.g., assessments or discharges), demonstrating the precision needed for such complex coordination. Even roles with more autonomy, like the PSW, align their activities with the planner's directives.

During these hours, the office transforms from a quiet space into a bustling hub of activity between 9 AM and 5 PM. Up to 15 workers crowd the cramped area, with chairs often pushed aside in the commotion. Seating is frequently scarce, and on busy days, some team members resort to balancing their laptops on their knees, leaving no surface unoccupied. The size of the team is palpable, overshadowing the modest office space. There is little opportunity for privacy, and the atmosphere feels tight and imposing as workers squeeze in close proximity. Movement becomes restricted, the room stuffy, and each shift prompts bumped chairs and strained apologies. It is an environment of enforced intimacy, with connections forged through sheer vicinity.

Unsurprisingly, the space is filled with a variety of fluctuating noises. Conversations overlap as coworkers discuss issues, visit changes, and other details. Administrators come and go throughout the day, delivering messages to the shift lead. Due to the limited space, everyone can hear these interactions. The atmosphere is dominated by intense focus, with workers deeply absorbed in their tasks, their attention fixed on their laptop screens. The constant sound of keyboards fills the air as care notes and reports are typed diligently. Phones ring out with urgent shrills, followed by muted voices handling calls, while rushed footsteps echo in the outside corridor. Indistinct sounds

from the hospital corridors filter through the walls, and occasionally, the emergency alarm blares, prompting a team member to rush out and assist. These sounds serve as constant reminders of the office location, fracturing brief moments of concentration. Tracking the interactions, tasks, and actions of the PSW is challenging in this overstimulating, busy, noisy, and distracting environment. However, the steady rhythm of the team's work and routine persists despite the ceaseless noise and bustle.

Occasionally, a calm descends, providing a brief respite from the constant motion. As some workers leave for community visits, the number of people in the space dwindles, shifting the energy from frenetic to more relaxed. The familiar tap of keyboards continues but at a more measured pace, underscoring the importance of documentation. Conversations soften into sporadic murmurs, with cases discussed in unhurried tones. Gentle laughter occasionally breaks the silence as workers share jokes or amusing stories. Without the pressure of urgency, people appear more relaxed, sipping their coffee and tea as they work. These moments of calm provide relief, allowing tension coiled from the chaos to dissipate. There is time to think, and details become more noticeable as the focus shifts beyond immediate tasks. Workers take the opportunity to engage in informal conversations, posing questions about the PSW role without worrying about interrupting clinical activities. Yet, this calm is always temporary; the energy soon shifts back, flooding the room with busy intensity as workers return from visits and the noise gradually resumes. Once again, the atmosphere tightens as the relentless demands press in.

The office returns to its familiar rhythm of dynamic, kinetic energy. The urgency is palpable, with multiple referrals and urgent assessments bombarding the team each shift. The whiteboards overflow with names, visually representing the daunting and overwhelming workload. In a formal interview, one psychiatrist reflected on how the increasing caseload has changed over time:

> *We must see 120 people a month; when we started, when we were first at [hospital site] 16 years ago when I started with the team, 20 people, yeah five to six times what it was, we have twice as many staff now than we used to have and we are easily three times as busy as what we were* [In #9, Psychiatrist].

This quote illustrates why urgent assessments can occur at any moment, causing plans to fracture, reshuffle, and reform. As workers rush to respond, a sense of urgency and tension builds, prompting them to realign their schedules, tasks, and expectations quickly. Continuous short staffing intensifies this turbulence, straining resources to their limits. The shift lead constantly adjusts the planner, yet time always feels scarce. The need for this rapid pace is summed up in an informal conversation with one clinician who noted:

> *I think for the NHS, it's about moving people on as quickly as possible* [IC, 28.03.22].

From my unobtrusive corner nook, I can see the simmering stress unfold as workers struggle to meet competing demands. This vantage point allows me to observe the

team and PSW without interrupting their workflow. However, when I find myself in the centre of the office, the tension becomes palpable. No longer hidden away, I become part of the busy environment - visible, exposed, and aware of the mounting pressures beneath the surface. In informal conversations, the strain is evident: staffing shortages, computer crashes, slow systems, and an overwhelmed, target-driven atmosphere. The unrest is apparent in the lowered voices and strained expressions of those around me, particularly regarding the growing pressure to meet targets and outcomes:

> *The services are being run like a business is an issue because targets and outcomes drive their practice - the more people they see, the more funding they receive* [IC, 28.04.22].

In the field, I am immersed in the palpable unrest, stress, and overwhelming burden of trying to manage the unmanageable. The workplace tension is vividly reflected in an entry from my reflexive diary:

> *Though I'm here now as a researcher, an observer rather than a nurse, the stuffiness of the room feels like a shared weight - anxiety, stress feel inescapable, it feels claustrophobic, and a non-participatory role feels almost impossible. In reflecting on these perceptions and experiences, I have to consciously remind myself that these visceral sensations may be more a reflection of my own past experiences invoked by memory rather than an accurate depiction of the reality and what exists 'out there for everyone to know*

and feel. The weight I'm experiencing is an echo, a ghost of those arduous shifts, watching the struggle to maintain composure amid stress, the strain of ensuring safety while also providing therapeutic care. My personal history has undoubtedly coloured and amplified my current perceptions in ways I am trying to reflexively untangle. As I continue with my observations, I remind myself of the importance of continuing to be reflexive, but I also cannot discount the very real way this environment is making me feel - a visceral reaction amplified by the memory of working in this setting, perhaps, but likely also rooted in some fundamental, inescapable truth about the mental and emotional tolls of this crucial work [Diary entry, 10.05.22, Past experiences].

The strain becomes evident in tired sighs, candid venting, and dark humour. I witness how the relentless pace wears people down, with words like "*horrendous*," "*crazy*," and "*stressful*" often surfacing, revealing the mounting pressure simmering beneath. In both formal interviews and informal conversations, a clearer picture emerges as several team members describe the unrelenting demands placed on their practices and the wider team:

I'm really, really, really, busy, but definitely from when I first started, a lot busier, but then you go through periods… and then it really ramps up and you feel like it's chaos all the time [In #3, Nurse].

*The services are always oversubscribed, and I guess that just makes everyone's job harder. And if people are sort of struggling to do their role, that just has a cascading effect onto everything [*In #1, CPSW].

I don't know what success looks like now with the team, we're too busy to be able to manage it, so success would be the [team name] doesn't to have to exist but we're getting busier and busier [In #12, Nurse].

A prominently displayed poster [DE, Poster] at one of the hot desks encapsulates the relentless pace that defines the work of the HTT. The bold heading, "*Quick response to all*", highlights the service's primary mission: prioritising individuals in acute distress and responding within the critical 4-hour target window. Another directive on the poster, "*Gatekeeping/early discharge*", reflects the pivotal role the team have in deciding who is hospitalised, shaping each service user's care path. These guiding tenets underscore the urgency behind every decision, the pressure that informs each encounter, and the need to assess and manage perceived risk. They demand speed, judgment, and efficiency, creating a mandate that reverberates through the hectic routines of the team and the PSW.

The poster reveals the root of the team's frenetic energy in just a few lines. Every referral and assessment carry weight. Structured routines and systems are essential to bring order to the time-critical work, enabling consistent care amid the rising demands on the service. As the team moves forward in a continuous rush, the poster acts as a reminder of their purpose.

5.4 Institutional logics in use

To provide further context and address Objective 1: *to identify the institutional logics in mental health organisations that pertain to the implementation of PSW roles* - three steps were used. As discussed in Section 4.7, each step helped in identifying the dominant institutional logics within the community mental health team environment, which, as described above, is characterised by its busy, resource-constrained, and, at times, frantic nature.

Step one

In step one, I drew on established research that outlines institutional logics within well-documented settings, as well as the preliminary typology of institutional logics discussed in Section 3.5. and presented in Table 5-2.

Table 5-2 - Preliminary typology of institutional logics

Institutional logic	Description
Professional logic	Conflicting priorities among different mental health clinicians (e.g., nurses, psychiatrists), direct support roles (e.g., HCAs), and PSWs, each operating under a role-specific logic (e.g., nurses adhering to the Nursing and Midwifery Council's code of conduct)
Managerial logic	Mental health services include hierarchical structures, managerial duties, and administrative obligations
Policy logic	Variations in how different professional groups interpret and implement healthcare policies
Recovery logic	The framework and practices focused on recovery, such as the implementation of recovery-oriented roles and the use of recovery-based interventions
Medical model logic	The traditional medical framework focused on assessment, diagnosis, treatment, and medication adherence
Risk logic	The prioritisation and management of risk, including actions related to risk assessment, enactment of policies, and use of procedures such as the Mental Health Act in care delivery

Step two and three

In steps two and three, I used the ethnographic data to identify emerging institutional logics, while also incorporating my experiences as a mental health nurse. Initially, the study revealed multiple, sometimes competing, institutional logics, some of which are outlined in Table 5-1. However, through analysing the ethnographic data, I was able to prioritise three primary institutional logics that were particularly significant in relation to implementing the PSW role. Engagement with the reflexive data further refined these logics, clarifying their labels and definitions. The implementation of the PSW role within the community mental health team was significantly influenced by three distinct yet interconnected institutional logics: professional, managerial, and therapeutic. These logics are explored in greater detail below.

Professional logic

The professional logic was well-established and strongly associated with respective clinician groups. For example, clinician roles, those requiring accreditation and clinical training, such as nurses, clinical psychologists, and psychiatrists, were more aligned with professional logic. Table 5-3 summarises the characteristics of the professional logic within this setting.

Table 5-3 – Professional logic characteristics

Characteristics	Professional logic
Basis of legitimacy claims	Professional role skills acquired through clinical training; central role as managers of risk
Core values	Mental health care and support as an application of accredited knowledge to acute mental health distress and potentially high-risk cases

Core practices	Diagnosis, treatment, and management of mental health distress and risk through clinical interventions
Guiding narrative	Risk of service user decline
Overarching rationale	Expert
Primary associated actors	Professional roles with accreditation and clinical training such as nurses, clinical psychologists, psychiatrist

All clinicians were aligned with a professional logic. Whilst nuanced between different clinician groups (Currie and Spyridonidis, 2016), its common features were rooted in or 'honed' in clinical expertise derived from clinical training (Thornton et al., 2012b) and affiliation with a professional regulatory body (Blomgren and Waks, 2015, Andersson and Liff, 2018). This training enabled clinicians to provide specific forms of professional care, such as assessment, diagnosis, treatment, and decisions around mental health care (Reay and Hinings, 2009), and reflected strong linkages to professional identity.

The data emphasised significant differences in the responsibilities and expectations associated with qualified versus non-qualified roles. Individuals who have completed accredited clinical training and are responsible for making judgments about service user's care - such as psychiatrists, nurses, and clinical psychologists - were strongly aligned with the professional logic and primarily relied on it to frame their work and decision-making. Representative examples of terminology adopted to reflect this logic include "*professional accountability*", "*duty of care*", "*qualified*," "*intervention*," and "*professionals*".

Professional logic legitimacy was framed as a series of expert acts. These were connected through an overarching professional process: assessing symptoms, treating with medication, and monitoring through community visits, among others. While the professional logic aligned heavily with the traditional clinical recovery model described in Section 2.1, with psychiatrists having overall responsibility, it also included other aspects such as specific role-related tasks, e.g., Band 6 nurses carry out initial assessments.

In addition, when enacted, the professional logic also directed attention towards risk. This was reflected in the ongoing vigilance regarding mental health symptoms and/or risk potentially escalating into more severe or complex issues, justifying the central role of professional groups. The intense focus on potential decline and/or increased risk underscored the power of professional roles tied to their responsibilities as monitors and managers of risk. This logic validated the necessity of professional oversight and intervention, reinforcing the authority and hierarchy of clinicians within the HTT.

Managerial logic

The second institutional logic identified, the managerial logic, also played a significant role in shaping the implementation of the PSW role. Similar to professional logic, the managerial logic was well-established and strongly associated with specific professional groups. For example, the team manager and senior clinicians, such as Band 7 or 8 nurses and the psychiatrists, were more aligned with the managerial logic.

Table 5-4 summarises the characteristics of the managerial logic within this study context.

Table 5-4 - Managerial logic characteristics

Characteristics	Managerial logic
Basis of legitimacy claims	Managerial role with mandated professional background; central role in managing the team to ensure they deliver the service's remit
Core values	Better outcomes for service users attained through service provision
Core practices	Building an infrastructure of procedures and processes
Guiding narrative	Benefits of service as evidenced by service metrics
Overarching rationale	Pragmatic
Primary associated actors	Team manager, Senior professional roles

The managerial logic focused on efficiency, performance, improvement, and healthcare quality. Joint working, collaboration, and meeting targets were seen as the appropriate means of achieving organisational goals. This logic was primarily invoked by the team manager and closely aligned with senior clinicians, who are the main decision-makers and frequently rely on the principles of efficiency in their decision-making. Common frames and terminology attached to this logic include "*targets*," "*evidence*", "*available resources*," "*budgets*," "*statistics*", and "*metrics*."

Managerial legitimacy was framed as pragmatic acts adopted through managerial practices: managing caseloads, addressing staffing gaps, monitoring performance,

ensuring adherence to best practice policy standards, emphasising control, cost containment, and improving service efficiency. Referencing the Trust's goals, clinicians made statements like "*Organisational processes are in place, for example, monitoring staff, supervision requirements, documentation*" [In, #3, Nurse], and the "*manager informing the team they have reached their target set for the month relating to logging their visits on the system*" [Ob, 06.05.22].

The managerial logic emphasised a systematic business-like approach to mental healthcare, with organisations behaving and organising similarly to regular businesses (Reay and Hinings, 2009). In this context, this logic aligned professional actions with broader managerial and organisational goals, including cost containment, resource allocation, and efficiency imperatives. Validated by the mandated managerial position, this logic ensures managerial oversight and reinforces the business-like goals of the Trust along with quality of care within the team.

Therapeutic logic

The third institutional logic identified was the therapeutic logic. While institutional logics provide foundational principles for guiding work practices (Meyer et al., 2014), they are subject to interpretation (Voronov et al., 2013) and can incorporate elements from other logics, sometimes creating internal conflicts. This complexity can lead to the emergence of new logics within highly complex domains such as mental health settings. In the POETIC study, the setting contained additional, less clearly defined aspects, which resulted in a novel therapeutic logic emerging alongside the established professional and managerial logic.

The therapeutic logic represented a distinct logic within the HTT. The data illustrated how different team members related to and engaged with therapeutic work in varying ways through their practice. This logic was grounded in the belief that service users should receive the most appropriate mental health care and support tailored to their needs. It transcended specific roles, centring instead on providing care, support, and/or interventions or making decisions with the belief that these acts are therapeutic. When invoked, each actor, regardless of role or clinical training, perceives their actions as beneficial and potentially therapeutic for the service user.

Sources of legitimacy within this logic vary, as the values and practices of therapeutic care are driven by different groups depending on their professional or training background. Specific therapeutic advantages might be recognised and embraced by particular groups and acknowledged more narrowly by others. Different groups and actors engaged with this logic in ways that reflected their specific roles, values, and practices, contributing to a diverse and dynamic understanding of what constitutes therapeutic work, care, and support within this setting, as demonstrated in Table 5-5. While many team members aligned with the therapeutic logic including but not limited to the PSW. The PSW appeared distinct from all other team members in having a therapeutic logic as the centre of gravity, their core purpose, whereas all other uses of the therapeutic logic were utilised in distinctly different ways or when time and capacity allowed, which in a busy, over-stretched team was challenging.

Table 5-5 - Therapeutic logic characteristics and uses among different roles

Characteristics	Therapeutic logic uses among different roles		
Actors'	**Psychiatrist**	**Manager**	**PSW**
Basis of legitimacy claims	Care based on utilising medical training and accredited knowledge	Ensuring the service meets organisational goals and targets within resource constraints	Lived experience of mental health distress and/or systems as the foundation for PS
Core values	The application of accredited knowledge to make decisions, deliver interventions to help alleviate distress, and keep people safe	Balancing clinical needs with service efficiency and productivity targets	Strengths-based and recovery-oriented approach utilising embodied and situated knowledge
Core practices	Diagnosing, prescribing treatment, and managing risks through clinical interventions	Overseeing processes, allocating resources, and managing the team to provide quality mental health care to all those deemed to need it	Engaging through a peer-based approach, community and social inclusion work, along with using experiential knowledge
Guiding narrative	Recovery journey guided by medical expertise from referral to discharge	Enabling service users' recovery by delivering effective and efficient care	Walking alongside an individual's personal recovery through PS
Overarching rationale	Upholding professional norms and standards of accredited medical practice	Blending clinical norms with pragmatic service management objectives	Leveraging personal lived experiences as a knowledge base which is as legitimate as clinical training

Setting the scene

This section sets the stage for understanding the broader environment in which all team members, especially the PSW, operate. It provides a foundation for interpreting their behaviours, interactions, and actions while also outlining the three dominant institutional logics - professional, managerial, and therapeutic - which are identified. In the following two chapters, time and risk emerge as influential mechanisms that highlight points of tension and alignment between the three logics. Time acts as a unifying force, creating urgency and shaping both constraints and opportunities across the institutional logics. Risk reveals both shared elements and distinct differences between them. These two mechanisms help highlight where the logics contradict, complement, co-exist, and clash. The key findings, which explore these dynamics in more depth, are presented in the next two chapters, organised around two central themes:

1. Time's unifying urgency and cross-cutting constraint (Chapter 6)
2. Illuminating multi-dimensional aspects of risk (Chapter 7)

Summary

This chapter provided an overview of the context in which the PSW and MDT operate, including the team composition and an in-depth look at the PSW role. It also offered a descriptive walkthrough of the team office, highlighting key environmental features related to risk and time, as well as the dominant institutional logics at play. Time and risk emerge as influential mechanisms influencing the three institutional logics within the HTT setting, and their impact on the PSW role will be explored further in Chapters 6 and 7.

Chapter 6: Theme One: time's unifying urgency and cross-cutting constraint

The theme of *time* emerged as a unifying and cross-cutting mechanism within the data, highlighting its pervasive influence on team dynamics, interactions, and the implementation of the PSW. As outlined in Table 6-1 below, the subthemes illustrate how time is experienced differently across various roles, with particular attention to how the PSW uniquely navigates, benefits from, and contributes to the temporal challenges faced by the wider team.

Table 6-1 - Overview of findings in relation to time

Time's unifying urgency and cross-cutting constraint		
#	**Sub-theme**	**Description**
6.1	Differing role remits in relation to the use of time	Outlines the diverse tasks and responsibilities inherent in various roles, shedding light on how time is allocated across workers within the team
6.2	Goal-oriented therapeutic interactions	Explore how clinicians are faced with competing demands, leading to goal-oriented therapeutic interactions hindered by constraints like the increasing caseload, resource scarcity, and time restrictions
6.3	Perceived time benefits of the PSW role	Illuminate the perception that the PSW role operates with fewer time constraints, emphasising both the therapeutic opportunities and temporal advantages associated with the role
6.4	Rapid connection with the nature of distress	Reveals how a PSW experiential knowledge may facilitate swift and profound connections with distress, enhancing their ability to forge deeper and quicker connections with service users

6.5	Role of PSW in alleviating growing time constraints	Emphasises the PSW role benefits in alleviating mounting time constraints by leveraging their experiential knowledge, providing valuable temporal resources within the increasingly strained team landscape
6.6	PSW 'gifts' time to clinicians	Shows the PSW role as enhancing team efficiency, effectively redistributing time among clinicians, and allowing them to devote their attention to their respective roles and responsibilities

6.1 Differing role remits in relation to the use of time

Within the eco-system of the team, each role brings its unique remit, shaped by specialised training, contributing to the overall HTT function and each worker's role identity. For instance, clinical training significantly shapes an individual's sense of professional identity, and the perceptions held about them by others within the same group (e.g., nurses) and by the broader team. These views encompass beliefs about expertise, roles, responsibilities within the MDT, and core values like maintaining professional boundaries. Together, these factors shape how workers from different backgrounds view themselves and how they prioritise and allocate their time within the HTT, helping to form a logic.

Nursing roles centre on acting as vigilant assessors, monitors, and gatekeepers, constantly attuned to overt and subtle mental state changes and signs of potential risk. Their expertise, cultivated through extended clinical training, revolves around assessing, documenting, and managing perceived risks - particularly the risk of harm to self or others. One nurse described this risk-focused approach as:

> W*e're looking at risks and at symptomology, in terms of symptoms and if the person is improving* [In #13, Nurse].

Formulating care plans provides a framework for supporting and treating service users. Employing specific tools and assessments shapes their understanding of evolving needs, informing their decisions. Documenting care notes - such as initial impressions, changes in risk levels, and details of visits - along with administering, monitoring, and reviewing medications contributes to a holistic view of each individual's care. Band 6 and 7 nurses steer the team, drawing on years of clinical experience to lead shifts, make key decisions about initial assessments, determine the need for hospitalisation, discharge service users, and adjust RAG ratings. Their role is pivotal in shaping the course of care. While Band 5 nurses have a more limited scope, they play a vital role in supporting the Band 6 and 7 nurses and carrying out clinical tasks.

Psychiatrists act as authoritative leaders within the HTT, their expertise rooted in extensive medical training. This background reflects a focus on traditional clinical priorities such as the use of medication, clinical pathways treatment, and physical health considerations such as sleep. Their primary duties include assessing, diagnosing, prescribing, and reviewing service users, consulting with other team members, and leading or contributing to MDT meetings. They also engage in clinical discussions to determine the most appropriate care approach and evaluate the suitability of referrals. For consultant psychiatrists, a significant responsibility involves managing risk and conducting Mental Health Act assessments when necessary.

Although decisions regarding care and treatment are made collectively by the MDT, psychiatrists often hold the ultimate responsibility, which gives them authority and the most power within the team.

HCAs play a vital role in the day-to-day functioning of the team, working closely with both the MDT and the nursing staff. They are always "*on the shop floor"*, carrying out hands-on tasks such as assisting with care plans, delivering medication, and documenting visits and observations [In, #P8, Nurse]. These tasks enable HCAs to provide service users with emotional, social, and practical support while identifying and reporting potential risks to senior clinicians e.g., Band 6 nurses. Two team members described some of the duties and expectations associated with the HCA role:

> *Undertaking the nurses care plan, … medication drops and following the lead nurse… saying can you please go out, kind of planning care…and doing… sessions* [In, #7, HCA]*.*

> *HCAs wouldn't be expected to take responsibility for the regular assessments of the more vulnerable patients [*In, #8, #2, Nurse and ANP].

On the periphery of the team, in smaller numbers, are other clinicians and roles providing direct support to service users with specialised training, such as psychologists, ANPs, CPSWs, and PSWs. Each of these roles brings unique expertise to the team, whether through the ability to prescribe medication, offering family, carer, or individual PS, or providing psychological interventions and clinical supervision.

These roles contribute valuable knowledge and support, complementing the broader team efforts.

The manager, a qualified mental health clinician - a requirement for the role - is at the helm of the team. Their responsibilities span operational and strategic domains. They ensure the service runs smoothly, overseeing budgets, managing resources, monitoring targets, and making staffing decisions. The manager also advocates for the team, making financial cases to commissioners, identifying staffing needs, and attempting to remove obstacles that hinder the ability of the team to deliver high-quality mental health care in line with the service's time-sensitive demands.

One HCA pointed to how "*there are big differences between what qualified and non-qualified can do*" [In, #7, HCA], emphasising the importance of being a clinician within the team. This distinction significantly influences team dynamics, subtly shaping daily routines and interactions. The HTT, predominantly comprised of nurses and psychiatrists, highlights the priority given to professional expertise and clinical training. This concentration of clinician roles reinforces existing hierarchies, power dynamics, and a professional institutional logic rooted in the legitimacy, status, and authority traditionally associated with professional roles in healthcare. The data highlights the significant influence clinicians have on the PSW role, further reinforcing the dynamics within the team. Building on this, the following two themes and their sub-themes will explore the dynamics between clinicians and PSWs. Specifically focusing on how the mechanisms of time and risk are navigated and managed in relation to the three dominant institutional logics within this setting.

6.2 Goal-oriented therapeutic interactions

Formal interviews revealed that clinicians often found themselves caught between competing demands when interacting with each other, especially with the PSW. Their expertise - rooted in professional training and knowledge - clashed with the practical demands of service delivery and managerial expectations. This dynamic created constant tension between professional and managerial logics, forcing clinicians to make difficult choices and compromises in their decision-making processes, ultimately shaping their ideals of care and the care provided.

In essence, clinicians approached therapeutic interactions, processes, behaviours, and decisions with a goal-oriented mindset. For example, prioritising how best to support the service user and facilitate their discharge and transition to another team if required. As a result, their pursuit of ‘ideal’ care appeared to be frequently compromised by constraints such as time limitations, increasing caseloads, documentation requirements, limited resources, and working with reduced staffing. These obstacles, driven by managerial priorities and an associated managerial logic, hindered their ability to fully realise these ideals in practice.

The data highlights a tension between the aspiration to provide the best care and the dominant focus on discharge goals. Most clinicians’ insights and observational data emphasise how efficiency imperatives often overshadowed the ideals of providing the best care. This prioritisation of efficiency, rooted in a managerial logic, was particularly evident in MDT meetings, where the implicit and explicit focus was on discharging service users or referring them to other services or teams to ease capacity constraints. These meetings, led primarily by senior Band 7 nurses and consultant psychiatrists,

consistently emphasised efficiency-driven objectives. The regular attendance of the PSW at these meetings - especially when not engaged in planned visits with service users - underscores the pervasive influence of efficiency-oriented goals within the overall dynamics of the team which is illustrated in the following observation:

The consultant's voice rings authoritatively in the crowded office as they steer the meeting, assertive and unwavering. Systematically talking through each colour-coded name on the whiteboard, they fire targeted questions to the team, eliciting context to direct care - assessing risk, adjusting medications, progress, and formulating next steps for each service user. Beside them, a senior nurse types up notes, documenting each action or decision called out. Their collaboration helps keep the meeting on an efficient and focused course. Around the table, the team including the PSW listens rapt, interjecting insights when directly addressed and/or when they have updates to share.

The PSW contributes intermittently with rich context about service users they have worked with (e.g., updates relating to their work together) and contribute with signposting the team to nearby local community resources that could offer support. However, the consultant's dominance is palpable, their clinical language (e.g., bi-daily, clusters, care pathways, specific medications) jargon-like yet commanding respect. The Discussion centres on movement - "How soon can they be discharged?" - a stark reminder of the swelling caseload and service remit - to manage risk, and when stable (on green), then discharge or refer to services providing more long-term support (e.g., general practitioner).

> *Names and distress blur into problems to be solved, symptoms to be stabilised, medications to be fine-tuned. In this hour, care is reduced to brisk interrogation - is it efficient, pragmatic, and task-focused? Progress equals the formulation of plans that support service users moving towards discharge, creating space on the board, and freeing up capacity within the team. The team strain against the relentless influx of referrals, and exhausted resources - mainly staff. However, the consultant drives the meeting agenda forward. But perhaps in their voice, sharpened by urgency, a trace of weariness comes through, a wish to slow down, to see behind the colours. For now, this pragmatic orchestration of streamlined service provides order, structure, and efficiency. This raises the question: where is the focus on recovery-oriented care?* [Ob, 04.07.22, MDT].

The ethos of efficiency extended beyond MDT meetings and was frequently mentioned by clinicians when discussing their community visits and interactions. Many clinicians reported how it shaped their practices, including the use of repetitive prescribed questions, structured conversations, and routine implementation of standardised protocols (e.g., assessment tools) during visits:

> *Professionals have structured conversations and set questions with service users* [In, #6, Clinical psychologist].

This strong emphasis on discharge goals reflected a task-oriented, efficiency-driven approach focused on identifying risk factors, monitoring medication adherence, and tracking changes in service users' mental states - key elements prioritised in the

professional logic. Formal interviews revealed a perception that many clinicians saw these goal-oriented and task-focused engagements as important - not only for providing support to service users but also for helping the team manage the increasing service demands by facilitating quicker discharges:

> *We have to be able to manage patients and move them on, and I think that's a crucial aspect of it, and I* d*on't want to… set a colleague up to be in this kind of bind where a patient might want a relationship to continue or have false expectations about the relationship that actually the service provision specifies that we don't provide* [In, #9, Psychiatrist].

One nurse described their visits as not being "*normal*," using an exaggerated tone to emphasise the contrast, perhaps, between idealised care and the reality of task-oriented approaches often adopted by clinicians. This notion of "*norma*l" appeared to reflect a desire for more flexible, person-centred interactions instead of the rigid, structured protocols followed and emphasised in the professional logic. It also might highlight the responsibility and accountability clinicians face when making decisions about service users' care:

> *Yeah, I think because of our scope as Band sixes, we do assessments, we do discharges, and we don't really get to have normal visits with people, I suppose, sometimes we're a lot more constricted* [In, #4, Nurse].

A "*normal*" visit might allow more time to explore a person's interests, strengths, or passions, deviating from strict protocols. However, the data suggests that task-oriented working helped clinicians maximise their clinical expertise and training rooted in the professional logic, enabling them to handle multiple visits and clinician-specific tasks efficiently:

> *Our role, we end up seeing different patients every single day yeah because of the pressures of the service* [In, #8, Nurse].

While clinicians acknowledged the value of a person-centred, holistic approach, they also recognised the need for efficiency-driven practices to manage increasing workloads and limited resources. The tension between managerial/professional logics versus the therapeutic logic was evident in the data, as the pressure to maintain efficiency and manage large caseloads often reinforced an efficiency-driven approach. For example, during community visits, clinicians often prioritised professional logics related to tasks such as medication management over a more holistic understanding of the individual's social and economic experiences and needs. One nurse encapsulated this tension, stating:

> *There's probably 100 names on our boards at the moment…probably 60 or 70 of them will see a doctor in our team at some point. And… 50 or 60 of those, 60 or 70 would be prescribed some medication which they may or may not need. So much of what we do is driven by medication. It, it's, like there's a pill, there's a diagnosis, and there's a pill for every condition known to man and*

> *woman… I don't know how that's going to change… a lot of people don't have great lives… they might not live in good areas, they might not have much money, they might not have good relationships, you might be unemployed, might have substance misuse problems, there can be any number of things, but, chucking a pill for each and every one of those isn't necessarily the answer, I don't think* [In, #12, Nurse].

This quote also reflects a pharmaceutical focus aligned with a medical model logic, potentially overshadowing a more therapeutic approach or logic. However, for psychiatrists, prescribing and managing medication may itself be seen as therapeutic work or invoking a therapeutic logic. Likewise, the complex decision-making and "*difficult*" choices clinicians face with finite resources could also be viewed as part of their therapeutic work, as one psychiatrist explained:

> *I think the advocacy aspect of working with patients for peer support workers can be a little… it's a very easy position to be in, to simply echo or advocate for everything that a patient wants. For example, rather than be the difficult person who has an eye on the available resources and who says, it would be wonderful if we could do this for everybody, but we cannot, and this is what's available* [In, #P9, Psychiatrist].

In addition to the complexities of decision-making, the data highlights that professional role expectations also involved managing a range of task-oriented demands, such as prioritising documentation and administrative work. While some clinicians saw these

tasks as crucial for maintaining service continuity and securing funding, they added an extra layer of task-driven responsibilities that did not directly contribute to community care or aspects of therapeutic care. Instead, these activities were primarily focused on generating financial evidence for commissioners, aligned with managerial logics:

> *We need to be putting everything that we're doing down so we can show the commissioners what work we're doing and so they might give us a bit more budget… team expectations are to record contacts to make case for more funding … team budgets are evaluated to make a case for new roles* [In, #5, Manager].

This administrative focus aligns with the broader systems-driven approach reflected in the traffic light system used by the whole team, which underscores their collective effort to create order and efficiency amid rising referrals. However, this system-driven approach also reflects the challenges of working within a strained, stretched, and time-pressed system, particularly for senior clinicians responsible for managing the overall caseload. As both a mental health nurse and a recipient of care services, I grappled with mixed emotions - empathy and sadness for the challenges of the team, alongside a growing internal conflict over the increasing focus on efficiency in mental health care delivery, often at the expense of more personalised, holistic, and recovery-oriented care. This tension is reflected in my diary entry:

> *Sitting here observing the whiteboards, I'm struck with a new perspective. This familiar traffic light system, which I've seen and experienced as an effective*

visual aid in my nursing role, now gives me pause. Scanning the boards crammed with names reduced to coloured squares, I'm hit with how impersonal it seems. Seeing individuals distilled down to levels of risk unsettles me in a way it never did before. It feels at odds with recovery-oriented approaches to care. However, the efficiency of the colour-coded system is undeniable. With services strained to the breaking point, it provides a clear, visual way to triage the vast numbers of referrals. The team has no choice but to rely on tools like this to stay afloat. In an ideal world, perhaps we could give each person under our care more individualised time and attention. Perhaps instead of names, colours, and risk levels, they should display snapshots of lives, communities, strengths - the humanity behind each referral. But with referrals flooding in, there needs to be ways to quickly target those most critically at risk. Is it possible to find balance between person centred/recovery-oriented care and managing the volume?

The colour-coding, as imperfect as it may be, helps the team maintain that equilibrium. It keeps them focused on those who need follow-up immediately, while still providing a way to monitor all their care. With space for reflection, I wonder if, in our attempts to manage the unmanageable, we've lost sight of what matters most. Could the system be dehumanising if taken too far? Absolutely. But for now, it allows the team to handle a caseload far beyond capacity. And it helps ensure they don't miss signs that someone is experiencing extreme levels of distress. In the current climate, services need tools that make intricate, demanding, and exhausting mental health work more efficient. And though it feels clinical at times, its purpose is far from cold or

impersonal. It's a desperate attempt to create order amidst chaos, maximise strained resources, and provide safety nets where there are far too few. For that, its efficiency is invaluable in the current climate of mental health care [14.03.22 - Diary Entry, Observing].

This sub-theme reveals a complex interplay among different clinician roles, resource constraints, and the power dynamics that shape the responsibilities, duties, and tasks within the team. It highlights how clinicians - such as nurses, managers, and psychiatrists - guided by professional logics are situated within a broader system affected by efficiency-driven measures, resource limitations, and significant service pressures. There is a sense that market principles, focusing on targets and metrics aligned with managerial logics, are increasingly imposed on clinical practice. This managerial logic appears to conflict with clinicians' training, expertise, and knowledge - the professional logic, creating tensions between the two.

Moreover, the data provides insights into the diverse interpretations of what constitutes "therapeutic" work among clinicians. It highlights the potential dissonance among roles, as clinicians may interpret "therapeutic" work in various ways, encompassing different aspects such as prescribing medication or monitoring available resources. These differing perspectives point to the emergence of a therapeutic logic, which appears to be particularly important for effectively implementing the PSW role, which is explored in further detail in the following sections.

6.3 Perceived time benefits of the PSW role

In this context, the data indicates that increasing time constraints and focus on efficiency led clinicians to view “therapeutic” work as primarily the responsibility of HCAs and the PSW. This perception seemed to arise from the belief that direct support roles had more flexibility and available time than clinicians. However, observations and interviews painted a different picture. Interviews indicated that while HCAs did have more time than clinicians, they were still expected to strictly follow nursing care plans and remain flexible to accommodate schedule changes as needed. For instance, HCAs were often tasked with delivering medications to service users in the community. However, despite being perceived as having more time, the work of HCAs was constrained by the need to adhere to care plans and respond and adjust to sudden diary changes. Their roles were closely aligned with professional and managerial logics guiding clinicians, reflecting similar values and practices.

In contrast, the working arrangements for the PSW differed from other team members. They managed their caseload, scheduled appointments, planned their diaries, and conducted their work without strict or externally imposed time constraints during visits. A recurring theme throughout the data suggests that “therapeutic” activities and the therapeutic logic were largely seen within the domain of the PSW. For example, all team members highlighted how the PSW offered a range of therapeutic activities, such as supporting service users in engaging with social activities or community groups, fostering social inclusion, encouraging them to leave their homes or go for walks, providing information on available social opportunities, assisting with social planning and benefits, and building therapeutic relationships. These examples highlight the perceived benefits of the PSW role, particularly the advantage of having more time

available to dedicate to such tasks compared to clinicians operating under professional and managerial logics, the manager explained:

> *<PSW name> can offer that bit more time than what we can... <PSW name> appointments are two, three, hours longer because <PSW name> does a bit more therapeutic work… whereas us, as practitioners, were often quite rushing around and getting the assessments in and bish, bash, bosh, getting the medicine drops and you know it can be quite fast paced. <PSW name> is able to kind of offer that little bit more time and build that you know therapeutic relationship with people and, it kind of really aids people* [In, #5, Manager].

Several clinicians also reported that the working arrangements of the PSW offered more autonomy, freedom, and greater ownership than clinicians. The data suggests this disparity led to a sense of frustration among some clinicians, who felt their holistic therapeutic understanding of service users was more limited in contrast:

> *<PSW name>… work a little bit differently to the other people in the team, just on a practical basis… they've got a bit more freedom I think… to plan their own diaries and to see people again on subsequent occasions who they've seen and there's a bit more continuity, and a bit more… ownership of what's going on, and a bit more emphasis on forming a good relationship with that service user and I think that's very lacking in the rest of the team… and if, if, the nurses and HCAs were working in a similar way I might not use <PSW name> as often*

because I think some of it is knowing that the patient is going to see somebody who is going to commit to them and offer some continuity… [In, #2, ANP].

Consistency was also perceived as integral in building therapeutic relationships, consistency not afforded to clinicians due to role constraints:

We can see someone once and never see them again, and you might, not that you form like attachments to patients, but I suppose If you're following them up, you want to see that journey progress… whereas I guess <PSW name> they might see some people repeatedly, so, kind of have that more of a buildup of a relationship with them [In, #3, Nurse].

I think doctors and nurses can be very guilty of having better working relationships with their peers than with their patients [In, #9, Psychiatrist].

Many clinicians reported challenges around providing continuity of care due to their shared caseload approach. This lack of consistency made some clinicians feel that they were not always meeting the wider therapeutic and recovery-oriented needs of service users:

Sometimes. It's difficult and when somebody is under <Team name> because consistency just isn't a thing unfortunately… and I think sometimes consistency is something that patients really struggle with… if they if they need extra support with something in particular, but they don't want to see a different person every

single time… we're not, not always going to have time to read every single note and know exactly what's going on sometimes when we go out and see someone… I think consistency is really helpful with the peer support workers [In, #4, Nurse].

One nurse observed that the PSW role carries fewer managerial expectations, demands, rules, and time constraints. They emphasised that the PSW role offers greater flexibility to engage in diverse types of work and is exempt from the immediate pressures, interruptions, or logic constraints that other team members face:

I suppose they've <PSW and CPSW name> got the benefit of being new to the team and with a slightly different brief, whereas the HCAs and others are just locked in an old system they've always been in I suppose and are expected by managers to work in a certain way [In, #2, ANP].

Can't imagine how we would work as a team without <PSW and CPSW name> a lot of patients would have struggled without their input, they can help, and they've got a different viewpoint, they can do things that we can't do… <PSW name> does different kind of work than what we do and really vital to the service, there's no limitations [In, #8, Nurse].

This distinction between the work carried out by the PSW and that of other clinicians, particularly the recovery-oriented, therapeutic focus of the PSW role, was strongly

reflected in the data. The data reveals that recovery-oriented work often seemed to take a back seat, especially for clinicians, highlighting the diminishing priority of therapeutic logics in their work. This is symbolised vividly by the image shown in Figure 6-1 [DE, Poster] and the accompanying observation notes:

> *When I sat in the office, I noticed that placed amongst the bookshelf resources, there is only one folder labelled 'Recovery Resources' [DE - Poster] packed with various policy documents relating to recovery and printouts dating back to 2012. Most of the documents are out of date. The folder's location and contents suggest it has not been used for some time. Inside the folder contains various recovery-oriented resources such as an implementation plan, vision for an ideal recovery service, the team's strengths and resources, the team's barriers and challenges, and priorities for development around recovery. Some of the pages have been completed but mostly the pages are blank. The folder is the only environmental indicator of the service's recovery-orientation, and whilst it indicates the inclusion of recovery, its out-of-date contents points to potential conflicting models of care. Whilst looking through its content, I informally asked a worker what the purpose of the folder was, and they said, [Name of nurse] was assigned as the professional recovery lead and was tasked with updating the folder, but since leaving the team - the role had not been assigned to anyone else, or they might have, but I don't know who this is* [Ob and IC, 27.04.22].

Figure 6-1 - Recovery folder

The data within this sub-theme highlights how some clinicians conceptualise aspects of therapeutic work through the lens of managerial and professional logics. They identified several key factors as crucial for delivering this type of care: having enough time, maintaining consistency, ensuring continuity, having autonomy in their approach, and feeling a sense of ownership over their work. However, some clinicians often found that time shortages, role restrictions, assigned duties, and the pressures of managerial and professional expectations limited their ability to engage in certain types of therapeutic work. A recurring theme surfaces around the dilution of professional logics - where their meaning and scope are being increasingly eroded, not by deliberate choice but as a consequence of the broader social, political, and economic contexts in which clinicians operate.

This appears to create a dynamic where professional logics, resource constraints, managerial logics, power dynamics, and therapeutic logics intersect with time, shaping the responsibilities and tasks of various roles within the team. The data suggests the PSW role offers a way to reclaim aspects of therapeutic work or logics that resource constraints and demands prevent clinicians from providing. This division of labour, where therapeutic tasks are delegated to the PSWs because of their perceived time flexibility, highlights the unique position of the PSW within the team. This temporal dimension of their role provides insights into their value and potential acceptance and integration within the MDT.

6.4 Rapid connection with the nature of distress

The recognition of the PSW's greater availability of time is intertwined with two significant historical shifts. The data reveals a narrative highlighting when health systems were better resourced, allowing clinicians to engage with service users more deeply and for extended periods. During this era, interactions could include sitting down for coffee or a cigarette, enabling needs to be understood organically through prolonged conversations. In contrast, the contemporary context of mental health care recognises that a lack of lived experience with mental health distress may limit the ability of clinicians to connect with those facing such challenges, regardless of their training. Additionally, there is a growing backlash against the concept of 'expertise,' as service users report instances of both vicarious and direct trauma from their interactions with mental health services.

Amidst this landscape, the PSW role emerges. As individuals who have navigated the system and found their own path to recovery, PSWs bring a unique form of experiential expertise. The data suggests that this lived understanding might enable them to form more immediate connections with service users, contrasting with clinicians who rely solely on clinical training and experience. For instance, a clinician who has never experienced mental health problems may struggle to understand why someone is not eating, potentially leading to the belief that the individual requires different support. Thus, the perceived value of the PSW extends beyond merely having time for therapeutic work. Their experiential knowledge is an invaluable asset, allowing them to quickly connect to the nature of mental health distress in ways that surpass the limitations of clinical training or professional logics.

One psychiatrist reflected on how the responsibilities of nurses have evolved over time and how the PSW has brought back a focus on recovery:

> *Having a PSW does; it fleshes out that social aspect of recovery… I think maybe historically, like, a really good CPN [Community psychiatric nurse] would have done it… back in the early days, of people developing the idea of what a CPN would do in the community, but that role has changed and has become more about risk and oversight of medication and treatment and care planning and documentation and all that sort of stuff. The kind of opportunity for a more holistic approach has perhaps been not, not lost on the nurses, but taken away from them and maybe <PSW name> reintroduced as a bit of that for the patient* [In, #9, Psychiatrist].

A recurring theme within the data points to the PSW being perceived as offering something uniquely different - a perspective shaped by their lived experience, which might enable them to connect more quickly with the nature of mental health distress. This sentiment is captured by two clinicians:

> *[PSWs] bring a fresh perspective or alternative perspective; I just think they're… not sort of wedded to the medical model like we are, and yeah, they look at things differently; they can probably empathise with a lot of people more than a lot of the other qualified staff, yes, we might have qualifications, but I've never been in the position that you're in* [In, #11, Nurse].

> *PSW provide the 'flavour' of the service user* [In, #6, Clinical psychologist].

Another nurse noted that the PSW can see the "*whole picture*," indicating an awareness of the broader context of service user's experiences. The use of the phrase "*I suppose*" during the interview suggested that this realisation was emerging as they spoke:

> *The peer support workers, they actually see more than we do you, you know, they see a whole picture of a patient. Erm, which is massive in terms of actually yeah, giving proper care to people, I suppose* [In, #4, Nurse].

Additionally, several clinicians reported that the PSW role is seen as providing a more holistic approach to care, reflecting a clear prioritisation of therapeutic logics in PSWs practices. This raises the question: is this holistic perspective intrinsically tied to the experiential knowledge that PSWs bring to their roles? Or, as the following quote suggests, is it more related to the PSW having increased face-to-face time with the service user:

> *They're a lot better placed, actually sometimes, to give feedback in MDTs, and I've been sat in MDTs sometimes, and the Band threes have got a hell of a lot more to say about the patient than I do because I've only seen them once in a month, and so it's really helpful to kind of get that holistic, you know* [In, #4, Nurse].

The unique nature of conversations, chats, and discussions involving the PSW, distinguishing them from those led by clinicians, is consistently highlighted within the

data. This contrast is illustrated in the following two quotes, which highlights tasks prioritised in therapeutic logic invoked by the PSW:

> ***What kinds of things do you think the PSW do compared to an HCA?***
>
> *Looking at how people structure themselves… in their houses, getting out of bed, for example, you know, getting routines, just the more practical, this will help you get better. You know, it seems like this is a silly thing to do… but actually, in a couple of weeks' time, it will have made a heck of a difference… and having the experience behind them, where they could potentially say, I've done this… it's worked for them, and so they can use different motivations to get people to do things they know, what's worked for them* [In, #12, Nurse].

> *<PSW name> is really good at knowing lots and lots of different things that the person might be interested in, in terms of maximising their independence… their reliance self-reliance, maximising their kind of inclusion within society, so <PSW name> was very good at knowing what, what kind of things would be really…useful for that person…around their interests what kind of things they're interested in … and trying to get them back to enjoying the things that they enjoyed before* [In, #13, Nurse].

The use of recovery-focused language by the PSW, was noted as contrasting sharply with the clinical communication style of clinicians. The data suggests that the PSW can explain complex health system processes in a relatable manner that resonates with the lived experiences of service users. By demystifying clinical jargon and discussing mental health through the lens of their own experiences, the PSW fosters

a more "*therapeutic dialogue*" [In, #7, HCA]. These practices illustrate how the PSW integrates therapeutic logics into their work, enabling them to establish connections more quickly and use their experiential knowledge for effective communication, as observed by a HCA:

> *<PSW name> has a more human approach and softens the team… a genuine sense of lived experience, and they're able to cut through the noise a bit instead of being so sort of medically terminology in the way they describe people symptoms, they're giving people some feedback. You know, this worked for me; this would work for other people, identifying opportunities in the community, just speaking to people on a level that's just like a bandwidth that they get. Do you know what I mean? Because sometimes the doctors and the nurses get a bit too much jargon, maybe they're over-medicalising things* [In, #7, HCA].

Two interviews, in particular, stood out as they conveyed a sense of sadness about the limited ability of clinicians to engage in specific types of "*therapeutic work*" or activities. One nurse, for instance, expressed a nostalgic longing for the opportunity to participate in more informal activities like going for coffee or having casual conversations:

> *I'd absolutely love to be able to like to go for a coffee and have a, a, chat because it is really therapeutic … it's not so kind of what's the word like regimented?... the peer support workers… see them continuously. Whereas,*

> *our role, we end up seeing different patients every single day… because of the pressures of the service* [In, #8, Nurse].

This difference in therapeutic approaches between clinicians and PSWs is clear in the PSWs experience of working with service users:

> *I love going and offer to walk alongside somebody rather than coming in and telling them right we've got this, this and this to do, let's get this, this, and this done. I like to go in and say, what is it that you want? It's about giving the person you're supporting the, the control… like supporting them to take back control of their own well-being, their own lives* [In, #10, PSW].

As a nurse, the approach of "*walking alongside*" somebody felt alien to me. Bound by Trust policies, rules, codes of conduct, and procedures, I felt unable to walk alongside someone under my care. My authority primarily shaped my interactions, requiring mandatory structured questioning to gather information for care plans. Though well-intentioned, recovery-focused, and person-centred, this power imbalance during interactions made truly mutually supportive relationships difficult, if not impossible. In contrast to the PS approach, which emphasises connection and shared experiences, nursing often prioritises task completion.

Like the nurse I interviewed, I felt sadness and guilt about my inability to provide therapeutic support - such as having a chat over coffee or playing chess - due to time constraints and the need to complete essential tasks like administering medication or

writing case notes. Within the system, these activities are often seen as time-consuming, inefficient, or outside the nursing role.

However, it raises the question of whether professional roles are the most suitable role for these kinds of conversations or work, particularly when PSWs, with lived experience of mental distress and/or the system can offer support. It is arguably more therapeutic for service users to be supported by someone who can relate or understand their struggles compared to a professional who may return to their relatively comfortable lives and is often discouraged from disclosing their own experiences due to perceptions and stigma surrounding mental health and professional roles. Disclosing lived experience as a professional has been a personal conflict for me, and it is a topic rarely discussed among professional colleagues. During one interview, I felt a deep connection with a nurse who shared similar struggles:

> *I've kind of been under services before, but it's not really something that I would want people to know… I think, cause there's a lot of stigma around it as really well as bad as it sounds, and I know I work with loads of mental health nurses, but it's I think there's still kind of a small sticker attached to it* [In, #8, Nurse].

This quote highlights some underlying beliefs and values associated with professionalism. It underscores the inherent tension between the vulnerability of sharing one's mental health journey and the perceived (sometimes appropriate) need to maintain professional boundaries. This conflict offers insight into how experiential

knowledge can impact clinical encounters. Whether clinicians choose to disclose their lived experiences is a deeply personal decision. However, the data reveals a clear contrast between clinician and PSW roles. While clinicians bring clinical training, expertise, professional logics, and possibly their own lived experiences, PSWs offer a unique form of knowledge rooted in their personal recovery journeys.

All team members interviewed expressed an appreciation for having the PSW on the team, recognising their contributions in terms of presence and the depth of understanding they bring to interactions. This experiential knowledge adds meaningful dimensions to service user engagements, fostering a sense of therapeutic resonance. The data suggests that despite being among the lowest-paid team members, PSWs form therapeutic alliances with service users quickly and effectively. This raises intriguing questions about the efficiency and potential impact of lived experience. For instance, the ability of the PSW to connect with service users, invoking the therapeutic logic, may, at times, be more efficient and meaningful than approaches adopted by clinicians.

6.5 Role of PSW in alleviating growing time constraints

The data reveals an emerging narrative about the potential efficiencies of implementing PSW roles into the team. On the one hand, the experiential knowledge of the PSW might enable them to connect more quickly and meaningfully with service users in distress, potentially making their contributions more effective than those of clinicians. This dynamic is especially significant given the increasing time constraints and service demands the team faces. However, this potential benefit must be

understood within the broader political and social context of public sector care provision.

There is a prevailing perception of the public sector as an economic burden, often described as a ‘drain on taxation.’ If it were revealed that relatively highly paid clinicians, like nurses, are spending considerable time on unstructured and less tangibly outcome-driven activities - such as having coffee or engaging in open-ended conversations - this could draw criticism from societal stakeholders and policymakers. Given these perceptions, alongside operational challenges like understaffing and rising referrals, there is a strong case for maximising the role of PSWs. Why invest in costly professional roles with inherent time constraints when a PSW can dedicate more time to service users and contribute to achieving HTT targets by potentially easing those time constraints?

Amid increasing service pressures, the data suggests that PSWs can also support the growing time constraints faced by the team. Interviews and observations highlight how the PSW can form meaningful connections and offer support that aligns with the broader contexts of service users' lives - approaches prioritised within therapeutic logics. In contrast, clinicians without lived experience of mental distress may struggle to build rapport and trust, particularly due to limited resources and role boundaries. Two team members highlight how the PSW helps bridge this gap, easing time pressures and facilitating deeper therapeutic work:

<PSW name> can make a connection that perhaps a nurse can't make with that patient or finds harder… large part of that is mediated by how good the PSWs we've had in the team [In, #9, Psychiatrist].

<PSW name> does some of that… work with just going back to basics and just addressing… some of the issues in sort of the day-to-day function… signposting opportunities in the community, essentially, all sorts of stuff really… short interventions in helping people, reflecting on their own experiences and just perhaps giving some of that therapeutic feedback that other people within the team perhaps aren't as good at sort of identifying or they overlook… I guess we're so, you know, the medic, medication model, and sort of symptoms and acute illness, but perhaps more so the peers are able to focus on some of some of the other stuff [In, #7, HCA].

The data indicates that the PSW possesses an intuitive understanding that likely arises from their experiential knowledge. One nurse noted that the PSW "*knows*" the right questions to ask, highlighting their ability to discern what might be therapeutically helpful. This unique form of knowledge, rooted in shared experience and aligned with a therapeutic logic, may allow the PSW to quickly identify pathways forward that clinicians may struggle to recognise or fully appreciate. For clinicians without this experiential insight, who primarily utilise professional logics, gathering such information may be more challenging and time-consuming. They lack the time to build relationships that might foster the emergence of these critical details. For the PSW, the skill of asking relevant questions can potentially enhance the effectiveness of

clinicians, enabling them to develop care plans more efficiently and thoroughly - demonstrating an alignment between the use of therapeutic logic by the PSW and professional logic adopted by clinicians. The following quote illustrates the ability of the PSW to prompt new lines of inquiry:

> *Sometimes, it just takes little changes in people's lifestyles they need to make, and I think the PSWs are probably quicker to spot that quite often than the rest of us… we're going in and say are you taking your sleeping tablets? Are you taking your antidepressant? And they might come in and say… have you thought about not having two cups of coffee in the evening that's affecting your sleep or smoking weed till three o'clock in the morning? That might be affecting your sleep… We value their opinion greatly…somebody might tell them something that they've not mentioned to any of the nurses, so we need that feedback. It helps inform our sort of care planning* [In, #11, Nurse].

Additionally, the PSW approach to understanding what might work seems to stem from the relationships they build and the community spaces they utilise for visits, as I reflected upon in my diary:

> *Today, I accompanied the PSW to a garden centre to meet with a service user. As we entered the cafe, I immediately felt the relaxed atmosphere created by the sights and smells of the vibrant plants all around us. The PSW had mentioned that leaving the house can be an immense struggle for some, so I sensed that visiting this restorative space may have been a positive step forward for the service user we were meeting. Even though the PSW had*

already obtained the service user's consent for my presence, I still wondered how they truly felt about having an outsider observe their conversation and how that might alter the interpersonal dynamics between them.

The PSW led us to a table where we could sit together. They introduced me as a researcher, explaining that I was there to learn more about their role. I then introduced myself and asked for consent, clarifying that I would just be observing, not taking notes. As the conversation unfolded, I remained a quiet observer, nodding when appropriate but careful not to intrude. The PSW started by saying how the service had been doing lately in an unstructured and friendly manner. I noticed how attentively the PSW listened, picking up on the subtle cues about the service user's needs and challenges.

After a few minutes, the conversation shifted toward concerns about finances. When our drinks arrived, the PSW seamlessly explored potential support options, explaining how help with Personal Independence Payment applications and local community resources could be transformative. They emphasised the importance of financial support and a letter outlining the service user's circumstances and how this could help.

I caught glimpses of their demeanour - open, warm, and gently guiding the conversation toward identifying tailored pathways for the service user. In that café, surrounded by lively greenery and warm beverages, I realised that the PSW employed a refreshingly different approach: listening deeply, connecting,

and developing a sense of what might truly help. This extended time and relaxed setting allowed the PSW to understand how best to support the service user - not through rigid clinical frameworks but through a collaborative process of building a relationship and co-creating insights into their specific circumstances, struggles and aspirations.

Despite my presence, the PSW skilfully created an environment that allowed the conversation to flow naturally. I contemplated both their experiences in that moment. Were they compartmentalising my presence to protect the intimacy of their interaction? Could they fully express the vulnerability inherent in their roles with a researcher observing? While the PSW exuded confidence, I was acutely aware of the vulnerability they displayed by allowing me to witness their exchange. Yet, I couldn't shake the feeling that my observational role might have altered some essential aspect of their work, refracting it through a different lens [Diary entry, 21.03.22, Community spaces].

A recurring theme in the data was that most of the team perceived the PSW as possessing a "*wealth of knowledge*" about various community groups that can support service users. As an observer, I accompanied the PSW on visits to places like local cafes and community resource centres to collect informational materials. Team members frequently leveraged this extensive awareness of local resources during MDT meetings. Consultant psychiatrists and senior nurses often sought the input and recommendations of the PSW on community resources, highlighting the importance of their experiential knowledge in guiding HTT decisions and demonstrating their role as a vital resource in enhancing service users' recovery journeys. This highlights how

the PSW primarily uses a therapeutic logic while adjusting to managerial expectations, allowing them to carve out a unique role that means they are not using or expected to use professional logics. By blending personal experience with community awareness, the PSW may help clinicians make timelier, more recovery-oriented and informed decisions. The manager remarked on the contributions of the PSW during MDT meetings, implying that their insights not only enrich the team's understanding but also promote a collaborative approach to care:

> *And even recently in MDT when <PSW name> have sat in, <PSW name> been able to… from kind of a recovery-focused perspective… have you thought about this, or I know about this resource that might help this patient and so <PSW pronoun> can see that. I guess sometimes we kind of get a bit blind sighted with, you know medication and you know what's the next pathway, da, da, da? It's all quite regimented sometimes, which <PSW name> does bring a different perspective to it, and I think with <PSW pronoun> being lived experience as well… can see it more sometimes from the patient side of things and because <PSW name> spending a bit more time with somebody, <PSW pronoun> can kind of fill in what, what's really kind of going on* [In, #5, Manager].

There also appeared to be an association between the PSW role and enhanced overall team efficiency, particularly in managing caseloads, which is a priority within the managerial logic. The manager described how the involvement of the PSW helped meet increasing service demands by facilitating meaningful therapeutic engagement:

We have people that… don't go out for days and days and days… <PSW name> is able to maybe go along and have a bit of a chat, build up that relationship and have that consistency as well with the patients, whereas we can't, and kind of get them out… we reap the rewards really of them [PSW roles] being here….

What kind of rewards? What does that look like within the team?

A better, manageable caseload… what we'd find is that… some people without some therapeutic work, such as you… behavioural activation or graded exposure, they're kind of going to be on the caseload longer, Just because we haven't got time to do that, or if it's, you know, if an urgent assessment comes in and that's the first thing cancelled on our shift planner. [In, #5, Manager].

The PSW provided a detailed account of how the broader managerial and service pressures surrounding caseload management. While these pressures were of high importance within the managerial logic, the PSW primarily drew on the therapeutic logic to address and support these demands:

What they'll [Clinician roles] say to me, can we go in and do this piece of work… I keep that in mind, but I then go into the people and say… this is what I've been asked to do or support you with, is this what you want, or is there something else that you'd look at or help with, so they get the choice as to what, what we focus on, because quite often, I think for the NHS, it's about moving people on as quickly as possible, and sometimes, the steps are too big for the people that we're supporting… I pare it right back to what they [Service users] want… There

> *are some people who are given specific targets, and I go in and do that with them because that's what they want… if it's not in line with what they want to achieve, then I'm not going in and doing something different, but by the same standard, I think what happens is because I'm listening to what they [service users] want, their progress, it gives them, kind of support and their experiences validated, so it moves them on naturally because they're doing what they want to do, they're [service users] achieving the things they want to achieve, rather than what the system wants them to achieve… I guess proofs in the pudding because they [Wider team members and Trust] rarely saw the benefits that the people are experiencing, and I know that <Team manager's name> talked about people who have had peer support within the <Team name> have been discharged 40% earlier, something like that, so that's the power of like being able to share lived experience* [In, #10, PSW].

The data within this sub-theme suggests that the PSW role subtly and overtly supports the team in alleviating time constraints. Two key forms of interconnected knowledge stand out: the personal experience of the PSW with mental health and/or services and their deep familiarity with local resources gained through active community involvement. These unique resources, rooted in experiential knowledge and long-term community relationships, are not readily available to other team members. As a result, the experiential knowledge of the PSW, closely aligned with therapeutic logics, enables them to navigate and negotiate the dominant managerial and professional logics within the setting. This has allowed them to carve out a unique space to focus on recovery-oriented approaches, contributing valuable experiential insights without being expected to rely on or apply professional logics. In doing so, the PSW effectively

supports the overall goals of the service, addressing growing managerial demands and service pressures in a time-efficient, holistic, and recovery-focused manner.

6.6 PSW ‘gifts’ time

The final emerging sub-theme within the data suggests that, besides providing more time for direct engagement with service users, the PSW offers a more subtle yet significant ‘gift’ of time back to clinicians. This nuanced contribution highlights the PSW's capacity to ease time pressures, enabling other team members to focus more effectively on their roles. By embodying PS principles, sharing experiential advice with service users, and identifying creative solutions in care, the PSW facilitates efficiencies beyond direct service user interactions which are more aligned with managerial priorities.

The data provides a sense that the PSW can create meaningful connections and drive progress in clinical situations where clinicians may struggle due to role limitations and resource constraints. In doing so, the PSW effectively ‘returns’ or ‘gifts’ time to nurses, psychiatrists, and others, allowing them to focus more fully on their specific role-oriented responsibilities, as emphasised within their respective professional logics, such as medication management and risk assessments. One nurse shared an example of how the PSW achieved this:

> *It's about getting <PSW name> there as a peer support worker so <PSW name> can then pick that up and do that and be the consistent person. So <PSW name> was always a consistent face … would have their own caseload*

and people could see <PSW pronoun> once a week or twice a week… and they knew <PSW name>… have that familiarity. Whereas, as nurses we don't offer that… so <PSW name> would build a relationship with the patient, for us, that's not so much what I would do, so I suppose that would be a major difference between us…. I don't get attached then, and they don't get attached to me and it stays purely practical, these are the skills, these are the medications, this is what we do, this what you do and it's about them moving on their own [In, #12, Nurse].

The data highlights the importance of experiential knowledge of the PSW in the time-constrained environment in which the team works. Formal interviews and observations uncover the crucial role of the team manager in actively promoting the PSW responsibilities, ensuring that their expertise is not underutilised or redirected to other support tasks. Beyond simple advocacy, the manager provided various accommodations, such as adjusting work hours during challenging times, allowing for a "*patient-free*" week, facilitating a gradual return after time off, and offering ad-hoc supervision. These actions highlight the manager's awareness of the unique challenges faced by the PSW, prompting proactive measures to support their well-being and integration into the team. This also reflects a managerial logic that acknowledges the distinct capability of the PSW to assist and support the team in ways that clinicians without lived experience may be unable to, as illustrated in the following quote:

I mean, <PSW name> has that time, and everyone knows that's <PSW name> dedicated time… their work takes priority, and <PSW name> wouldn't ever get

asked to cancel work to fill in for urgent work, and I think that's good that's protected… And <PSW name> might, if <PSW name> has not much going on, then… offers and <PSW name's> quite happy to do bits and bobs. But whereas if, so if… the support worker was doing some, you know, graded exposure with somebody, it would be expected if an urgent assessment came in, and then that would get cancelled. So, <PSW name> is protected, and I think that's the key; their work is protected; they're not counted in the numbers, and I think that's the key, and they don't blur the lines, so I think when they when they first came there was, and I think rightly so as well, <Previous manager name>, the old manager, ensured that <PSW name>] and <CPSW name> would only do the work specific to them and I guess that was because <Previous manager name> didn't want the lines getting blurred [In, #5, Manager].

The manager's support and recognition of the unique contributions of the PSW in relation to therapeutic logics were pivotal. The data suggests that this validation empowered the PSW to perform their role more confidently, reducing the need to constantly justify their experiential knowledge and practices - allowing them to fully embrace and utilise therapeutic logics. This acknowledgement, alongside the perceived acceptance of the role within the team, enabled the PSW to effectively 'gift' time to the team, thereby enhancing the overall efficiency of care delivery, prioritised within managerial logics. This sentiment is reflected in the following interview quote:

I think, if you've got a manager that really values lived experience, it opens up a completely different team expectation, team treatment, team value, yeah, communication… because it's coming from the top down and the bottom up, so

it's kind of like, we meet in the middle… whereas if it's with a team that you just sort of like going into first of, you're at bottom, you've got to kind of buildup… if the management understand the peer role and value… then it's coming from both ends, we can sell the positives of it from both ends rather than having to prove ourselves [In, #10, PSW].

While the data suggests that the PSW role helps alleviate time pressures, these contributions often remain subtly integrated and not immediately visible. Observations reveal that the persistent combination of limited resources and increasing referrals has normalised a state of scarcity and strain within the daily HTT operations. Within this context, the ability of the PSW to create efficiencies may go unnoticed or be taken for granted, as it helps to maintain the functional capacity of the team amidst growing demands. The data indicates that the PSW acts as a vital, though sometimes unrecognised support as the team navigates rising mental health needs during a period of resource constraints and limited resources. This is exemplified in the following interview quote, which underscores the tangible impact of the PSW:

I think it's partly, partly because they've [Team members] seen the evidence of how it's… supported people to go through… discharge quicker, so there's actual evidence, but also feedback from everybody that I've worked with without question… has sung nothing but praises about how I've been with them [Service users] and how they [Service users] felt listened to and validated. So much so that there was somebody who came through the services was discharged, and I got a letter from their local mental health team and praising

me for how I'd supported them at the time, and they said it's very, very rare that we get such positive feedback. So, they wanted to give that feedback to me… it's something that goes with whoever… when people move on, it stays with them. And I think you know, having that positive feedback encourages the team… and helps to understand the value of peer support, and the difference of peer support [In, #10, PSW].

The ability to 'gift' time also presents a double-edged sword. While the PSW contributions appear to help relieve pressure on the team, the data shows they are sometimes asked to take on tasks beyond their intended role. Since the PSW is not officially counted in staffing numbers, they can be perceived as having greater availability. This demonstrates how the dominance of managerial and professional logics can supersede therapeutic logics. In informal interviews, the PSW expressed an understanding of the immense pressures experienced by the team and a willingness to assist wherever possible.

Observations showed that, when feasible, the PSW often provided additional support - handling administrative duties, rearranging appointments, accompanying visits, and even delivering medication. This blurring of responsibilities suggests that while the PSW is valued for enhancing efficiencies, they may also be viewed as a flexible resource. An informal conversation further emphasised this potential overreach and the risk of misusing the PSW role:

The PSW spoke about one instance when they attended an initial assessment with a psychiatrist due to staff shortages on that day. Normally, assessments are carried out solely by two qualified Band 6 professionals (usually two nurses or a doctor and a nurse), which involve meeting a service user, carrying out an assessment, and making decisions about their plan of care. The PSW explained that for the two qualified staff undertaking the assessment, having two qualified staff allows them to share responsibility and bounce ideas off each other about the next steps as they're ultimately responsible for making clinical evaluations and judgments based on the information gathered. During the initial assessment with the doctor, the PSW spoke about how their main role was to ensure all the required information was properly collected and made sure the doctor had covered all the areas and questions according to the assessment documentation. But any actual clinical assessment, evaluation or decision responsibilities remained solely with the doctor as PSWs are not supposed to attend assessments [IC - 14.03.22].

The data indicates a shared, implicit reciprocal understanding within the team. By 'gifting' time back to clinicians, taking on additional tasks, and doing the therapeutic work, the PSW is integral to sustaining service delivery. However, formal and informal conversations with the PSW highlight concerns regarding the potential blurring of boundaries. While the eagerness of the PSW helps demonstrate a deep commitment to the team, it also raises the risk that their role may inadvertently serve as a buffer for systemic pressures, potentially jeopardising their role integrity. Striking a delicate balance between helping the team and overstepping established boundaries is crucial. This tension is captured in the following quote:

Do you think the team understand the PSW role?

I think they do now. Yes, there was one incident the other week where I was asked to go in and do a deep clean, well kind of a deep clean with somebody, and it was like, that was, I spoke to the line manager about that, and they said no, we're not cleaners, that's not your role. Don't get me wrong, I'm happy to go in and support people if they want to do some cleaning; I will work with them… in the past, I have worked with somebody who wanted to do some cleaning, but we did it together,' It wasn't me doing it, and them sitting doing nothing, I was supporting, we were doing half and half… that's something they wanted to achieve. Whereas this particular situation they were saying can you go in and help them clean, but I think their lifestyle, it would, they need specialised help, not just somebody going in and helping yeah, yeah, and so that was that was kind of interesting [In, #10, PSW].

The willingness of the PSW to assist with tasks, even ad hoc, seemed to signal a commitment to the service's collective goals. The data suggests that clinicians may perceive this support as earned solidarity and a sign of successful implementation into the team. It might reflect an understanding that resource constraints often demand an all-hands-on-deck approach. This mutual recognition of navigating challenges within an overburdened system allows clinicians to focus more on their core responsibilities, leveraging their professional logics characterised by clinical expertise and training. One psychiatrist highlighted how the PSW worked within these established boundaries, acknowledging the limitations clinicians face in such a system:

<PSW name and CPSW name>… they've always understood… the limit of their work in a… healthcare system with limited resources… we try and allocate them as best as we can and as fairly as we can… and they work well within that paradigm, limited healthcare resources, but I've worked with some from the peer support model, perhaps don't recognise the limitations of the health system itself… It is the equanimity and the compassion that <PSW name> brings and the willingness to recognise that the system is trying, I guess, you know, rather than excoriate or criticise, like you know, an under-resourced, understaffed, under whatever system, intent that you know that's how the patients might see, even though I think we've probably got adequate resources to do what we're meant to do, it's just what we're meant to do is not what people want us to do a lot of the time [In, #9, Psychiatrist].

However, not all PSWs may share this perspective; some may perceive clinicians as overly rigid or flawed, which can create tension. The data indicates that actions diverging from task-oriented objectives may be viewed as unprofessional or counterproductive, potentially increasing the workload for clinicians and detracting from the overall HTT objectives. It was noted by the psychiatrist that PSWs who challenge or question the viewpoints and care approaches of clinicians might be seen as subversive, complicating their relationships within the team:

I've been in other MDTs with other PSWs, and sometimes, their goals are not aligned with the organisational goals. For example, the appetite for taking significant therapeutic risks with patients or trying to manage the expectations

and demands of that patient might have with a service that, if we were trying to fulfil those, the entire health service could be consumed by a tiny fraction of this user…I once asked a PSW to leave a review because they were drunk, and I've also had to speak to a PSW separately from a patient to explain the difference between advocating for a person's recovery and simply echoing… the patient's requests… The PSW I talked to separately was not employed by our organisation; they were employed by a third-sector charity, and you know the background was the patient had some misuse problems and was asking for X, Y and Z, and I was saying no to everything they asked for. And then, the appointment descended into the PSW kind of arguing with me about every decision I've made, which is, which is not helpful because essentially, they've been recruited into the patient's drug-seeking behaviour, and that's not helpful, and they seem to accept my rationale at the end. But it was difficult and unhelpful [In, #9, Psychiatrist].

Reflecting on the quotes of the psychiatrist, their black-and-white tone stands out. The clarity, decisiveness, and authority in these statements draw me in, especially given the stark contrast they present to the more relational and recovery-oriented perspectives of the PSW. These quotes appear rigid and definitive compared to the more nuanced, person-centred approach associated with the PSW or my experience as a nurse. It is this contrast that makes the perspective of psychiatrists so compelling. They represent a logic that I might instinctively question or critique. Their focus on clinical precision and decision-making echoes some of my experiences in healthcare, it also feels distinct from my emphasis on relational care and the subtleties of individual

recovery journeys. The power and authority they hold in the healthcare system are clear, reminding me of how these roles significantly shape care outcomes. These quotes prompt me to reflect more critically: Why does the black-and-white tone stand out so much? Does it bring into focus the systemic pressures and hierarchical structures that shape care delivery?

Summary

This chapter examined several dimensions of time, including its impact on goal-oriented therapeutic interactions, the perceived and actual benefits of the PSW role in managing time, and their ability to quickly connect with individuals in distress. Furthermore, it highlighted how PSWs might contribute to alleviating time pressures experienced by clinicians and the wider MDT. Together, these findings underscore the essential role of time in successfully implementing the PSW role. The following chapter will introduce risk as another key mechanism influencing the implementation of the role in Chapter 7.

Chapter 7: Theme Two: Illuminating multi-dimensional aspects of risk

The theme of *risk* emerged as a complex and multi-dimensional mechanism within the data, revealing varying understandings and approaches across team roles. Table 7-1 below outlines the subthemes that unpack how risk is perceived, managed, and mitigated, with particular emphasis on the distinctive contributions of the PSW, whose lived experience offers a valuable lens to risk, highlighting both their unique insights and the challenges of having only one PSW.

Table 7-1 - Overview of findings relating to risk

Unveiling multi-dimensional aspects of risk		
#	**Sub-theme**	**Description**
7.1	Clinicians understanding of risk	Explores the intricate nuances of how clinicians perceive, navigate, and manage risk within their professional roles
7.2	PSW approach to risk	Illuminates the distinct perspective that the PSW may bring to understanding and managing risk, informed by their lived experience and knowledge
7.3	PSW experiential knowledge of risk	Highlights the potential impact of PSW encounters with risk and recovery, offering a unique lens through which to quickly connect with, comprehend, and address risk dimensions
7.4	PSW as a risk mitigator	Discusses the role of the PSW as skilled navigators and mediators in mitigating risks, leveraging their experiential knowledge and rapport with individuals
7.5	PSW ‘gifts’ time for risk-related tasks	Emphasises the PSW role in supporting risk management, potentially enables clinicians to

		concentrate more on their role-specific risk management duties
7.6	There is only one PSW	It underscores the range of benefits the PSW brings while highlighting the inherent issues and risks of having only one PSW within the team

7.1 Clinicians understanding of risk

All team members working with service users shared a common clinical understanding of risk. This perspective centred on using indicators such as demographics and targeted questions (e.g., presence of a mental health diagnosis) to assess an individual's potential risk of harm to themselves (e.g., serious self-harm) or to others (e.g., violence). Risk management strategies predominantly relied on immediate, controllable interventions, such as medication and hospitalisation, which are prioritised within professional and managerial logics. These interventions aimed to address elevated or imminent risks and ensure the safety of service users.

Although monitoring risk was one of the core responsibilities, clinicians were expected to take the lead in identifying, assessing, prioritising, and managing these risks. Their clinical training and experience, alongside the use of standardised assessment tools, shaped their approach to risk, reflecting professional and managerial logics, and influenced the care provided. The data suggests that the processing of interactions, behaviours, and decisions of clinicians were fundamentally centred on prioritising risk - identifying, assessing, and mitigating potential harms through controlled interventions. This understanding of risk emerged as a pivotal factor guiding the perspectives of clinicians and care provision within the team.

The language employed by clinicians further illuminated their view of risk. Data indicated that risk was primarily framed as a concept to be managed through various professional practices and organisational Trust processes. Risk management was evident in professional logic practices such as assessments and diagnostic evaluations of service users. At the organisational level, protocols like clustering service users into risk categories and establishing care transition processes, emphasised within managerial logics - were crucial for managing perceived risk. The discourse surrounding risk emphasised identification, assessment, and mitigation through established clinical and administrative procedures. This was poignantly captured in an informal conversation where the PSW reflected on their early experiences with the team around learning these processes:

> *During a conversation with the PSW, they mentioned that when they first started, the clinical lead provided them with a Trust Mental Health Clustering Booklet for Clinical Staff to help them understand the team's processes. The booklet was intended to familiarise the PSW with the language used, the concept of clustering, and its purpose in relation to diagnosis and risk assessments. It is 61 pages long and covers topics such as what a cluster is, when and how to cluster a newly referred patient, care reviews, the clustering process, care transition protocols, a step-by-step guide for using cluster ratings, and cluster profiles during care reviews. It also includes a clustering tool, decision tree, and detailed cluster descriptions* [IC, 14.03.22].

Most clinicians articulated that managing risk was considered a fundamental part of their clinical responsibilities. In formal interviews, some clinicians shared how their interactions during community visits or assessments with service users predominantly focused on identifying clinical risk indicators and forming swift impressions to inform their clinical decisions. This strong emphasis on risk management was captured in the following quotes:

> *As nurses, the subtext is always, what are the risks here? Is this person going to end their life? How risky are they going to be?... in my head, I'm thinking sort of demographics, are they male or female? Have they got serious mental illness? Have they attempted to take their life before? Are they voicing suicidal ideas? Have they made plans for themselves?* [In, #11, Nurse].

> *We're trained to look for sort of deficiencies, we, we, look for what's going wrong* [In, #12, Nurse].

Service user engagement and interactions were driven by the urgent need to quickly identify high-risk individuals needing immediate support - demonstrating the dominance of both professional and managerial logics. One ANP noted that this risk-oriented approach resulted in a pattern of repetitive, formulaic, and prescribed interactions with service users:

> *All the nurses and HCAs do have risk very high up their agenda, and I mean, to the extent sometimes where it becomes a bit repetitive and a bit unhelpful…*

we often do find, find ourselves as a team, visiting people every day, and asking those same questions about, you know have you thought about suicide today? And it can be quite reinforcing, and… a negative set of ideas to bring on when meeting somebody [In, #2, #ANP].

Clinicians regarded documentation as a crucial element of risk management, serving dual purposes. It functioned not only as a clinical tool for tracking risks but also as a protective measure in its own right. The documentation process centred on meticulously recording the rationale behind each decision, creating a safeguard through a comprehensive paper trail in the event of unforeseen adverse outcomes. This practice helped mitigate potential risks for the clinicians and the Trust., as the psychiatrist remarked:

The amount of documentation… and the standard of documentation that you're required to do is far higher than it was even when I started as a junior doctor… and the move from paper records to electronic records means that you don't take contemporaneous notes… and I think all of that has taken time away from, the time to care, which is a big agenda for the trust… It's…like when, when you go to coroners' courts, a risk assessment hasn't been filled in very well recently, and that means that your risk assessment was poor. Whereas it can be that a really good risk assessment is poorly documented, and a really poor risk assessment is very well documented, and they are two different things. But in an adverse investigation or serious untoward incident investigation process identifies fault with the good risk assessment and praises the bad because it becomes about what's documented at the time rather than an understanding of

the thought process of clinician… or how eloquent the clinician is in explaining their thought process at the time [In, #9, Psychiatrist].

The data reveals a prevalent belief that risk is most effectively managed through adherence to the traditional clinical recovery approach as reflected in one nurse's perspective:

The role of <Team name> has changed over the years; for the first… ten years, we had very little medical cover, very little, there wasn't any psychiatrists in the team, it was very much a nurse-led team…and [date]-ish, we suddenly had… consultants put in the team. As with so much else within our [Trust], it was probably feedback from a coroner… who probably had a spike in the number of suicides one year, and the coroner would say, well, why did this person not see a doctor?... Then the [Trust] would have thought, oh yeah, we should probably put a doctor in the <Team name>. That very much changed the way that we worked as well. We became a lot more medically driven [In, #12, Nurse].

Another nurse described the challenges of working within a system that predominantly prioritises a medically driven approach to care. Their demeanour conveyed a sense of resignation as they explained how their role was intricately linked to a reliance on medication, which serves as a cornerstone in guiding service users' mental health recovery:

> *We're very much wedded to the medical model, really; you know, what medication is this person taking? Could you take something else? Could something work better? Do we need to change something? Do we need to get them to go and see a doctor?* [In, #11, Nurse].

While a psychiatrist pointed out that this emphasis on a medically driven approach was closely tied to the availability of resources. They noted that the limited options for therapeutic interventions often forced the team to rely heavily on medication as the primary means of support. As a result, aspects of therapeutic logics were sidelined in favour of professional and managerial priorities:

> *In psychiatry, we talk about the biopsychosocial model all the time, and really, we have ready access to the bio-model, and we have a little bit of access to the psycho bit of it, and we have a little bit of access to the social bit of it…we've got organisations with enormous waiting lists… that provide psychological intervention at some point… and we've got drugs readily available at the drop of a hat [*In, #9, Psychiatrist].

The data in this sub-theme reveals that various clinicians and their professional logics share a common understanding and interpretation of risk. Their risk assessments, documentation practices, and inquiry methods are governed by stringent protocols that centre on the potential for harm to individuals, whether to themselves or others. This clinical framework, rooted in their training and the imperative to mitigate immediate threats, frequently eclipses alternative questioning approaches that might uncover a broader spectrum of risk factors that are more aligned with therapeutic logics. Although

clinicians must prioritise safety, this emphasis on clinical-risk inquiries and standardised tools reinforces a conventional understanding of risk that aligns with professional and managerial expectations for delivering high-quality mental health care and support.

7.2 PSW approach to risk

The data suggests that the PSW embodies a distinctly different approach to conceptualising and addressing risk than clinicians. While clinicians rely heavily on standardised assessments, interventions, and specific questioning to identify clinical risks, the PSW situates risk within a broader psychosocial-environmental framework. The risk priorities associated with the therapeutic logic actively consider how social, emotional, and economic factors can contribute to an individual's distress. This unique, holistic perspective allows the PSW to explore risk through a different lens, considering other potential harms such as overtreatment, social isolation, and loneliness - issues that may be overlooked in the more narrowly focused professional logic or managerial understandings and approaches to risk.

Unlike clinicians, the PSW cultivates a more comprehensive and deeper understanding of an individual's risk by situating it in a fuller context. Most clinicians observed that, rather than adhering to structure and task-oriented dialogues typical of clinical encounters, the PSW engages in more informal and unstructured risk conversations, which align with more therapeutic practices. This organic method fosters a conversational space prioritising active listening and reciprocal dialogue over checklist-driven assessments. As one nurse reported, this approach might enable a

more open exploration of the individual's worries and/or stresses, as well as emerging risks that might otherwise go unvoiced:

> *The doctor will focus on, you know… lots of questions will come up with diagnosis… with suggested treatment plan, what medication we think we need to be giving. The nurse will write… I've been out to see this person, they still got some suicidal thoughts, but err, they don't have any to act on, this constant sort of risk assessment… and then you go to the PSWs thing [case notes], and it might say, continue to be worried about… her son who's using drugs or whatever, so again, it just sort of broadens the picture really, and so gives us an insight into… why this person is presented in the way that they are, which we may not ask. <PSW name> gives us insights into what might be contributing to the current presentation and the current risks…. the peer support worker will come in and not focus so much on risk but talk about… why this is happening to you now. What's your take on what's going on? Why do you think you feel this way? What support have you got? Do you have a family? Do you have friends? How do you function on a day-to-day sort of level* [In, #11, Nurse].

One nurse reflected on the constraints imposed by their risk-centred practices on their interactions with service users. They acknowledged that this narrow focus often resulted in structured engagements, which limited the depth of understanding. In contrast, direct support roles, such as that of the PSW, possess the flexibility to ask broader, more open-ended questions. This approach, more aligned with the

therapeutic logic, enabled them to uncover additional dimensions of risk that may be overlooked by more rigid lines of inquiry typically employed by clinicians:

> *Some Band 3s are really chatty, and they actually ask questions that I have probably forgotten about because I'm so fixated on the risk, I suppose* [In #4, Nurse].

During my observations, the PSW intentionally employed non-clinical language to reshape the conversation around potential risk issues. Rather than concentrating on risk factors, they emphasised the strengths and assets of service users invoking a therapeutic logic. For instance, instead of categorising or labelling behaviours with clinical terminology that implies illness and risk, the PSW described them as "*very strong emotions*." This deliberate choice of language aimed to cultivate a hopeful, strengths-based outlook. By emphasising resilience and positive attributes, the PSW fostered a more recovery-oriented dialogue, consciously avoiding the clinical language often associated with risk situations deemed in need of clinical intervention:

> *It's been about role-modelling those strengths rather than the challenges that we face… I'm hoping that's what the impact is… it's more strength-based rather than continually risk assessing and, er, the negative language as well that can be used, you know, people talk about non-compliance, or, er, kicking off, and I never used that language, so I suppose I, I lead by example. I use, you know, language around experiencing very strong emotions rather than kicking off or non-compliant. It's like I say… what is it we're missing that they're unable to*

connect with us as a team? What are we not doing or doing that's making it difficult for them to connect… it's about tapping into what it is that's missing for the people we're supporting in order to make that connection [In, #10, PSW].

The PSW approach to discussing risk was distinctly relational and recovery-oriented. Observations revealed their commitment to breaking down power imbalances by engaging with individuals on an equal footing. One nurse noted how this non-hierarchical approach, paired with a broader understanding of each person's context, allowed the PSW to build deeper rapport and gain nuanced insights into individual circumstances:

They [PSWs] … get to know more about the person underneath rather than the immediate presenting problems… and through that, subtly draws out… what assets do you think you've got? What strengths they think you've got and what skills do you have? What's enabled you to cope with this so far? What can we put in place to support you sort of moving forward? What can we do to try and prevent this happening again… they do use a different, maybe a different language [In, #11, Nurse].

Moreover, the data suggests that the PSW relationship-centred understanding, which focused on - meeting people "where they are", facilitated a more sensitive and exploratory examination of risk. This starkly contrasted with the one-sided assessments common in traditional clinical dialogues more aligned with clinicians invoking their professional logics. One HCA reflected on the need for a more

authoritative "*sergeant major*" stance, highlighting the tendency of clinicians to prioritise efficiency and goal-oriented risk mitigation in response to service demands deriving from managerial logics:

> *Speaking to the peer on our team and reading [PSW pronoun] notes in passing, I know that it's just speaking to people at their level. It hasn't got that level of authority like this is the care plan, this is what you need to be doing because obviously, the nursing staff, we need to have that bit of sort of sergeant major approach* [In, #7, HCA].

The data underscores the risk ethos and practices of the PSW in this context aligned with a therapeutic logic. These emphasise strengths and resources within individuals and the broader mental health care system. Rather than fixating solely on limitations heightening risk, the PSW sought to amplify the roles and strengths that could foster hope and serve as protective factors. The PSW navigated the dominant logics by using therapeutic logic in a way that acknowledges but also enhances the existing conventional risk-averse strategies in mental health. This shift moved the focus beyond mere risk avoidance, which is emphasised in managerial and professional logics, towards a more empowering and recovery-focused approach, aligned with therapeutic logics, as articulated by the PSW:

> *I think it was partly I think it's partly about character, I guess… if I would've come in… echoing the systems and the structure of the NHS, you know, it's quite a risk, risk-averse… whereas I've come in with a positive role, and I would hope,*

yeah, positive attitude about, you know. What can we do? What can we as a team do? What can we offer? What are we missing that? What are we missing, connection-wise? [In, #10, PSW].

The data in this sub-theme suggests that the PSW role opens up new pathways for understanding the complex contributors and manifestations of risk, transcending traditional clinical indicators. There is an emerging recognition that PSWs develop their insights by equalising power dynamics through a more therapeutic approach to risk - one that emphasises and prioritises exploratory, inter-subjective processes - aligned with therapeutic logics - instead of unilateral assessments and risk formulations - associated with meeting professional and managerial demands. The PSW's risk ethos prioritises the narratives of individuals and honours their self-knowledge, creating an egalitarian space where risk can be collaboratively explored and understood through sharing experiences. In other words, the PSW uses the therapeutic logic to frame risk differently.

7.3 PSWs experiential knowledge of risk

The data indicates that the PSW role presents an alternative approach to risk and embodies a fundamentally distinct type of experiential knowledge. While clinical interpretations of risk are often filtered through assessment tools, diagnostic frameworks, and protocol-driven interventions, the engagement of the PSW appears to be rooted in the intersubjective forged through lived experience. Having perhaps experienced being labelled as "*risky*" or having undergone interventions such as medication or hospitalisation, PSWs may carry a profound, embodied understanding

of risk and personal recovery. This shared knowledge - “I have travelled similar paths” - may cultivate an authentic relational safety that facilitates the exploration of risk dimensions often overlooked by the clinical perspective.

The unique position of the PSW, grounded in lived experience, allows for a broader, more appreciative, and nuanced view of risk’s multidimensional nature. Their experiential knowledge might enable them to intuitively discern which areas of inquiry or questions to explore during conversations about risk. Unlike clinicians, who are typically constrained by rigid clinical constructs, the PSW can build rapport more swiftly, allowing for a deeper exploration of distress and quicker identification of risk that might be achievable through professional methods or logics. Their ability to use therapeutic logics and connect intersubjectively with service users might foster a sense of safety and familiarity that can be more challenging, time-consuming, or unattainable for clinicians who are constrained by dominant logics. One psychiatrist’s observation underscores this sentiment:

> *Certain patients will open up to that approach that wouldn’t open up to other approaches that we have, they need the familiarity, they need to feel that they have a relationship there… cause otherwise, it’s kind of like going to see your GP [General practitioner] I suppose, and you get a locum every time and it’s difficult to open up, particularly about your very personal stuff… and we sometimes forget that as the… team, where PSW can offer more of that familiarity… <PSW name> is able to return some of that type of care; I think nursing staff don’t necessarily get anymore because people are banging on at them to complete their audits. Have you done the risk assessment on the man*

who's not eating or drinking rather than have you tried taking them to the chippy, that's five minutes' walk down the road [In, #9, Psychiatrist].

This quote illustrates the contrasting perspectives surrounding accompanying a service user to a fish and chip shop. For clinicians, this outing might be viewed as providing "unhealthy care," potentially seen as inappropriate, frivolous, or a misuse of public resources. They operate within a hostile and politically charged environment where media and public discourse often scrutinise public sector work. As clinicians attempt to shift towards more recovery-oriented or therapeutic practices, they may be at odds with entrenched discourses on risk and accountability standards imposed by the public sector, highlighting a significant tension between dominant logics and therapeutic logics. In contrast, for PSWs, accompanying service users to the "*chippy*" may be viewed as aligning with their role of providing relational therapeutic support and meeting individuals where they are. Free from societal expectations or dominant logics that burden clinicians, PSWs can focus on building therapeutic relationships through these outings without fear of criticism. These interactions, however, go beyond mere social activities; they present valuable opportunities to forge meaningful connections that facilitate the exploration of the life stories, concerns, and potential risks of service users, as described by the CPSW and PSW:

It's rare that I think people wouldn't benefit from peer support, but it's definitely when I feel just see that sort of, they're expressing that they're lonely and that no one understands… peer support workers are most likely to get across that they do understand [In, #1, CPSW].

I try to be an example… for me, peer support is not; it's not just a work role. It's very much part of who I am now, and that's something that's kind of grown over time… you can't be in a peer role without it not affecting who you are as a person and how you treat people or respond to people. So, even in the most difficult of situations, you know it's about looking for those connections [In, #10, PSW].

A prominent theme from the data highlights how the PSW effectively engages with individuals often labelled as "*hard to reach*" or "*difficult*." Their success in forming connections with those who typically avoid engagement with traditional mental health services might be rooted in a profound understanding of the need to empower individuals, fostering a sense of agency over their own lives. The psychiatrist shared an illustrative example of a visit where the PSW adeptly navigated potential risks by applying therapeutic logics, avoiding the coercive interactions often employed by clinicians:

It was me and <PSW name> seeing the patient together… and we, you know, we managed or rather, I kind of gently explained what my view was and all this sort of stuff… to the patient and… I've got a reasonable manner with them. So even though I say, look, I do think you're mentally unwell... I could do it gently enough that it didn't lead to a walkout or an angry denial or refusal or whatever and be kind of heard in my explanation, and then… ran with what could be helpful other than the medical interventions that I might have been focused on and talked about… what the patient had lost from their quality of life and how nice it would be to get those things back and… would the patient be open to

talking about those things or exploring doing those things again with <PSW name>…

So, from this <Service user name>… either just not being up for or cancelling all of [Service user pronoun] appointments with the team, and it being really hard to pin them down, [Service user pronoun] suddenly agreed, begrudgingly accepted some contact through <PSW name>, and with phone calls from the nursing team…. I'm not sure if it was successful as far as getting, persuading [Service user pronoun] to take an anti-psychotic so that [Service user pronoun] stopped believing [their] choir mates were conspiring to have [Service user pronoun] kidnapped... I don't know if [Service user pronoun] ended up being detained, but… It felt very valuable at that moment in time to attempt to engage the person on their terms without wading in heavy-handed with the Mental Health Act, coercive intervention approach and without the <PSW name>, I don't think that would have been possible [In, #9, Psychiatrist].

Similarly, the data indicates that PSWs may play a vital role in rebuilding trust in mental health services, particularly among those who have lost faith or become disillusioned with the system. Their effectiveness in this regard might stem from their lived experience with systemic risks, including the potential harm that can arise from the services designed to provide care, such as overtreatment. Having navigated the complexities of institutional protocols, PSWs might relate to service users through a shared understanding of these processes. In contrast, clinicians often find their roles constrained by training that emphasises the prevention of specific harms, which is prioritised within professional logics. Although their intentions might be good, their

ability to build trust can be fundamentally compromised due to their lack of experiential insights and the positional power they hold, which may be perceived as representative or associated with the very systems that have caused harm:

> *The peer support worker is good with those who are not engaging with us… they can relate to someone, might help them open up a little bit, and kind of trust services because I know a lot of service users find it hard to trust* [In, #8, Nurse].

The PSW approach to risk is deeply anchored in the principles of PS. They embody a fundamental belief in the inherent value of every life, even in its darkest moments, and maintain an unwavering conviction in the possibility of hope, regardless of circumstances. Observing the PSW, I noted that their communication radiated authenticity, personalisation, and a profound emotional resonance. In my professional capacity, I have endeavoured to express similar hopeful sentiments, but they did not seem to resonate in the same way. My formal role, imbued with implicit authority, often created a relational distance that the PSW could bridge effortlessly. Their ability to connect with individuals as peers, grounded in shared experiences, fostered a unique bond that my professional position could not replicate. This contrast likely stems from the differing institutional logics in relation to our roles, training, power dynamics inherent in our interactions, as the PSW poignantly noted:

> *I love the fact that peer support is a two-way process. I am often able to share with the people I have supported just how valuable my time with them has been.*

The supported person finds it unbelievable that they have helped me. I believe this gives them a sense of being valued and that they do have something to offer, even in their darkest moments. I like to share my gratitude and appreciation of who they are and the qualities they have. Being positive and affirming a person's attributes and skills helps to support the recovery and confidence the individual experiences. I believe it shows the individual that there is always hope, too, and the importance of recognising the smallest of achievements and positives [In, #10, PSW].

From my experience as a nurse, I observed significant differences between the PSW approach to engaging with service users and my own practices when exploring risk. Their style of relating felt markedly different from traditional nursing assessments or clinical conversations. What appeared to resonate most was the deep compassion and understanding of the PSW, which extended not only to those they supported but also to their colleagues and to me. I reflected on this in my journal:

Whilst driving back to the office, the PSW asked me how I was managing during our visits together. As I reflected on <PSW name> words, I thought back to my check-ins with other nurses after these types of visits. Their questions focused on logistics - "How did it go today?" or clinical issues - "Any changes to their mood?" No one asked how I was coping emotionally or whether the intensity was affecting me. We discussed tasks and physical health, not humanity. The PSW was the first to truly see me - not just as a researcher but as a person navigating complex feelings. While other nurses maintained polite professional

boundaries, the PSW reached past my role to connect with my inner experience. I realised how rarely my emotions were acknowledged in this work, and this made me emotional.

In response to <PSW name>, I confessed the rawness of it all, especially in my researcher role - waves of intensity and emotion that left me feeling helpless as an observer, unlike my usual rescuer role as a nurse. My instincts to provide solutions, to signpost and steer us out of discomfort. Yet <PSW name> described a different approach: simply listening, sitting with uncomfortable feelings rather than rushing to solve or rescue. Their words resonated within me, stirring up tensions I often ignore. I saw how I leap to fill silent space, fearing the powerlessness in it; I cling to my helper persona. Their courage to be fully present with pain and vulnerability without needing to make it disappear humbled me.

As we sat in contemplative stillness, I felt the urge to fill the void with noise. But for whose comfort? I realised my role identities protected me from sitting with the uncomfortable. The PSW modelled a gentler way; their approach impacted me. No wonder service users trust them - they make space for humanity, not tasks. Our time surfaced my tendencies to rescue and problem-solve. I left with the inspiration to bring more listening, silence, and compassion to all aspects of my work [Diary entry, 28.03.22, Common humanity].

This sub-theme reveals that the experiential knowledge of the PSW might allow them to forge deeper, more meaningful connections with service users grappling with distress and perceived risk, moving beyond traditional clinical risk frameworks. This experiential grounding may provide PSWs with a more visceral understanding of the realities of distress - insights that can be overlooked or simplified within professional, clinical approaches. Moreover, having personally navigated the complexities of clinical and administrative risk processes, they are uniquely positioned to provide perspectives that go beyond rigid risk conceptualisations. By invoking therapeutic logics in their practices, they can intuitively grasp contextual complexities that underlie socio-political constructions of risk.

In contrast, despite their best intentions, clinicians often find themselves constrained by institutional risk discourses and dominant logics, which limits their ability to fully engage with the nuanced, intersubjective aspects of risk. The data shows their clinical approaches tend to be more structured and disconnected from the lived realities of service users, which PSWs can more readily grasp. While clinicians tend to focus on narrow clinical conversations about risk, the data suggests that PSWs may create broader, more holistic spaces for discussion, allowing for collaborative exploration of risk as a multidimensional rather than a purely clinical construct. Their lived experience may enable them to address risk more quickly and effectively than their professional counterparts, using personal insights and applying therapeutic logics to foster deeper and more meaningful engagements with service users.

7.4 PSW as a risk mitigator

While the PSW adhered to mandated risk protocols - such as identifying, documenting, and escalating potential risks to senior clinicians - tasks prioritised in professional and managerial logics - the data suggests they brought a unique and complementary approach to risk management. Their experiential knowledge provided an additional invaluable resource for exploring risk, enhancing the overall capacity of the team to monitor and mitigate potential risk issues. The PSW role functioned as an extra safety net, they used therapeutic logics in ways that offered an alternative perspective on risk that enriched rather than merely duplicated existing clinical practices.

In the context of under-resourced, understaffed services grappling with growing demands, the PSW approach may offer a distinct, cost-effective, and more efficient form of risk management. Their insights, shaped by lived experience, enable them to identify nuances and dimensions of risk that clinicians - often confined by clinical frameworks and dominant logic - might overlook. Although the PSW followed formal Trust risk procedures, clinicians reported how their experiential knowledge allowed them to delve into the deeper contextual factors underlying clinical risk markers and presentations. One nurse noted that this broader understanding served as invaluable support for clinicians in their risk oversight efforts:

> *<PSW name> approaches things differently… they are acutely aware of risks as we are and will always, if they have concerns for somebody's well-being, will sort of feed that back to one of the nurses; I think they're just as aware of risks*

as we are…but… approach it differently, but then will sort of pass on what's appropriate for all sorts of concerns for somebody's well-being [In, #12, Nurse].

The data underscores the distinct relational risk practices of the PSW, which are deeply rooted in their unique positionality and informed by PS principles, providing a sense of relational security and embodied hope. An ANP remarked that these elements coalesced to create an alternative yet "*crucial"* avenue for managing risk:

And I suppose something that [PSW name] … do very well is and well… is bringing a different set of ideas or… bringing some hope and trying to help them map what the way forward might look like, and that is a very crucial piece of risk management as well really, and that's not usually seen in that light, but you have to offer people meaningful lives to, to give them something to go onto, don't we? [In, #2, ANP].

A broader understanding of risk was seen as a valuable enhancement to the perspectives of clinicians. Clinicians highlighted that the insights of the PSW helped expand risk assessments aligned with professional logics, allowing them to foster a more holistic, therapeutic, and non-clinical framing of risk rooted in lived experience. This enhanced the ability of some clinicians to formulate their risk assessments more efficiently, comprehensively, and therapeutically:

I think PSW works just the same as we do… if risks were changing, they would phone in… if and they have on many occasions or they come back and

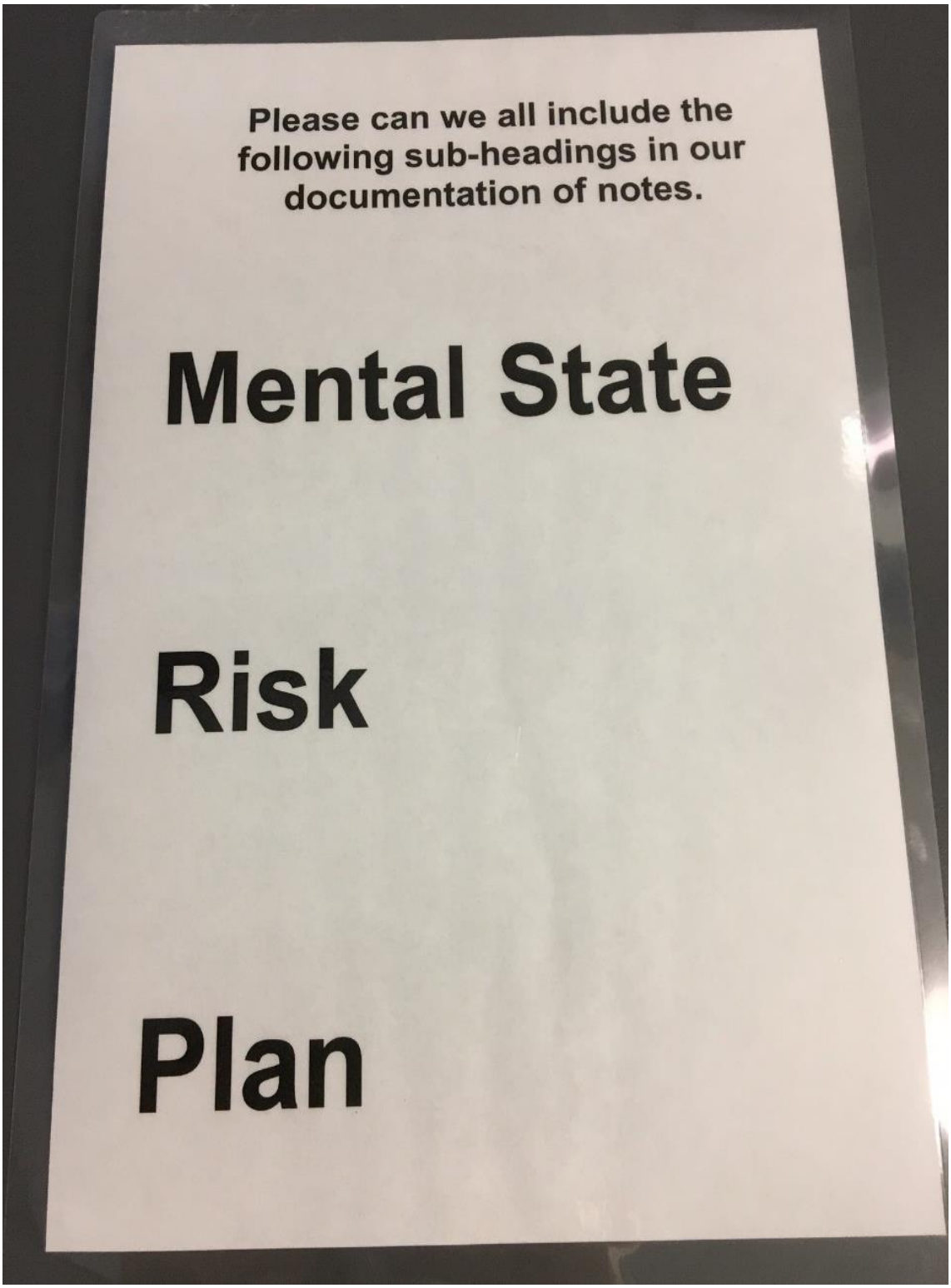
feedback to us [Nursing team], feedback to the doctors... it's very much the same model, it's just a slightly different… it's that familiarity, isn't it? It gives them the ability to work in a slightly different way… it always reminds me of the domestics on the wards, the domestics would always talk to the patients on the wards and find out all kinds of things because they're just there, and they're there for the patient to talk to and all the rest of it [In, #2 - ANP].

While the PSW adhered to the same documentation standards displayed on a poster within the team office, as shown in Figure 7-1 [DE, Poster], the PSW articulated how documenting the broader life contexts of service users enriched their notes. In an informal interview, the PSW shared their commitment to including personal strengths and support networks alongside clinical information, emphasising the recovery and strengths-based nature of their approach which is strongly aligned with therapeutic logics:

When asked about their process of writing notes after meeting someone, the PSW spoke about how they follow the standard care note template used by the team. Although they aim to emphasise positives in their notes, they understand the necessity of documenting any risks arising due to the team's strong focus on risk management. The PSW spoke about how they try and highlight strengths and progress from the visit. The PSW includes information they believe is important, even if it falls outside the standard headings. They acknowledged the importance of noting risks according to the team's mandated procedures. However, within that structured template, the PSW also strives to

capture additional insights they view as relevant to conveying a fuller understanding of the person's well-being. The PSW aims to balance meeting the clinical team's risk documentation requirements with providing a holistic perspective rooted in their peer support role [IC, 21.03.22].

Figure 7-1 - Sub-headings for documentation



Several clinicians noted that the documentation of the PSW offered invaluable insights into the lived dimensions of risk, contributing to a more contextualised understanding that bolstered the decision-making processes of clinicians. This perspective allowed for a thorough application of the factors influencing service users' experiences moving beyond clinical assessments alone, as described by one nurse:

> *If I'm going to see somebody that I've not met before, I'll have a quick scan through somebody sort of notes, to sort of see why they've been referred to us, what the issues are, what the progress has been under the team, I always make a point if, they've seen the PSW, I always make a point to the read PSW entry because I think that will probably tell me something that I wouldn't necessarily get from the doctors write up or from nurses write up… The PSW might document oh they've got an appointment for a scan such and such, or he's worried about an upcoming appointment with the doctor or the hospital or something which sometimes we might get, probably by accident, it's not the sort of question we'd ask, somebody might volunteer it, but I think PSW would be more likely to ask.* [In, #11, Nurse].

However, tensions arose regarding the boundaries between PSW responsibilities and those of professional roles. The psychiatrist acknowledged the contributions of the PSW to risk management while also expressing concerns about their accountability, which is prioritised in professional and managerial logics. They raised questions about whether PSWs would be subject to the same level of scrutiny as clinician evaluations, pondering the implications this could have on the PSW role and the integrity of their documentation:

> *[PSWs] still document stuff…I mean, it'd be interesting when someone kills themselves just after they've seen a peer support worker and no one else for a month. What the coroner's response is, because if the coroner turns around and says this peer support worker didn't do a very good risk assessment because they didn't, you know, document every time they saw them…you might find that the peer support worker value starts to be…needed a bit less, but… Who knows…I suppose as a healthcare professional and the manager, you would hope that the manager said, well, if you're going to say that this person needed more up-to-date risk assessment, then we should have done it with qualified nursing staff rather than asking a peer support worker to do it* [In, #9, Psychiatrist].

The data in this sub-theme indicates that the value of the PSW role in managing risk lies in its unique liminal position within the system - functioning alongside institutional and clinical risk management protocols without being fully subsumed by them. While PSWs adhere to established risk assessment, documentation, and escalation procedures, aligned with managerial and professional logics, they appear to enhance these processes by drawing on therapeutic logics and their lived experience. This integration appears to foster a more enriched, multidimensional approach to understanding, addressing, and mitigating risks, complementing and expanding the capabilities of clinicians.

Their experiential knowledge may equip them to identify risk factors that may evade clinical conceptualisations and practice frameworks. However, concerns regarding accountability and risk management surfaced in the data. Despite these worries, the

theme suggests that this distinctive perspective and use of therapeutic logic alongside the dominant logics enables PSWs to approach risk holistically and dynamically. This balanced approach appears to enhance the MDT's capacity to deliver care that is responsive to risk and firmly grounded in a recovery-focused approach and PS principles.

7.5 PSW 'gifts' time for risk-related tasks

The PSW is increasingly recognised as an essential partner in risk mitigation and a valuable contributor to the MDT's timely, efficient mental health care delivery. In addition, there is a growing sense that the PSW might 'gift' clinicians additional time by enhancing the overall risk management capabilities of the team, aligned with managerial logics. The findings indicate how the PSW might help ease the workloads of clinicians by managing aspects of relational risk. This support allows clinicians to focus on their role-specific risk-related tasks like comprehensive risk assessments and interventions.

For instance, the data emphasises the critical role of the PSW in maintaining therapeutic connections, especially with service users who find it challenging to engage with traditional services. Observations and interviews reveal that PSWs build relationships that significantly enhance the risk management capacities of clinicians. By prioritising maintaining essential contact pathways for individuals deemed "higher risk" or those with histories of disengagement, the PSW enables clinicians to focus their limited resources on adhering to risk protocols, more aligned with their professional training. The PSW's ability to quickly establish genuine rapport creates a

division of labour, enabling clinicians to concentrate more fully on their comprehensive risk assessments, safety planning, and targeted interventions - all tasks prioritised in professional logic. In this capacity, PSWs serve as intermediaries, using therapeutic logics to bridge gaps that might otherwise impede consistent or more comprehensive risk monitoring and mitigation efforts by clinicians, as described by the PSW:

> *I think the team quite often have, um, referred people who struggled to connect with the services, either because the services have let them down so many times or they don't, they have a mistrust of some sort. For me to go in with those people, quite often it's breaking down those barriers, and it may be easier for the team to then work alongside, so… for me, the peer role for me is very much about, it's not, in competition with the team, it's, it's, working alongside and supporting the team to kind of be, sort of sort support the people we're caring for, and, you know, I think the team has recognised the value of having the peers being the bridge* [In, #10, PSW].

The data further suggests that the PSW is critical in expediting specific clinical processes often overlooked by clinicians. Their ability to quickly establish rapport allows them to navigate sensitive topics that might feel overly clinical when broached solely by clinicians. This use of the therapeutic logic and unique position of the PSW allows them to offer a fresh perspective that might help smooth and accelerate the "necessary" processes employed by clinicians, which may sometimes feel disempowering. By aligning with both professional logic's authority and the therapeutic needs of the service user, PSWs might contribute to a more balanced and empowering approach, as illustrated by an example provided by the clinical psychologist:

<PSW name> brings a different angle when talking about admission [In, #6, Clinical Psychologist].

The contributions of the PSW also appeared to improve team efficiency by adding an extra layer of support, allowing clinicians to monitor identified risk factors more consistently and effectively, which are high priorities within professional and managerial logics. The distinct role of the PSW was recognised as a unique resource, and this bolstered acceptance within the team, as highlighted by two senior team members:

I think that is part of how it can be more acceptable to patients because it's seen as a slightly separate process, but, I don't see them as, you know, floating around and we don't know what they're up to or what's going on with, I think it's like a parallel process to the other routine care of <Team name>, I think it can greatly enhance that, but I can also, facilitate it [In, #P9, Psychiatrist].

I think it improves our patient care massively by having them, and you know, it opens a whole different resource there [In, #5, Manager].

Notably, one HCA emphasised how the PSW role stood in stark contrast to the rest of the team, helping to "*soften*" and humanise their approach:

<PSW name> has travelled through the system and wants to make it better versus rest of team associated with power… I think [PSW role] it softens it, doesn't it?... gives it more human approach, so I think, a lot of people don't like, because obviously we use enforced treatment that we would bring people into hospital under section shelter do you know what I mean? So, we have got power over people whether or not we acknowledge it. And then, you know, we say to people on their care treatment orders, you must take this very strong psychotropic medication, or you're coming into hospital. Do you know what I mean? There's a lot of authority and power we wield over people's lives, and perhaps the peers are, in fact, saying that, you know, I've travelled through this, I've recovered, and I'm in the system trying to make it better [In, #7, HCA].

However, the capacity of the PSW to potentially 'gift' time back to clinicians also led to some confusion regarding their role. For example, one situation surfaced within the office dynamics among team members:

A nurse approached the PSW about helping a service user with benefits and payments, suggesting the involvement of the PSW. Shortly after, a second nurse raised the same issue, implying that while another nurse "could do this," it was clearly outside their professional role. The PSW acknowledged their training in PIP [personal independence] but indicated they would need to check with their manager before rescheduling existing meetings, advising the nurses to speak with the manager first.

Evidently, the PSW was setting boundaries, pushing back against the assumption that they would cancel appointments, as HCAs or support workers might. The first nurse went to the manager and then returned to confirm the manager had approved the involvement of the PSW. The second nurse, however, assumed the PSW would proceed and asked about contacting the service user. The PSW again reinforced their boundaries, stating they would arrange the visit themselves.

Throughout the interaction, the PSW upheld their role's boundaries despite the implicit expectation to defer to the nurses' requests. They ensured their priorities were aligned with managerial approval and resisted being bypassed without proper consultation. [Ob, 28.03.22].

This tension stems partly from the dynamic interplay between the experiential knowledge of the PSW and the formal expertise of clinicians. While the previous example illustrates tensions between these two forms of knowledge and institutional logics, the data reveals a recurring theme and logic: integrating lived experience with professional perspectives was viewed as a means to streamline care. In other words, this combination harnesses the unique strengths of both knowledge bases, resulting in more multidimensional, person-centred support. The findings suggest that by utilising these complementary insights and skills, the team can maximise limited resources, delivering a more holistic, therapeutic, cohesive, and economically viable model of service provision. This synergy is aptly captured in the reflections of the psychiatrist and PSW:

<PSW name> brings a different philosophy, and we can talk about severe mental illness, and we can talk about personality difficulties or distress or trauma, and know what we're both talking about, but in terms of life and recovery and what happens to the patient after their clinical contact with the team. I think that's where things diverge. And maybe the language <PSW name> uses is different, but for me, it's more a different framework to intervening, to helping, to trying to help [In, #9, Psychiatrist].

I have consciously made it my mission to lead by example. I choose my battles to win the war, so to speak. Mostly I have found walking the talk and living by showing the peer values within a team, has been the most effective way to help the team understand how peers work and the value they can add to the team. I have always talked about being complementary to the service being provided rather than in competition with the team. I am not anti-medical interventions and believe a combination of the two approaches gives a more cohesive and consistent quality of care [In, #10, PSW].

The data in this sub-theme indicates that the PSW role significantly augments and enhances the capacity of the team to navigate and mitigate risks effectively. By utilising their experiential knowledge and strategically using therapeutic logics, the PSW can connect with service users and approach risk through a different lens. Their lived experience bridges the gap between clinicians and service users, especially those considered higher risk.

Moreover, by facilitating ongoing engagement, the PSW might enable clinicians to allocate their efforts more strategically, allowing them to focus on using their clinical training. Their presence helps establish trust and allows for sensitive discussions on potentially distressing subjects. This, in turn, enables clinicians to concentrate on clinical risk assessments, safety planning, and implementation of interventions, all while benefiting from the supportive rapport fostered by the PSW. This allows the PSW to contribute information which is valued by other team members who prioritise professional and managerial logics The findings suggest that integrating experiential and clinical expertise cultivates a more efficient, therapeutic model of risk-responsive care. Ultimately, the data positions the PSW as an indispensable asset within the MDT, enhancing the collective ability to monitor, mitigate, and deliver care through their use of therapeutic logics and distinctive ways of understanding, embodying, exploring and engaging with risk.

7.6 There is only one PSW

The data suggests an appreciation for the PSW role in enhancing care grew over time, adding an experiential dimension to their clinical expertise. The PSW contributed significantly to managing risk, fostering therapeutic relationships, and improving time management. Beyond these benefits, the PSW influenced professional attitudes and practices, gradually shifting the team towards a more holistic, recovery-focused approach. For instance, the PSW prompted some team members to reflect on their practice without conflict, as noted by one nurse:

One of them [PSW] challenged me on it and said, but the patient said this, and I thought, oh, yeah… I was kind of wrong in that because they kind of saw it from a different perspective. So, it's, it's helpful to reflect as well…, it made me take a step back and kind of think about things from a different perspective here, maybe from a service user perspective [In, #8, Nurse].

Another nurse highlighted how the PSW brings a transformative perspective that encourages clinicians to re-evaluate and enrich their therapeutic approaches to care:

Do you think it makes a difference having the PSW embedded in the team?

I think originally, it was because the peer support worker was present. I thought, oh god, I've got to be mindful of my p's and q's, as my mum would say. I've got to, you know, not be derogatory about a service user, or whatever, whoever we're talking about, so, I was consciously having to do that probably for the first six months or…year with the peer support worker in the team. Now, it… just comes naturally, I don't have to think about that ... I think it made me think differently in a way as well and see people as people, not just a collection of symptoms, and somebody who's at risk and they might need admitting to hospital, because… we're a busy team, we, see… one thousand five hundred new people every year and you do start to see people not as people, you start to see them as potential risks, or potential problems or potential people who need admitting to hospital and we do lose sight of, you know, these are people, these could be my family, it could be me, it could be my neighbours, could be

anybody, they're just people experiencing mental health difficulties… [In, #11, Nurse].

The data suggests that while the PSW may enhance service efficiency and bring numerous other benefits to the MDT, implementing the role is not without its challenges. One of the primary difficulties stems from the limited number of PSWs within the team, raising concerns about sustainability. Although the PSW approach is valued for its therapeutic support, time-saving benefits, and innovative contributions to risk management, the notion that the role has "*no limitations*" is misleading, as noted by one nurse [In, #8, Nurse]. While the integration of the PSW into the MDT has been largely successful due to using therapeutic logic to frame risk in ways that complement and support the two dominant logics, the data suggests a significant risk of the PSW becoming overwhelmed. As the demand for their work grows, driven by the increasing awareness amongst the team about their role and its benefits in relation to time and risk, there is a concern that the PSW may shift towards more goal-oriented, task-driven interactions to meet these rising expectations. This shift in practice could mirror the professional and managerial logic priorities, potentially undermining the therapeutic logic that harnesses the unique peer-based, recovery-oriented approach that makes the PSW role valuable.

Numerous well-being resources, plans, and frameworks in the shared PSW resource folder highlight this concern. Informal conversations with the PSW revealed they felt the pressure of an increasing caseload due to a referral surge. Although this growing demand for their services was viewed as a positive development, there were moments

during the study when the PSW expressed increasing stress. One such moment led the PSW to seek managerial support, which they later recounted to me during an informal conversation. This suggests that while the role is beneficial, careful attention must be paid to workload management alongside maintaining PSW well-being to ensure they can continue to provide PS without becoming overburdened, as emphasised during an informal conversation:

> *The PSW spoke about how they had discussed having a patient-free week with the manager. They agreed that the PSW could spend time catching up on work and slowly get back to seeing people again, and next week, they said they would go back to normal* [IC, 16.04.22].

The data reveals that, alongside the positive impact of the PSW role, challenges emerged relating to the emotional labour involved. Emotional labour is the impact of managing the emotions resulting from work relations and interactions (Hochschild, 1983). While some team members, including the manager and CPSW, recognised the emotional toll of the PSW role, others demonstrated a lack of clarity about how their duties differ from those of HCAs. This confusion was notably captured in an interview where a nurse expressed uncertainty regarding the tasks distinguishing the PSW from other direct support roles:

> *During my interview with a newly employed nurse, it became apparent that they felt uncomfortable due to their lack of clarity about the PSW role and the distinctions between a PSW and a support worker/health care assistant within the team. I attempted to adapt my questions to be more open-ended to*

accommodate their uncertainty, but the interview did not progress as smoothly as anticipated and concluded sooner than expected. Despite the incomplete responses, the interaction prompted several significant reflections.

While the nurse was new to the team, it was evident that the PSW had been a longstanding member, and their colleagues generally understood their role well. The nurse's uncertainty about the differences between the PSW and support worker roles revealed important gaps in understanding, particularly among new team members. This uncertainty underscores the need for clearer delineation of the peer support worker role, especially for individuals whose primary reference point is their past experiences with support workers and healthcare assistants who typically provide therapeutic support [Diary entry, 14.06.22, Role uncertainty].

Despite this ambiguity, the PSW remained highly valued within the team. One nurse reflected on the significant contribution of the PSW, viewing them as equals to other clinicians, even though they are paid considerably less. This sentiment speaks to the respect the PSW commands for their experiential knowledge and therapeutic approach, transcending the conventional hierarchical distinctions often present in clinical settings. The nurse's reflection highlights the integral role of the PSW, not merely as direct support staff, but as a peer who enriches the collective ability of the team to connect with service users and manage risk:

How does that look, now the PSWs have come in, has that changed the team? Or does it feel the same?

It's not changed the hierarchy, the doctor is very much on top, then the PSW could come in on the next level down along with the rest of us. They probably started off at the bottom, but because of the way they've been, the things we've discussed are now sort of considered to be on the level with the rest of us… but we're all handmaids to the doctors [In, #11, Nurse].

In this sub-theme, the data reveals that while the PSW role is perceived as a highly valuable addition to the team, significant challenges emerge because there is only one PSW. Although the singular PSW brings numerous benefits - such as enriching therapeutic engagement, contributing to a wider understanding of risk management, and fostering recovery-oriented care - the pressure on this individual increases as the team becomes more aware of the benefits of the PSW. As the demand for their unique skill set rises, concerns about role sustainability and the risk of burnout grow. The data suggests that the commitment of the team to fully integrating the PSW role is complicated by pre-existing challenges, such as staffing shortages and the constant demand for immediate, reactive responses to urgent issues, often described by several team members as "*firefighting*." These conditions create an environment in which the PSW, despite their positive impact, may struggle to keep pace with increasing responsibilities without additional support.

This situation raises the need for careful resource management to prevent the PSW from becoming overwhelmed, which could undermine the very strengths they bring to the team, including their use of therapeutic logics. For the PSW to continue thriving

and for the team to maximise its potential benefits, there must be a balanced approach to managing resources, supporting the PSW, and addressing the growing demands on their time and emotional labour.

7.7 The mechanisms of time and risk in peer support work

Overall, the data portrays PSWs as potential catalysts of greater efficiency within the mental health community team. While this assertion may vary in practice, there is a strong perception that PSWs are seen to bring a level of understanding and relational expertise that facilitates a more streamlined, efficient, and recovery-oriented service. Ethnographic data underscores the PSW's use of therapeutic logics to enhance recovery-focused care while simultaneously addressing time and risk management challenges faced by the wider team. Their role complements the practices of clinicians who are strongly aligned with professional logics and, in some instances, accelerates aspects of care delivery, thus supporting managerial priorities and logic, contributing to a more efficient and responsive service system.

The integration of time, risk, and experiential knowledge is a defining aspect of the PSW role. The intersecting mechanisms of time and risk not only underscore the tensions between logics but also highlight opportunities for the PSW role to enhance team efficiency. By leveraging therapeutic logics, the PSW frames time and risk in ways that exempt them from the constraints typically associated with professional and managerial logics. Their distinctive approach to time and risk, shaped by their lived experience, positions them uniquely to reintroduce elements of therapeutic work that have gradually diminished in the practices of other team members. Their contribution

as effective risk mitigators complements and potentially enhances existing risk management strategies within the team. This allows them to offer perspectives and insights highly valued by team members while supporting the demands of professional and managerial logics.

Moreover, the data highlights how the PSW occupies a liminal space, simultaneously adhering to Trust processes while maintaining a unique identity distinct from other MDT roles. This dual positioning appears to facilitate their acceptance and successful implementation into the setting, offering a bridge between the dominant institutional logics - professional and managerial - by strategically employing therapeutic logics to complement and enhance both the work of clinicians and the team's overall objectives. By leveraging these strengths, the PSW has carved out a unique and valuable niche within the team, offering meaningful contributions that balance therapeutic, professional, and managerial priorities. The interplay of the three logics - how they coexist, clash, and occasionally undermine each other - provides a nuanced understanding of PSW role implementation within the team. Furthermore, it sheds light on the broader OC influencing their work, revealing how the PSW navigates and balances competing priorities to contribute effectively to the team's goals.

Summary

This chapter explored risk as a critical mechanism shaping the implementation and practice of the PSW role within the MDT. Risk was examined as a multi-dimensional concept, including how clinicians perceive it, the strategies PSWs employ to address it, and their unique role as risk mitigators. A notable contribution of PSWs is their ability

to ‘gift’ time back to the team, streamlining processes and easing pressures related to time and risk management. Despite these benefits, the presence of only one PSW highlights a pressing need for additional support to manage growing demands effectively. These findings illustrate how the PSW role enhances team efficiency by streamlining processes and alleviating both time and risk constraints faced by the clinicians and the wider MDT. The interplay between institutional logics and the PSW role will be further explored in Chapter 8.

Chapter 8: Discussion

This chapter will provide a comprehensive discussion, starting with an overview of the four key knowledge contributions of the thesis. It will then delve into the interactions and relationships among the identified institutional logics. The subsequent sections will explore how these logics highlight the constraints imposed by austerity measures, examine the potential of the PSW role in addressing these challenges, and offer novel theoretical insights. The chapter will conclude with a reflection on my positionality and its influence on the findings. It will also discuss the strengths and limitations and provide recommendations for policy, clinical practice, and future research.

Four knowledge contributions

The POETIC study explores the implementation of a PSW role within a community mental health team, guided by the central research question**:** *how do institutional logics influence the implementation of PSW roles in mental health organisations?* The study aimed to identify the institutional logics - defined as the fundamental beliefs, values, and practices that shape organisational behaviour - within the team, particularly concerning the PSW role. By employing this theoretical approach, the research sought to uncover influences affecting the implementation of PSWs and highlight critical aspects of OC that influence PSW roles.

The findings revealed two central themes: (1) the unifying urgency and cross-cutting constraint of time and (2) the multidimensional aspects of risk. These themes highlight the key mechanisms of time and risk, offering insights into the dynamics of implementing PSW roles within a community mental health team. The empirical

chapters also address Objective 2, which sought to *characterise how these institutional logics support, compete with, or conflict with PSW implementation*, and Objective 3, which aimed t*o describe how PSWs navigate and negotiate competing institutional logics*. This thesis has involved a first-in-field application of institutional logics theory to explore PSW role implementation and makes four knowledge contributions:

1. Identifying and understanding the interactions between different institutional logics
2. Illuminating the austerity constraints exposed by intersecting institutional logics
3. Highlighting the potential of the PSW role in ameliorating systemic constraints
4. Discovering multiple institutional logics and their dynamic nature

These knowledge contributions collectively advance the discourse on PSW role implementation in a mental health community team, offering a nuanced understanding of the structural, contextual, and cultural factors that shape this process.

8.1 Identifying and understanding the intersections between logics

The first significant contribution to knowledge is the identification of three distinct yet interconnected institutional logics within the community mental health team: professional, managerial, and therapeutic logic. These institutional logics, which are discussed in detail in Section 5.4, directly address Objective 1, which seeks *to identify the institutional logics in mental health organisations that pertain to the implementation of PSW roles*.

Building on this, Objective 2 focuses on characterising *how these institutional logics support, compete with, or conflict with the implementation of PSW roles*. The data revealed the intricate ways in which these three logics influenced the daily practices and decision-making processes of both team members and the PSW. Through this analysis, time and risk emerged as crucial, cross-cutting mechanisms, highlighting how these institutional logics co-exist and interact within the setting. These mechanisms provide a deeper understanding of the dynamic tensions and alignments that underpin and influence the implementation of PSW roles in a mental health setting.

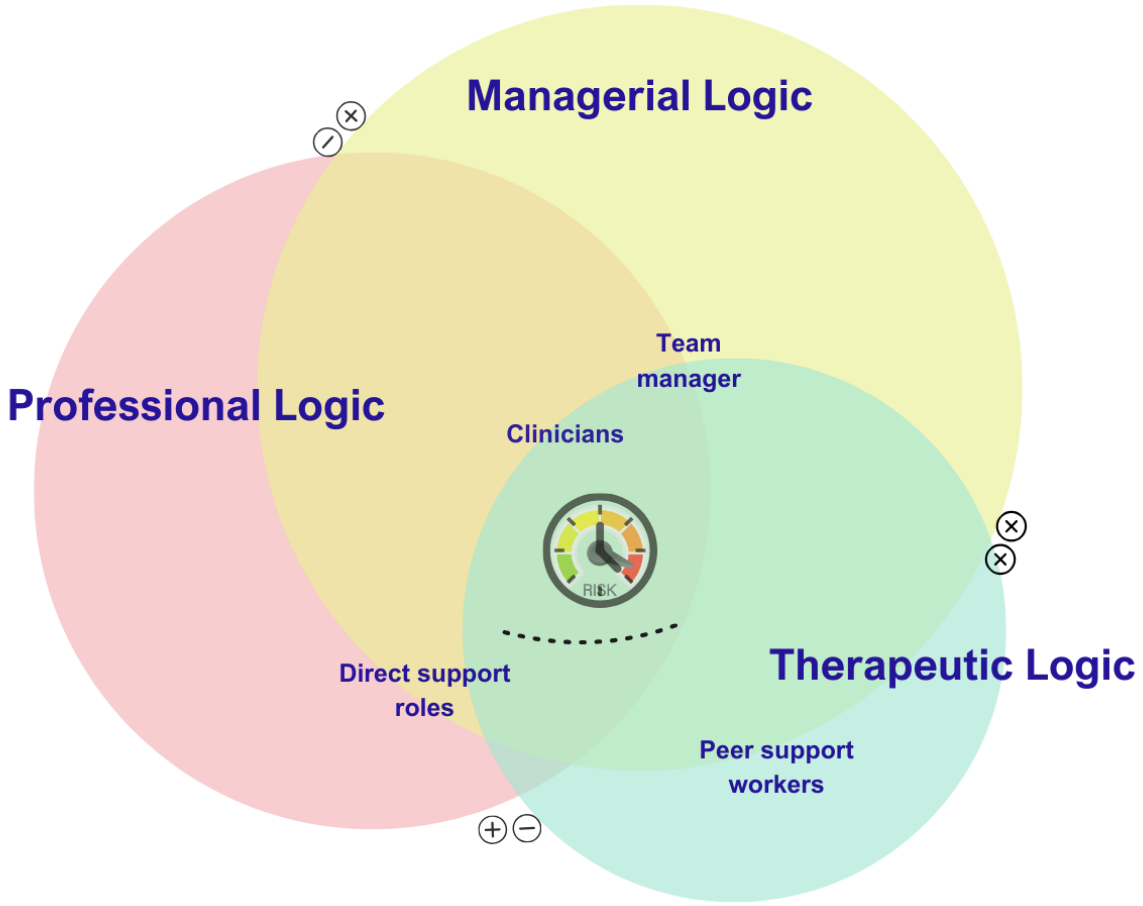
The mechanisms of risk and time intersected with each logic, bringing their nuances into sharp focus and exposing areas of tension and alignment. This intersection not only made the logics more visible but also illuminated the complex dynamic created by the coexistence of three institutional logics. The intersections between these logics shaped the approach adopted by the team when working alongside and with the PSW and revealed how the PSW navigated and negotiated their role being accepted and implemented.

Conflicts often arose between the professional logic, which emphasises clinical expertise, and the managerial logic, which prioritises efficiency and resource management. For example, the professional logic's insistence on rigorous clinical protocols sometimes clashed with the managerial logic's drive to streamline operations and reduce costs. However, the therapeutic logic, with its emphasis on holistic care and association with time, presented both challenges and opportunities. It often aligned with managerial objectives when considerations of time and risk were factored

in, such as in decisions about the allocation of time for service user interactions versus professional tasks. The interplay between these logics was not purely antagonistic; there were moments of reinforcement and synergy. For instance, the focus of therapeutic logic on service user-centred care dovetailed with the managerial logic goals of improving outcomes efficiently. These synergies and conflicts shaped the unique pathways for implementing the PSW role, influencing how the role was perceived, understood, and implemented into the daily routines and practices of the team.

These intersections between institutional logics are illustrated in Figure 8-1, where the three overlapping institutional logics circles are arranged hierarchically. The largest circle at the top represents managerial logic, emphasising dominant system priorities. Below it, the professional logic circle reflects the focus on role duties and risk management primarily adopted by clinicians. The smallest circle at the bottom represents the therapeutic logic, indicating its relatively smaller position in the system. The central intersection contains the mechanisms of time and risk, illustrating their influence across all three logics. The plus and minus symbols indicate areas where institutional logics complement and conflict. The placement of different groups reflects their alignment with specific logics. For instance, while each group claims to work therapeutically, the figure shows managers at the top (system-focused), clinicians in the middle (task-focused), direct support roles bridging both professional and therapeutic logics (predominantly task-focused), and PSWs in the therapeutic logic circle (recovery-focused). The dashed line across the lower circles represents how PSWs, unbound by systemic and professional role constraints, bridge the three institutional logics within the community mental health team.

Figure 8-1 - Logic relations



Professional logic relationships

The relationship between professional and managerial logics was nuanced, characterised by opposition and alignment. While all clinicians integrated aspects of managerial efficiency priorities into their practices, their perceptions of this integration differed. Some viewed the managerial focus on efficiency and throughput as conflicting with the goal of providing comprehensive therapeutic care, viewing it as a business-like approach that compromised the quality of outcomes.

Time constraints and pressure to "*move people on*" clashed with professional autonomy and aspects of therapeutic logics, such as the holistic understanding of service users. As one nurse noted, the PSW can "*actually see more than we do you, you know, they see a whole picture of a patient" [*In, #4, Nurse]. This contrast highlights the tension between managerial imperatives and therapeutic priorities.

However, by contrast, psychiatrists were more likely to embrace managerial elements like structured approaches and goal-oriented resource allocation, viewing these as essential to their role due to increasing demands. For example, goal-oriented work reinforced, rather than diminished, their therapeutic work, as one psychiatrist explained, describing their role as "*being the difficult person who has an eye on the available resources* [In, #P9, Psychiatrist]. This acceptance of managerial priorities may reflect a pragmatic adaptation to the growing resource constraints and/or may reflect the professional logic of a psychiatrist who might value such attitudes as central to effective practice.

Tensions emerged regarding PSWs working within a system where professional logics and managerial demands often clashed. As one psychiatrist noted, "*I've been in other MDTs with other PSWs and sometimes their goals are not aligned with the organisational goals. For example, the appetite for taking significant therapeutic risks with patients or trying to manage the expectations and demands of that patient might have with a service that if we were trying to fulfil those, the entire health service could be consumed by a tiny fraction of this user*" [In, #9, Psychiatrist]. This illustrates the concern that addressing the complex needs of a few service users could disproportionately drain resources, undermining the broader goal of equitable and

efficient service delivery. Nevertheless, there was a perception that the PSW was aware of this tension, as noted, *"they've always understood the limits of their work in a healthcare system with limited resources… we try and allocate as fairly as we can" [In, #9, Psychiatrist].*

Despite these differing perspectives, all clinicians navigated this interplay in ways that reflected their identities and values. They continuously negotiated how to balance the increasing pressures for productivity with core therapeutic principles defining their roles. However, the growing emphasis on efficiency and goal orientation caused by an increasing workload and reduced resources impacted the work of clinicians. In particular, these challenges appeared to intensify as managerial logics became more entrenched in their everyday practices. The tension between professional and managerial logics notably affected clinicians understanding and approach towards therapeutic work in three ways:

(1) **Eliminating**: certain aspects of therapeutic care were entirely removed from practice due to time pressures and efficiency demands. This is illustrated in the data: *"the kind of opportunity for a more holistic approach has perhaps been not, not lost on the nurses, but taken away from them"* [In, #9, Psychiatrist]. This emphasises how managerial priorities might have eroded the space for therapeutic care.

(2) **Reframing**: some practices were redefined as therapeutic, even if they were not traditionally viewed as such. For example, one nurse reflected on how "*It's*

about getting <PSW name> there as a peer support worker so <PSW name> can then pick that up and do that and be the consistent person… Whereas, as nurses, we don't offer that… so <PSW name> would build a relationship with the patient for us" [In, #12, Nurse]. This reframing allowed clinicians to integrate managerial elements while maintaining a sense of therapeutic purpose.

(3) **Reassigning**: specific therapeutic tasks were delegated to PSWs, who had more time and flexibility to build meaningful relationships with service users. As explained by the clinical psychologist, "*I think they're [PSWs] good at making people feel like that their time is important… I think the nursing staff, the qualified nurses… sometimes, you know, 6-7 visits in a day, which is just back-to-back, and they, they don't have the time to sit, and problem solve in the same way*" [In, #6, Clinical Psychologist]. This reallocation of duties reflects an adaptation to managerial pressures, allowing clinicians to focus on efficiency while addressing therapeutic needs through the PSW role.

Managerial logic relationships

The managerial logic was pervasive across professional roles, with an awareness of this logic extending to all roles within the MDT. The team manager, a key proponent of this logic, played a key role in bridging tensions between managerial, professional, and therapeutic logics by carefully balancing competing demands. A major ongoing managerial challenge for all roles was the Trust goal of "*moving people on as quickly as possible*" [IC, 28.03.22], which created tension between the need for efficiency and the time to provide therapeutic care, and possibly even more medically oriented care.

Further friction also arose from the burdens of documentation, which some felt reduced their time for direct care. As noted by a psychiatrist, the "*amount of documentation…, and the standard of documentation"* detracted from "*time to care"* [In, #9, Psychiatrist]. However, in contrast, the manager viewed documentation as essential for clinical purposes and to demonstrate the team value to commissioners. As noted in the data, "w*e need to be putting everything that we're doing down so we can show the commissioners what work we're doing and so they might give us a bit more budget"* [In, #5, Manager]. This highlights the persistent struggle between administrative demands and the provision of direct care, underscoring differing priorities between management and other roles.

In managing the PSW role, the manager employed specific strategies to navigate power structures and support role integration. At times, this involved pushing back against entrenched traditional views and attitudes that undervalued the PSW role. For instance, the manager shared their approach to addressing misconceptions about the PSW role, "*I think there was a bit of misconception that <PSW name> visits are just for an hour… if you get in there, getting someone out for a walk maybe going for a coffee … It's more than that… it's just about communicating that to the team* [In, #5, Manager].

By advocating for the unique contributions of the PSW, the manager gradually shifted team perspectives, encouraging them to embrace the distinct value PSWs bring through their experiential knowledge. This approach subtly challenged conventional clinical norms, though tensions persisted, particularly around the expectations for roles

such as HCAs, which were described as "*locked in an old system… expected by managers to work in a certain way*" [In, #2, ANP].

Aligning managerial logic with the therapeutic benefits of PSW support helped foster a more holistic approach to care, balancing productivity demands with therapeutic goals. To achieve this, the manager focused on clearly defining PSW roles, facilitating joint working opportunities, and emphasising service user feedback, which highlighted the positive impact of PSWs. This included communicating role boundaries, offering well-being support to PSWs, and making workplace accommodations that acknowledged the complex interplay of time, risk, and professional expectations. For example, the manager explained, "*It also depends on what <PSW name> caseload is like… and I said to <PSW name>, you tell me when it comes too much, come to me*" [In, #5, Manager]. This open communication ensured that the PSW role was balanced within the team while maintaining their well-being and support needed for success.

The manager's approach balanced the interests of all groups, recognising the importance of professional expertise and lived experience while meeting service productivity requirements. A key aspect of this balance was maintaining the integrity of the PSW role. Instead of assimilating PSWs into a clinically defined support role, the manager recognised their experiential knowledge as vital and, in many cases, more "*therapeutic*" than traditional clinical approaches. However, there were instances where the PSW was tasked with responsibilities driven by managerial needs, such as being asked to assist with initial assessments due to staff shortages and managing an increasing number of referrals for PS because aspects of therapeutic care were not otherwise being provided.

Despite these challenges, the manager's approach in navigating these dynamics appeared to foster a "*completely different team expectation, team treatment, team value*" towards the PSW role, effectively bridging gaps between top-down managerial pressures and bottom-up to "*meet in the middle*" [In, #10, PSW]. This balanced dynamic was crucial as it allowed for the PSW role to be understood and valued from both perspectives, "*if the management understands the peer role and value… we can sell the positives of it from both ends rather than having to prove ourselves*" [In, #10, PSW].

By integrating diverse viewpoints, the manager – guided by core managerial principles – stabilised team dynamics despite time and risk constraints, creating a valued space where the PSW role could thrive alongside clinical efforts. This, in turn, potentially enhanced the overall capacity of the HTT to deliver high-quality, streamlined care within a constrained system. Yet, despite the manager recognising the importance of the PSW in enhancing therapeutic care and increasing team efficiency, the PSW role remains a response to austerity – defined as **a difficult economic situation caused by a government reducing the amount of money it spends**.

The manager framed the experiential knowledge of the PSW as a vital complement to professional expertise, especially in a context defined by time pressures and a focus on risk management. By integrating PSWs into the team, the manager believed they enhanced the quality of care, increased service user engagement, and improved the efficiency of the team by bridging gaps that purely routine clinical approaches might overlook. However, despite their essential contributions, PSWs are paid a fraction of what other team members earn, positioning them as cheap labour in a system that

appears to rely heavily on their unique skills and perspectives to deliver arguably one of the essential elements of care. This raises concerns about overburdening the PSW, especially since only one PSW was employed.

Therapeutic logic relationships

Different groups within the team related to and engaged with the therapeutic logic and conceptualisations of therapeutic care in distinct ways. As shown in Table 5-4 in Section 5.4, engagement was shaped by an individual's respective roles, values, priorities, and practices. For the team manager, the therapeutic logic was primarily viewed through the lens of organisational needs. The manager's engagement with therapeutic logic centred on ensuring efficient service delivery, resource allocation, and adherence to Trust goals and targets. While the therapeutic well-being of service users was an integral consideration, the interpretation of the therapeutic logic for the manager was intrinsically linked to the overall functioning and performance of the Trust, including a recognition that the PSW may enhance this.

In contrast, some clinicians approached the therapeutic logic through the lens of their professional training and clinical expertise. Their engagement with therapeutic care was rooted in risk management, distress alleviation, and applying formal treatment protocols. This perspective often led clinicians to prioritise goal-oriented tasks over aspects of therapeutic care, aligning more with structured professional demands than broader therapeutic values. Consequently, some clinicians tended to eliminate, reframe, or reassign certain aspects of therapeutic work. Tasks traditionally part of a more comprehensive therapeutic approach, such as holistic understanding and fostering relationships, were often delegated to PSWs to focus on meeting clinical and

organisational goals. This allocation of therapeutic tasks to PSWs highlights tensions between managerial demands and professional logics. This allocation may help counterbalance the diminishing focus on these aspects within broader professional practices, which are increasingly shaped by managerial logics and professional constraints.

Introducing PSWs into the HTT highlighted a distinctive aspect of the therapeutic logic. Initially, the PSWs employment of therapeutic logic resonated with a broader care logic, often associated with social inclusion, community engagement, and holistic values, as documented in the literature (Andersson and Liff, 2018, Dunn and Jones, 2010). Care logic is typically associated with less professionally differentiated groups and emphasises legitimacy through community-based and holistic approaches (Fincham and Forbes, 2015).

However, data from this study shows that the PSW engaged with therapeutic logic through the lens of their lived experience and the principles of PS, offering a profound personal understanding of recovery. This finding directly addresses the third objective: *to describe how PSWs negotiate competing institutional logics*. The PSW focused on "*building trust, fostering connections, and offering holistic support"* [Ob, 28.03.22]. The PSW transcended conventional therapeutic roles or conceptualisations of being therapeutic by integrating embodied, situated, and experiential knowledge into their work. As noted in the data, "*I have consciously made it my mission to lead by example… I have found walking the talk and living by showing the peer values within a team* [In, #10, PSW]. This unique approach aligned with a therapeutic logic,

elements of care logics, and met managerial expectations, as the PSW managed risk and time differently from other roles.

The PSW's ability to navigate competing institutional logics was crucial. They balanced their lived experience with the clinical expectations of clinicians, allowing them to maintain credibility and influence within the team. The data reflects this acceptance: "*PSW does different kinds of work than what we do and is vital to the service"* [In, #8, Nurse]. By carefully negotiating their role, the PSW was able to integrate their unique perspective with professional and managerial standards, using their understanding of time and risk to carve out a distinct and valuable niche.

This nuanced understanding of different logics allowed the PSW to harmonise conflicting clinical and administrative demands, enhancing the overall capacity of the HTT to deliver quality and efficiency in care while addressing the impacts of austerity reforms on the practices of the team. Within this context, clinicians came to recognise, accommodate, and utilise the unique value of PSWs in relation to the therapeutic logic for several reasons:

1. **Filling gaps left by reframing**: The PSW took on tasks that clinicians could no longer prioritise, particularly those focused on holistic and/or recovery-oriented aspects of therapeutic-based care. While clinicians were pushed toward efficiency, the PSW provided the flexibility to engage in deeper, more meaningful therapeutic interactions.

2. **Offering time, continuity, and consistency**: The PSW offered greater continuity and consistency in their interactions with service users, contrasting with the fast-paced, task-driven environment that limited clinicians' ability to engage in long-term connections. The PSW's value in relation to risk was also beneficial in several ways, such as freeing the capacity of others by gifting time, bringing broader knowledge about the person, and increasing awareness of community resources.

3. **Providing unique experiential knowledge**: The PSW brought experiential insights which allowed them to build trust and rapport with service users in ways that clinicians, constrained by time, risk, and managerial pressures, could not. This perspective enriched the therapeutic process by adding experiential knowledge and understanding beyond clinical knowledge.

These factors positioned the PSW as critical to the therapeutic offering provided by the HTT, bridging the gap between professional responsibilities and the therapeutic care that service users require. Their role enhanced the quality of care and appeared to address systemic gaps created by managerial and professional constraints.

8.2 Illuminating the austerity constraints exposed by intersecting institutional logics

The second key contribution of this thesis is demonstrating how two critical mechanisms – time and risk – expose the dominant institutional logics shaping the work of the community mental health team. These mechanisms reveal the complex landscape all team members must navigate, balancing role-specific duties, managerial

demands, and therapeutic work. The mechanisms of time and risk illustrate how the resource constraints and efficiency demand driven by managerial logics have shaped and continue to reshape mental health care delivery within the team. These mechanisms expose underlying aspects of OC, which significantly influence the implementation of the PSW role. This finding addresses Objective 2, which aimed *to characterise how institutional logics support, compete with or conflict with the implementation of PSW roles*.

Impact of austerity on mental health services

Service pressures highlighted in this thesis, manifesting through growing caseloads, reduced resources, and rigid Trust targets, reflect the broader impact of austerity measures and policy reforms since 2010. The UK government's significant public spending cuts, framed as necessary for economic recovery (Farnsworth, 2021), have led to a substantial slowdown in NHS budget growth. This 'age of austerity' has seen average annual NHS budget increases drop from 4% historically to just 1.1% between 2010 and 2021 (The Kings Fund, 2018).

Budget cuts have directly and indirectly affected NHS services (Charlesworth et al., 2021). Directly, they have led to reduced services, longer waiting times, and staffing shortages. Indirectly, they have increased the need for such services due to societal factors like food insecurity (Jenkins et al., 2021), poverty (Stuckler et al., 2017), the cost-of-living-crisis (England et al., 2024), and welfare reforms (Wickham et al., 2020). Simultaneously, the NHS faces mounting pressure to improve efficiency and reduce costs, with the most recent yearly efficiency targets set at 2.2% (NHS England, 2024a).

At the same time, demand for mental health services has surged (NHS England, 2021b, Bell, 2024) with waiting list estimates reaching 1.2 million people in 2023 (National Audit Office, 2023). Demand has been further driven by reduced mental health stigma (Henderson et al., 2020) and the impact of COVID-19 (British Medical Association, 2024b). Despite a commitment to mental health services in England (NHS England, 2019a), including an additional £2.3 billion a year pledged for mental health services by 2023/24 (NHS England, 2019b), it has been argued that the finances have not kept pace with the growing need (British Medical Association, 2024b).

The combination of these factors - increased demand, staff shortages, insufficient funding, and systemic pressures – is illuminated in the POETIC study through the mechanisms of time and risk. One clinician's account encapsulates this: "*there are staffing shortages, not enough people doing the work, not enough bodies on the floor, chronic lack of funding impacting the entire system*" [IC, 18.3.22]. Time manifests through increasing caseloads and stringent Trust targets, reflecting the broader efficiency demands of managerial logics. Risk focuses on service user safety and adverse event prevention, mirroring the heightened accountability in a resource-constrained system. These mechanisms reveal how the HTT are strained by increasing service demands while attempting to balance, allocate, and/or reframe their practices with the demands of an underfunded and resourced system.

The interaction of time and risk in service delivery

The thesis demonstrates how these pressures undermine a service aimed at ameliorating mental distress, aligning with existing work (Cummins, 2018, Mattheys, 2015). The data reveals how macro level policies create micro level challenges for

mental health workers. Specifically, it shows that time, intrinsically linked to professional, managerial, and therapeutic logics, profoundly shapes and reshapes the priorities and approaches of mental health workers. As one clinician noted, "*I think for the NHS, it's about moving people on as quickly as possible*" [IC, 28.03.22], highlighting how austerity has reconfigured services around throughput and efficiency, often at the expense of therapeutic logics.

The nuanced ethnographic insights show how time constraints manifest in daily practice. Clinicians balance measurable outcomes, such as completing assessments within four-hour targets, managing with short-staffing, and providing mental health care. This tension partly echoes the concept of goal displacement, where the mindset of "what's measured is what matters" prevails (Bevan and Hood, 2006). While efficiency measures, such as operational performance targets and protocols, are designed to enhance service user outcomes while reducing costs (Bevan and Hood, 2006, McCann et al., 2013), the findings suggest these approaches can diminish professional discretion and control over work delivery (Dent, 2007).

Under austerity conditions, the dominance of goal-oriented working to meet targets is evident within the data. As one participant observed, "*the services are being run like a business is an issue because targets and outcomes drive their practice - the more people they see, the more funding they receive"* [IC, 28.04.22]. This supports existing research highlighting how target-driven cultures can create a divisive situation for healthcare workers, who must navigate competing demands and priorities (McCann et al., 2015). It also mirrors a broader shift toward a target-focused working environment, as perceived by clinicians (Hoyle and Grant, 2015). Kerasidou and

Kingori (2019) similarly found that austerity and welfare cuts in the UK significantly shaped the roles of Accident and Emergency clinicians. These changes expanded their responsibilities to encompass complex social needs, while simultaneously limiting their ability to provide holistic care due to pressures for efficiency and standardisation (Kerasidou and Kingori, 2019). Furthermore, a qualitative study of NHS physiotherapists revealed that despite political claims of austerity ending, staff continued to experience its effects, including constrained resources, insufficient community provision, and understaffing. In response, physiotherapists adopted strategies such as re-professionalisation to preserve their practice and professional identity (Tucker et al., 2022).

In this austerity context, risk takes on added significance. This study shows that risk is primarily 'owned' by professional groups, who focus on service user safety and controlling adverse events (Perkins and Repper, 2016). While risk management is an important component of mental health care (Beck, 1986), its ownership intensifies in an austerity context. Clinicians, traditionally playing a key role in managing risk, must discharge service users quickly while remaining responsible for their risks, all with fewer resources (Moon, 2000). As highlighted in this study, the dual concern of protecting individuals and maintaining professional accountability becomes more challenging as caseloads increase, reduced staffing, and systems strain under budget cuts. As one psychiatrist observed, "*we've got organisations with enormous waiting lists" [*In, #9, Psychiatrist], illustrating how reduced resources linked to funding across the system and community services delay access to support and place greater pressure on the HTT.

The data suggests that, over time, clinical decision-making has shifted from providing therapeutic support to prioritising risk-control practices, a change exacerbated by neo-liberal measures (Disney and Schliehe, 2019). This aligns with research highlighting that mental health workers recognise how management practices and risk assessments can conflict with the goals of mental health recovery (Coffey et al., 2017). The enactment of different institutional logics through the mechanism of risk reveals coping strategies in the face of austerity. The professional logic, emphasising clinical expertise in risk assessment, aligns with work on professional dominance in healthcare (Scott et al., 2000). In this thesis, the professional's clinical knowledge and expertise become central to risk-related decision-making and justify goal-oriented ways of working that support safe but also quicker discharges.

Together, the mechanisms of risk and time highlight a significant contribution of this work in shaping the intersections between institutional logics within a complex healthcare setting. This study reveals how various groups interpret therapeutic logics under these pressures in different ways. Consequently, the therapeutic concept appears to have shifted. No group entirely dismisses the therapeutic nature of their work but rather view it through different lenses. For instance, psychiatrists see their work as therapeutic, focusing on resource management and medication, but their approach contrasts significantly with that of the PSW. This variability in perception highlights the complex and multifaceted nature of therapeutic logics within a community mental health team. This disparity points to potential sources of tension, as different groups believe their contribution aligns more closely with an 'ideal' form of therapeutic care. These ideals are often at odds with constraints imposed by austerity, limited resources, and organisational priorities.

In this context, the PSW role emerges as particularly significant. The data suggests PSWs provide a form of therapeutic support that requires time, continuity, and consistency, elements that are marginalised in professional practices due to increasing time and resource pressures. Assigning and allocating specific therapeutic tasks to PSWs may counterbalance the erosion of these aspects within broader professional practices, which are increasingly influenced by managerial logics. This reconfiguration of therapeutic as a concept underscores the evolving nature of mental health care delivery in response to systemic pressures, limited resources, and political choices, and the potential for roles like the PSW to address these challenges faced by clinician roles. The professional navigation between managerial and professional logics, as demonstrated in the data, could be linked to Julia Evett's work on the reframing of professionalism (Evetts, 2011). This work may also have some utility for future research aiming to understand the development of the PSW role and its positioning within shifting organisational and professional landscapes.

More broadly, risk and time mechanisms correspond with results from a recent NHS survey (NHS England, 2023b). The survey highlighted significant levels of burnout and moral distress among healthcare workers, with nearly one-third of staff reporting burnt out and over a third finding their work emotionally exhausting (NHS England, 2023b). Time and risk closely align with the primary factors contributing to these issues, including unrealistic time pressures, insufficient staffing levels, and difficulties managing competing work demands. This alignment highlights a tension between the NHS's founding principles of universal, comprehensive care and recent policy reforms prioritising efficiency and measurable outcomes. This underscores a troubling cycle:

increased workload leads to burnout, higher staff turnover and staffing shortages which further increases the workload.

The POETIC study contributes to the scarce literature on how systemic pressures can exacerbate workforce challenges, particularly staff shortages (Iacobucci, 2019) within the mental health sector (Unison, 2017). The mental health workforce is reportedly at “breaking point” (Mahase, 2020), with 17,000 NHS mental health staff leaving between 2020 and 2022, amounting to 12% of the workforce (Commitee of Public Accounts, 2022-23). This highlights the urgent need for addressing systemic pressures that not only strain the mental health workforce but also jeopardise the sustainability and effectiveness of mental health services overall.

8.3 Highlighting the potential of the PSW role in ameliorating systemic constraints

The third knowledge contribution of this thesis demonstrates how the PSW role may offer an innovative and helpful solution to addressing the risk and time challenges facing the wider team. This supports Objective 3 which aimed to *describe how PSWs navigate and negotiate competing institutional logics*. This ethnography highlights how the PSW leverages their experiential knowledge to navigate and reconcile the tensions between the institutional logics, offering nuanced perspectives on risk dimensions, while upholding a recovery approach – a critical balance in resource-constrained environments. This positions PSWs as versatile and valued team members within the MDT, helping address some of the limitations uncovered by the dominant institutional logics.

Previous PSW implementation research has extensively explored mental health PSWs. This includes focusing on roles and responsibilities (Matthews et al., 2023), implementation barriers and strategies (Mutschler et al., 2022, Ong et al., 2023, Zeng and McNamara, 2021), effectiveness across various global contexts (Shorey and Chua, 2023, Smit et al., 2023, Cooper et al., 2024, Triece et al., 2022), and organisational actions (Reeves et al., 2024b). However, these studies have largely overlooked how austerity constraints influence aspects of OC in relation to PSW role implementation. While economic, regulatory, and political factors such as financial regulation and various policies have been identified as important regarding PSW implementation (Vandewalle et al., 2016, Mirbahaeddin and Chreim, 2022), the specific impact of austerity on PSW working practices alongside the MDT has not been explored.

This gap is significant because broader social, economic, and political factors can profoundly shape the environment and aspects of OC in which PSWs work. As discussed in Section 2.8, while OC is a critical area of focus, it remains poorly defined in relation to PSW implementation. This thesis addresses this oversight by exploring how austerity-related pressures interact with and shape aspects of OC in implementing the PSW role.

The data reveals a unique organisational context shaped by time, risk, and resource constraints. This environment both challenged and potentially enhanced the implementation of the PSW role. Despite these constraints, the team consistently utilised the PSW role, recognising its benefits in mitigating challenges, particularly in aspects of therapeutic work. This builds on work showing that once PSWs navigate

and establish a legitimate space within the team, their role becomes highly valued (Ehrlich et al., 2019).

The POETIC study demonstrates how this legitimacy was maintained and even strengthened under austerity conditions. The findings show that the PSW has to be a full member of the team to make an impact, and the management was positive and supportive in this regard. This involvement aligns with a systematic review which highlights that regular inclusion of PSWs in the team is crucial for role integration (Reeves et al., 2024b), which can, in turn, lead to positive experiences, acceptance by colleagues, worker retention, and the provision of authentic PS (Kuhn et al., 2015).

Crucially, in this thesis, the contribution of the PSW not only persisted but potentially became more valuable in the face of austerity-induced pressures. This likely fostered their integration into the HTT, promoting a sense of team cohesion, buy-in, and trust, which are essential elements for successful implementation (Kivistö et al., 2023, Mancini, 2018, Shepardson et al., 2019). The PSW role may address some of the problems faced by clinicians, such as limited interactions with service users due to time pressures (Wright et al., 2011, Killaspy et al., 2009), competing priorities when supporting recovery (Le Boutillier et al., 2015), and constraints posed or less considered by traditional risk assessment methods (Dixon, 2015, Higgins et al., 2016). The willingness of team members to engage with and utilise the PSW role, even under challenging circumstances, suggests a possible shift in attitudes and OC that recognises the value of lived experience in addressing systemic issues exacerbated by austerity.

The role of the manager in PSW implementation

The findings also underscore the crucial role of managers. The data shows how the team manager leveraged the experiential knowledge of the PSW to mitigate the impacts of risk and time constraints, ensuring the integrity of the PSW role and fostering an environment where their expertise enhanced care delivery despite limited resources.

They actively incorporated PSW knowledge during MDT interactions to draw on their experiential community knowledge, offered ad-hoc supervision and support and communicated role boundaries via team emails to maximise efficiency. By highlighting PSW contributions in MDT and team meetings, particularly through service user feedback, the manager demonstrated the value of the PSW role in a resource-constrained setting. These managerial practices fostered a team environment where the PSW role was understood and accepted. This aligns with literature emphasising the importance of such acceptance and support for successful PSW integration (Ramesh et al., 2023, Reeves et al., 2024b, Byrne et al., 2019, Mancini, 2018, Stefancic et al., 2021). Additionally, the findings highlight the importance of leadership in showcasing PSW benefits and garnering team support (Clossey et al., 2016, Byrne et al., 2019).

The success of the PSW role likely stems from a combination of factors. This includes the openness of the team towards the PSW role, a reduction of in-system stigma over time, and a clear team structure that avoids entanglement in decision-making. These elements may have created a favourable environment for successful PSW implementation, which could serve as a model for other community mental health

teams. Critically, the personal qualities of the PSW must also be considered, as these may have significantly contributed to their acceptance and integration.

However, it is crucial to note that this success is contextually complex and may not translate to all settings. In other teams, PSWs might not have a clear role (Moran et al., 2013, Asad and Chreim, 2016), may experience stigmatising attitudes from colleagues (Vandewalle et al., 2016), or may feel less recognised or supported due to more closed or different team configurations (Gillard et al., 2013, Kemp and Henderson, 2012). The same institutional logics may also not emerge, depending on factors such as the experience level of the PSW or how new they are to the team. Additionally, some PSWs may be less willing to adapt within systemic constraints, instead adopting a more activist approach.

The emerging role of PSWs in addressing systemic pressures

Uniquely, this thesis demonstrates how the PSW can serve as a solution to challenges posed by austerity. The PSW appeared essential in delivering therapeutic support, particularly in resource-limited, high-demand settings. Clear role boundaries and the preservation of the distinct working practices of the PSW role were also integral for team understanding (Kivistö et al., 2023, Kuek et al., 2021), cohesion, and optimal resource allocation.

The approach of the team manager suggests new innovative pathways for bridging professional and PS paradigms, especially around the benefits of the PSW role in relation to time and risk under austerity conditions. This expands upon discussions in the literature regarding the crucial role of managerial endorsement in PSW

implementation (Byrne et al., 2022, Reeves et al., 2024b) by demonstrating how PSWs can be strategically positioned to address time and risk challenges.

In the HTT studied, the PSW is recognised for making a significant contribution by offering a distinct approach that supports with and encompasses all institutional logics at play. This finding builds on the limited but growing body of research that highlights the significant contributions of PSWs within clinical community teams (Berry et al., 2011, Ehrlich et al., 2019, Nash et al., 2022, Davidson et al., 2012, Ley et al., 2010, Gillard et al., 2013).

This thesis highlights a functioning team operating under challenging conditions, where functionality comes at a cost to all team members. The data vividly describes the team pressures – such as speed, noise, and tensions – and how each worker, including the PSW, strives to make the best use of the available resources. Despite these challenges, the PSW role stands out for making a significant impact by offering solutions to issues and bridging gaps caused by conflicting institutional logics.

The data reveals that the PSW excels in this environment, showing that both the individual's contributions and supportive team context are crucial to this success. Implementing PSWs in broader healthcare teams is widely recognised as challenging (Gates and Akabas, 2007, Berry et al., 2011, Gillard et al., 2013), particularly in hierarchal services where PSW roles often face additional barriers (Zeng and McNamara, 2021). Rather than presenting the PSW role as a one-size-fits-all solution, this thesis highlights how the role has been effectively implemented within the HTT.

This finding offers a positive outlook on the potential impact of PSWs within other mental health teams and underscores the various benefits they can bring to service delivery (Solomon, 2004). It aligns explicitly with the potential service benefits outlined by Owen et al. (2024), including contributing to a more responsive, equitable care and an enhanced service user experience (Owen et al., 2024).

Role of experiential knowledge

Experiential knowledge can play a crucial role in mental health design and delivery of care (World Health Organization, 2022b). As highlighted in this thesis, well-integrated PSWs in community mental health teams can enhance care delivery by utilising their experiential knowledge alongside professional expertise. This aligns with findings from a longitudinal study by Oborn et al. (2019), who found that PSWs contribute to care through their unique interactional expertise and subjective knowledge, offering contributions distinct from and complementary to formally trained staff (Oborn et al., 2019). The findings also contribute to the emerging body of research on experiential knowledge, including a narrative review categorising service user knowledge into three learning sources: the self, the system, and the community (Dumez and L'Espérance, 2024), and a working model for using experiential knowledge in lived experience practitioner roles (Grundman et al., 2021).

By illuminating this experiential knowledge in action, this thesis underscores the value of lived experience in complementing and enriching traditional clinical practices. While previous research has noted the limitations of PSWs use of formal risk checklists (Scott et al., 2011), the findings in this thesis demonstrate how PSWs can utilise these tools and go beyond them. By incorporating their unique experiential insights, PSWs

can foster more profound, meaningful interactions with service users, challenging some constraints of the prevailing medical culture (Byrne et al., 2016).

Moreover, the findings show that most of the team now views the PSW as a legitimate part of the MDT (Ehrlich et al., 2019). The "*human approach* "of the PSW appeared to soften team dynamics and counteract the rigidity of formal risk practices [In, #7, HCA]. Their flexible and holistic approach adds a valuable dimension to therapeutic work, providing support and engagement that might be overlooked or inaccessible in clinician roles. This suggests incorporating diverse perspectives and experiential knowledge can complement professional expertise and managerial objectives. Moreover, this could lead to a potentially more comprehensive, streamlined, therapeutic, and responsive care model.

Mental health systems are gradually evolving to move beyond just laboured experience. There is now a growing emphasis on research-led NHS Iearned experience, the now routine employment of people with lived experience, and the new introduction of the CPSWs (noted in this thesis but not explored in-depth), who bring loved experience into the workforce. These developments signify a notable epistemological shift, expanding the types of knowledge valued in mental health care and emphasising the importance of epistemic humility. To adapt to these changes, the mental health workforce must cultivate conceptual competence – a deeper understanding of how background assumptions, or institutional logics, held by clinicians, service users, and society shape aspects of clinical care (Aftab and Waterman, 2021). Achieving this requires rethinking in how psychiatric knowledge is created and taught, particularly through training (Gardner and Kleinman, 2019). For

example, this could involve training clinicians to embrace a diversity of “systems of knowing” (Wegerhoff et al., 2022), fostering epistemic humility (Potochnik, 2017) necessary to utilise a variety of models, including conceptual competence, in different aspects of mental health care, such as diagnosis (Karter, 2019).

There is only one PSW

The data also raises critical concerns about the implications of having only one PSW in a team. While PSWs might enhance efficiency in relation to time and risk, the data also highlights the importance of ensuring fair treatment and preventing exploitation, particularly in the context of austerity and existing pay disparities (Burr et al., 2020). This also points to a broader ethical concern: the ‘burden’ of therapeutic, and therefore emotionally labour-intensive work, is increasingly being placed on one of the lowest-paid members of the team. Organisations must recognise the unique value and experiential knowledge that PSWs bring and ensure they receive fair compensation that reflects their contributions (Vandewalle et al., 2016, Gates and Akabas, 2007). Given the added pressure on PSWs to succeed as pioneers in their roles, as highlighted in a recent qualitative interview study (Otte et al., 2020), and reflected in this thesis, it is crucial to balance the benefits of PSW implementation with well-being and ethical considerations. Guidance also suggests that, wherever possible, PSWs should be employed in pairs to reduce isolation, provide mutual support, and strengthen the overall impact on team culture (Repper et al., 2013).

Striking this balance is crucial for the long-term success and sustainability of the PS workforce in mental health services. Failing to address these concerns could exacerbate the cycle of workforce challenges highlighted in the NHS survey (NHS

England, 2023b), potentially undermining the efficiencies and care improvements that PSWs appear to be bringing to mental health teams. This oversight also raises critical questions about the sustainability and fairness of depending on PSWs within the broader mental health services system.

Future directions

Lived experience is reshaping mental health care. As mental health services continue to evolve, integrating lived experience expertise in various roles nationally and internationally (Byrne et al., 2018, Byrne et al., 2021) is increasingly recognised as a vital component of mental health service reform and recovery (Procter et al., 2022). Therefore, understanding the impact of broader political, social, and economic factors becomes crucial.

This thesis builds on previous work highlighting the unique value of lived experience in mental health care (Gillard et al., 2014, Berry et al., 2011), by offering a new and novel perspective on how experiential knowledge can mitigate the impacts of broader austerity-related constraints on mental health service delivery. It demonstrates how the unique perspective, knowledge, and skills of PSWs can be particularly valuable in navigating these OC constraints and arguably provide more meaningful and efficient care than traditional clinician roles. This raises two key questions for the future of mental health care:

1. **Emerging roles**: how can new roles address complex institutional challenges and complement existing care models as services evolve?

2. **Incorporating experiential knowledge**: how to find and adjust the optimal balance between the three institutional logics in the team membership, coming both from people with dual identity (how and in what ways should team members be expected to bring more than one type of experience to their role e.g., when is it helpful and when not helpful for a nurse to talk with a service user about their own mental health experience) and from employing new roles (e.g., PSW and CPSW)?

8.4 Discovering multiple institutional logics and their dynamic nature

The fourth contribution of this thesis is in relation to the theory of institutional logics. Institutional logics have been described as the "engines of institutional influence" (Thornton and Ocasio, 1999) that guide practical action, and as the big ideas that define organisational rules of the game (Jackall, 1988). This thesis demonstrates how logics are enacted and put into practice at an individual level, offering further understanding of the ground-level processes that render logics consequential and relevant. This supports Objective 1 and 2 which aimed *to identify the institutional logics that relate to PSW implementation* and *characterise how these institutional logics support, compete with, or conflict with PSW implementation*.

By employing an immersive, ethnographic approach, this thesis is the first to utilise institutional logics as a theoretical framework to explore PSW role implementation. It provides novel empirical evidence capturing how three distinct logics, through their employment by team members, become tangible in everyday decisions and activities in relation to PSW role implementation. The research offers insights into a highly complex mental health field characterised by multiple interacting and co-existing

logics. It also builds on the institutional logics theory by challenging the tendency to view logics as static and instead highlighting their dynamic nature in practice.

This thesis highlights the institutional complexity when groups embracing different institutional logics work with PSWs as part of the MDT. The data shows that there is conflict between the intersection of logics, as also demonstrated in other studies (Dunn and Jones, 2010, Purdy and Gray, 2009). It also shows negotiation as clinicians and the manager utilise the PSW role to solve problems and actively meet the needs of the Trust. The intersections and tensions between groups and multiple logics is an area of growing interest within institutional theory (Dunn and Jones, 2010, Pache and Santos, 2010).

However, research into this complexity has often been criticised for oversimplification by focusing on the relationship between just two logics (Greenwood et al., 2011). Previous studies examining institutional logics in healthcare settings typically adopt a binary approach, focusing on the competing dichotomy between professional logics, usually associated with medical doctors (Thornton et al., 2012b, Freidson, 2001) and managerial logics (Andersson and Liff, 2018). These studies often highlight power struggles or incompatibility between the two logics (Scott, 2000, Reay and Hinings, 2009), leading to outcomes such as the colonisation of professional practices by managerial imperatives (Hunter, 1996; Courpasson, 2000) or a lack of significant change due to the decoupling of managerial influence (Kitchener, 2002, McGivern, 2015).

Critics argue that these binary approaches misrepresent multi-logic fields such as healthcare settings, failing to capture the interactive or cooperative dynamics within these environments (Greenwood et al., 2011). Research has explored areas of heightened complexity across various settings. For instance, some studies have identified logics that are more loosely assembled and adaptable to institutional forces, such as ‘fields of flux’ (Van Gestel and Hillebrand, 2011), broader ‘constellations’ of logics, (Goodrick and Reay, 2011), and the strategic use of logics as ‘tools’ by individuals as needed (McPherson and Sauder, 2013).

This thesis advances the understanding of institutional complexity in mental health care settings by exploring how multiple institutional logics coexist and intersect. By remaining open to emergent logics and recognising the strong ties some logics have within specific groups (e.g., professional logics among clinicians), it highlights the intricate dynamics of multi-logic fields, aligning with research that conceptualises such complexity (Fincham and Forbes, 2015). Notably, this thesis identifies three key processes – eliminating, reframing, and reassigning – that enable the coexistence of professional, managerial, and therapeutic logics. These processes help maintain the integrity of each logic, often relying on leadership and power structures. For instance, psychiatrists leverage their authority to manage swift decision-making processes aligned with professional logics, while managers use their discretion to exempt PSWs from specific team rules, preserving therapeutic logic. These strategies for resolving inter- institutional logics conflicts highlight the importance of leadership and power structures.

Moreover, by conceptualising mechanisms like time and risk as part of a ‘broader constellation’, the thesis moves beyond binary comparisons to offer a more nuanced understanding of the intersections of institutional logics within a mental health community team. These findings foreground the coexistence of multiple institutional logics and the processes sustaining them, offering valuable insights into the intricate dynamics of complex institutional fields.

Exploring local-level intersections

The ethnographic approach adopted in the POETIC study uncovers how institutional logics manifest at the ground level. The findings illustrate how clinicians and PSWs actively interpret and utilise institutional logics daily. While existing literature primarily focuses on macro level interactions between organisations and institutions (Lounsbury, 2002, Haveman and Rao, 1997, Scott et al., 2000, Thornton, 2004), they often overlook how logics manifest, operate, and intersect at an individual level. This thesis fills that gap by providing nuanced insights into how PSWs and other team members collaborate, revealing how their perspectives and actions translate into practice.

This focus on the local level aligns with research highlighting the role of social actors in institutional processes (Hallett and Ventresca, 2006, Battilana et al., 2009) and emphasises how individuals’ enactment, interpretation, and negotiation shape the meaning and relevance of institutional logics (Coburn, 2004, Binder, 2007). By exploring how logics are embedded in daily activities within the MDT and specifically concerning the PSW role, this thesis seeks to open up the “black box” of how logics function on the ground (McPherson and Sauder, 2013), offering a more nuanced

understanding of their effects and manifestations. It reveals aspects often missed in macro or meso level studies, such as the focus on risk in everyday practice and the importance of professional role identities.

Unpacking the dynamic nature of institutional logics

A key theoretical contribution of this local-level focus is revealing the dynamic nature of institutional logics. Initially, the chosen theoretical framework helped differentiate the three logics, but traditional representations were found to be overly static. Immersion in the daily routines of the PSW uncovered a more dynamic and nuanced understanding of how different workers from various backgrounds and the PSW employ institutional logics to manage institutional complexity and perform their roles. Ethnographic methods proved uniquely valuable in capturing the subtle, fluid, adaptable aspects of institutional logics, which speak to the differences between logics, and in revealing aspects that may be hidden when utilising more structured research designs.

The data highlights the micro level processes team members use to negotiate demands in response to service pressures. For example, this dynamism is especially evident in how team members navigate time and risk in their daily work. Risk and time mechanisms served as critical lenses that expose the interplay of static and dynamic aspects of different logics, capturing the more relational and emergent aspects and challenging static conceptualisations. For instance, a clinician's approach to risk assessment is framed as a static thing, but how it is operationalised will change based on the context – the service user's state of illness or available resources – reflecting the fluid nature of the professional logic in practice.

Similarly, while PSWs role in sharing their recovery story can be conceptualised as static, the specifics of what and how they share are dynamically negotiated, often changing based on situational factors. The dynamic aspects negotiated at the moment are highlighted in this thesis, including how the PSW spends their time and their approaches to risk. These are more dynamic and speak to differences between logics that otherwise would be hidden. This nuanced view is particularly valuable for understanding the implementation of PSW roles. It suggests that implementation requires an understanding of how different logics intersect and how they are employed strategically by different workers within an organisation.

Bridging interdisciplinary gaps in mental health research

Notably, this thesis bridges a significant interdisciplinary void by applying sociological theory to psychiatry. It demonstrates the value of bringing sociological perspectives into psychiatry, offering a more holistic understanding of mental health care delivery. A traditional psychiatry focus on biological advancement can result in overly static knowledge contributions. As a result, attention to the more relational and emergent features centred on a critical realist epistemological choice is neglected.

By bridging this interdisciplinary gap, this thesis highlights the limitations of static knowledge. It emphasises the dynamic, relational aspects of mental health care, especially in relation to the implementation of the PSW role. For instance, my epistemological choice enabled me to ask questions and observe different system aspects often overlooked by more structured research designs studying PSW roles. For instance, despite the existence of over thirty RCTs on mental health PS (Smit et al., 2023) and a growing number of systematic reviews and meta-analyses (Cooper et

al., 2024), these studies typically focus on overly static aspects of the role, e.g., modifications (Charles et al., 2020). Similarly, critical components of the PSW role, such as relationship building (Kotera et al., 2023), are often highlighted, but the specific ways in which this support is provided and a detailed description of this support are not reported.

The value and strength of this in-depth ethnographic research lies in its ability to capture relational and emergent mechanisms, such as risk and time. These mechanisms offer insights that structured research designs like RCTs cannot. This thesis suggests that understanding and exposing the dynamic, on-the-ground pressures highlighted by institutional logics are essential for future research. It lays the foundation for developing more nuanced strategies for implementing PSW roles in complex institutional environments like mental health settings. This aligns with recent recommendations to explore how NHS cultures can better value lived experience expertise (Cooper et al., 2024). An ethnographic approach may provide the deep, detailed, theoretically driven exploration needed to understand the barriers and enablers of implementation concerning aspects of OC, offering answers and future solutions that more structured reviews or research designs continue to highlight but fail to provide answers to.

Summary of knowledge contributions

Table 8-1 below summarises the four key knowledge contributions detailed in the preceding sections.

Table 8-1 Four knowledge contributions

#	Knowledge contribution	Description
1.	Identifying and understanding the intersections between different Institutional logics	Offers a theoretical understanding of how three distinct institutional logics interact and impact workers' practices within a community mental health HTT about the implementation of PSWs
2.	Illuminating the austerity constraints exposed by intersecting institutional logics	Highlights how institutional logics reveal constraints and opportunities related to time and risk mechanisms while also revealing aspects of OC impacted by austerity measures
3.	Highlighting the potential of the PSW role in overcoming systemic constraints	Emphasises the unique contributions of PSWs, particularly in navigating and mitigating systemic constraints, thus underscoring their crucial role in enhancing service delivery and service user care through utilising experiential knowledge
4.	Discovering multiple institutional logics and their dynamic nature	Reveals three distinct logics within a mental health setting, moving beyond binary logics to provide a more profound and novel understanding of their dynamic, complex and evolving interplay in a mental health community team

8.5 Critical reflexivity and positionality

Reflexivity is a fundamental aspect of ethnographic research. This process enables researchers to recognise and articulate how their personal experiences, backgrounds, and perspectives shape every stage of the research process. Positionality refers to the researcher's relationship to the social and political context of the study (Coghlan and Brydon-Miller, 2014). It involves how aspects of the researcher's identity- such as gender, race, knowledge, background, culture, and education - affect interactions and

influence the research process (Finlay, 2002). This dynamic interplay can impact how trust in the research is built and how knowledge is produced, making it essential for researchers to be mindful of these influences and their potential effects on the ethnographic findings (Berger, 2015).

In this thesis, my positionality was shaped by multiple, intersectional identities: mental health nurse, informal PSW, and researcher. Each identity brought unique perspectives, challenges, and insights, influencing my engagement with the study. To examine the impact of my positionality, I maintained reflexive diaries and regularly participated in supervision sessions. These practices helped me critically reflect on and untangle my motivations, understandings, and influence throughout the ethnography. I will explore my positionality by offering a transparent account of my multiple identities and how they shaped my methodological choices, fieldwork experiences, ethical challenges, role conflicts, the process of data analysis, and subsequent findings. This section will provide deeper insight into how my positionality influenced the research process and findings.

Navigating multiple identities

My intersectional identities all significantly influenced and shaped this thesis. Each identity offered a unique perspective while influencing how I was perceived and related to others in the field.

The benefits and limitations of an ‘insider’ or ‘outsider’ position have stimulated debate (Heritage, 2013). Proponents of an ‘outsider’ position assert that this distance from

participants reduces the potential for bias that can occur with familiarity and affiliation with participants (Kanuha, 2000). However, advocates for an ‘insider’ position argue that this shared identity, experiential base, and language with participants enables the production of ‘authentic’ accounts of the phenomena of interest (Asselin, 2003).

As a registered mental health nurse, I approached the field with an 'insider' perspective of the healthcare system, well-versed in its clinical language, policies, and procedures (Savage, 2006). This professional identity provided me with credibility, particularly among nursing staff, and allowed me to interact more ‘authentically’ without needing to perform my role. However, this familiarity also carried risks, as I had to remain aware of how this lens might shape my observations and interpretations, particularly when engaging with those in other roles.

Though informal, my PS and advocacy involvement, along with my own experiences, introduced another identity layer. This background created a connection with the PSW, enabling me to engage with their experiences from a place of shared values around lived experience. Yet, because I was not formally employed as a PSW, I occupied a liminal space - both an 'insider' in spirit and an 'outsider' in practice. This duality offered advantages in building rapport and limitations in fully integrating into their community. It required ongoing reflection on how this partial affiliation influenced my interactions and insights with the PSW.

Finally, my role as a researcher positioned me as more of an 'outsider,' distanced from the daily pressures and immediate pressures within the team. This detachment

provided a critical vantage point, allowing me to observe dynamics and patterns that might go unnoticed by those fully immersed in the work. It also allowed me to ask probing questions that someone embedded in the team might not feel comfortable exploring. These intersecting identities demanded constant reflection as they influenced my engagement with the field and how my positionality affected the data I collected, the interpretations I formed, and the findings I presented (Fetterman, 2010).

Methodological decisions

My positionality had a significant impact on several methodological decisions. In this thesis, ethnography emerged as the most fitting methodology for this study, not only because of its capacity to capture the intricate, fast-paced, and evolving nature of mental health settings but also because it resonated with my own prior experiences within these environments.

During my final management placement as a student nurse, I spent considerable time working with the HTT selected for this study. This immersion allowed me to build familiarity with the team, understand their dynamics, and gain deeper access to the environment. It also provided valuable insights into the everyday interactions within the team, which reinforced my belief that ethnography could effectively reveal the aspects of OC in relation to the implementing the PSW role. In addition to this placement, my experience working as a mental health nurse in various settings has given me a strong understanding of the nuances, rhythms, and unspoken dynamics that shape daily practice. I had also employed ethnography in a prior research project, which further strengthened my confidence in its ability to capture the richness of daily interactions and uncover layers of meaning, such as institutional logics that shape

practices. Together, these experiences - working closely with the team, my nursing background, and applying ethnography in other research contexts - guided my decision to pursue ethnography. I believed it would provide a deeper understanding of the PSW's routines and emerging institutional logics, offering a more nuanced and immersive understanding of OC than more detached methods might have provided.

However, my familiarity with ethnography also required careful reflexive consideration. I needed to ensure that my comfort with this methodology did not limit my openness to alternative approaches. While I felt confident in its potential to provide valuable insights, I remained mindful of the possibility that other methodologies might offer equally meaningful perspectives. Supervision, further reading, and the specific research question played key roles in ensuring that ethnography was the most suitable methodology, rather than simply the default choice based on past experience.

The selection of the research site was also significantly influenced by my positionality, particularly my prior knowledge of the hospital and familiarity with some of the HTT nursing staff. This familiarity offered practical advantages, such as easier access to the field and a smoother recruitment process for participants. However, it also required deeper reflection on how my past positive experiences might shape the research process and how I was perceived by the participants. I was acutely aware that my pre-existing relationships with the team would influence how I was viewed by the participants (Reeves et al., 2008). I had to be aware of how my positive perceptions of the team might influence my view of their current dynamics, potentially leading me to overlook or downplay certain aspects of their behaviour or the challenges they faced. Ultimately, while my familiarity with the environment helped reduce discomfort

for both the participants and me, creating a more relaxed atmosphere for data collection, I had to remain vigilant, ensuring that I explored my previous experiences within the setting and how this might shape my interpretation of the new data being generated.

Fieldwork experiences

The influence of my multiple identities on my fieldwork experience is another important consideration (Pezalla et al., 2012). These identities were crucial in shaping how I approached the research, influencing how I built rapport, established credibility with participants, and how they perceived my presence throughout the study.

As noted in other ethnographic studies (Pellatt, 2003), my background as a mental health nurse enabled me to integrate easily within the clinical environment and connect with nursing staff through shared professional experiences, expectations, and understanding (Innes, 2009). This connection fostered a sense of familiarity and trust but also carried the risk of being seen as 'just another mental health professional.' For example, during informal conversations, nurses would often discuss how the team dynamics had changed since I was last there or mention previous colleagues known to me. These exchanges created a sense of camaraderie and belonging as they drew on our mutual professional histories and networks. Comments such as, *“You remember how things were when you were here - everything's different now,”* or *“Do you remember working with [former colleague]?”* reinforced this familiarity. While these moments facilitated trust and rapport, they also blurred the boundaries between my role as a researcher and my identity as a nurse.

This overlap could inadvertently position me as an insider within the HTT. It also carried a risk of me being seen as another mental health clinician. This perception might have limited my ability to fully engage with the PSW and CPSW, whose roles and experiences often contrast traditional clinical practices. My intersectional identities as a nurse and an informal PSW shaped these interactions. While my PS background helped build trust and rapport, they also introduced moments of tension and required careful navigation to uphold the integrity of my researcher role. On the one hand, this shared PS background helped build a sense of trust and rapport, creating a space where the PSW might feel more comfortable opening up to me (Dwyer and Buckle, 2009). On the other hand, my experience in PS was not within a formal PSW role, which also positioned me as somewhat of an 'outsider,' which introduced benefits and challenges.

This outsider status provided a form of critical distance that was valuable in the research process. Without being fully immersed in the role, I was able to ask clarifying questions and notice aspects of the PSW role that might have been overlooked by someone who shared the same role identity (Merriam et al., 2001). For example, I noticed that PSWs approached documentation differently from my experience as a nurse. This contrast prompted me to ask, *"How do you decide what to include in your notes?"* These discussions revealed the values of PS - mutuality, lived experience, and relationship-building over clinical goals. By maintaining some distance from the PSW role, I gained a fresh perspective that deepened my understanding of their unique contributions to mental health services.

This distance also allowed me to maintain a reflexive approach to my interpretive lens, helping me to identify and reflect on any problematic aspects of the field (Bonner and Tolhurst, 2002). For instance, I became more aware of my own goal-oriented practices as a nurse and how they contrasted with the approach of the PSW. This reflexivity enabled me to articulate the meanings behind actions without being constrained by preconceived notions that could arise from being too embedded in the PSW role (Bridges, 2001). By stepping back, I could better appreciate the distinct philosophies guiding PS and remain open to insights that might otherwise be overlooked.

However, this position also carried challenges. Not having the same formalised experiences meant that there were moments when I felt I could not fully grasp the deeper intricacies of their role (Labaree, 2002). For example, while I could observe the emotional labour involved in their work, I sometimes struggled to appreciate its full weight and impact. Despite being able to ask questions and engage in discussions, I sensed that my lack of direct experience - particularly around the initial PSW training process - placed certain boundaries around our discussions and my understanding. There was a level of insight into the emotional and practical challenges of PS work that may have been out of my reach. This awareness required me to continuously reflect on how my outsider perspective influenced the data I gathered and how it shaped how I interpreted the role. Balancing this critical distance with empathetic engagement was an ongoing reflexive process throughout the study.

In navigating my multiple identities throughout the research process, I continuously shifted between roles, with each interaction requiring careful reflexive consideration. I needed to remain constantly aware of how my presence and positionality shaped the

participants' responses and the insights I generated. For instance, while I primarily introduced myself as a PhD researcher, I was mindful of when disclosing my background as a mental health nurse or informal PSW might be beneficial.

When introducing myself to clinicians in the team, I often foregrounded my experience as a nurse and my previous time working with the HTT as a student. This helped establish credibility, foster familiarity, and ease conversations about the study by drawing on our shared professional context. In contrast, when introducing myself to the PSW and CPSW, I mentioned my time with the HTT but emphasised my reasons for pursuing this research, such as my interest in PS practices and my informal experience as a PSW. By shifting the emphasis of my background, I was able to navigate the complexities of my identities and better connect with the diverse participants involved in the study. This flexibility in how I presented myself became an important aspect of my positionality, as it influenced how participants perceived me and shaped the depth and quality of our interactions.

As a researcher, I often leaned toward an 'outsider' stance, especially given my purpose of being in the field, my ‘outsider’ position to certain roles e.g., psychiatrists, and my data from the perspective of multiple participants. Ethnographic inquiry demands that researchers maintain an awareness of the initial questions that brought them to the field while critically engaging with their perspectives and experiences. However, my outsider status was not fixed; it was dynamic, shifting in response to the specific contexts and interactions with participants. This liminal space, where I was neither fully an insider nor entirely an outsider, created a certain ambiguity. I sensed that participants were sometimes unsure of how to relate to me - was I one of them

due to my clinical background, or was I an outsider because of my primary identity as a researcher?

This uncertainty often appeared subtly, influencing how participants interacted with me. Some were more reserved or formal, while others became more open, particularly when I shared aspects of my nursing or PS experience. Navigating this variability posed challenges; I often found myself balancing the role of being seen as 'one of them' with that of an external observer. For example, sharing my clinical background helped build trust, as nurses for example, assumed I understood their professional context. However, it may have led to a sense of 'othering' to others, where I was perceived as part of the academic research system. This sometimes created a sense of distance between me and some participants, particularly the PSW. Initially, this distance made it difficult for me to fully connect and understand their practices, as my role as a researcher may have been perceived as lacking insight into their unique role.

Over time, the initial distance began to shift as trust gradually developed. I made a conscious effort to foster this trust by approaching each interaction with curiosity, openness, and a genuine commitment to understanding their experiences. Building rapport with the PSW was not just important for the research - it was integral to creating a space where they felt comfortable sharing their perspectives on their role. This process, however, was not immediate. It required me to spend long periods with the PSW, engaging with them in a way that was sensitive to the nuances of their role and respectful of their experiences. My approach was guided by patience and genuine interest, as I wanted to understand not only what they did but why they did it and how it shaped their role. A turning point came when the PSW, initially hesitant to participate

in a one-on-one interview, approached me later and asked if they could participate. This shift was a powerful reminder to me of the importance of patience and respect in the research process and how these elements can foster an environment where participants feel heard.

Over the course of the POETIC study, my presentation of self shifted significantly. Initially, I felt fractured, unsure of where I fit within the team and how to balance the different aspects of my identity. However, by the end of the study, I felt more integrated as my sense of self began to align with the multiple roles I was navigating. A key moment in this shift occurred when I was given my own access fob to the building. This small but significant gesture felt like an important step in being recognised as part of the team rather than an outsider. It symbolised a deeper level of integration into the setting. Similarly, being greeted warmly by staff, who had initially viewed me with some distance, reinforced this sense of belonging. My layered identities - researcher, nurse, and PSW - were continuously negotiated and renegotiated in response to the evolving field dynamics (Allen, 2004). By embracing this fluidity, I could foster meaningful interactions while critically examining how my experiences and assumptions influenced the research process.

Spending a longer period in the field allowed me to build trust and gradually integrate into the setting. A key factor in this was the positive, pre-existing relationships I had with some team members, which helped ease my entry into the field. My relationship with the team manager was particularly supportive, and their trust in me facilitated a smoother integration into the team. This connection, along with the familiarity with the setting, gave me a sense of stability and access that was crucial to the research

process. Ongoing reflection also helped me remain sensitive to evolving relationships, allowing me to adjust my approach as needed and continue to foster trust within the team. The longer I was in the field, the more fluid and integrated my identity became, enabling me to gain a deeper understanding of the PSW role, aspects of OC, and the broader context.

Throughout the study, ethical challenges and role conflicts consistently challenged my position as a non-participant observer, requiring continuous reflexivity (Watts, 2011). There were several instances when my position as a researcher became blurred, particularly when a nurse asked me to assist with tasks like collecting medication. These requests often came during visible understaffing, and the pull to step out of my observer role and assist was strong. My empathy for the team's struggles created an internal conflict between maintaining my researcher's integrity and wanting to help, raising questions about the boundaries of my role. In these moments, my commitment to non-participation was tested. I had to critically reflect on my motivations and the extent to which I could step outside of my researcher identity.

Navigating these ethical and role-based dilemmas required a great deal of reflective practice. I often revisited these moments in supervision, unpacking the discomfort they created and examining how my assumptions and professional background influenced my reactions. I also sought additional support by reading about how others have managed similar tensions and sought guidance from fellow PhD students, drawing on their experiences and self-management strategies. This reflexive engagement helped me stay aware of the emotional weight of these interactions and the stress of researching within such a pressured environment. The intensity of the field impacted

and regularly took a toll on my well-being (Coffey, 1999). For example, maintaining a critical distance while being sensitive to the challenges faced by the team and the PSW was not always easy. My empathy sometimes blurred the boundaries of observation and made it difficult to remain detached.

One particular encounter with a PSW became a pivotal moment of reflexive learning for me. Their approach to care, deeply rooted in lived experience, contrasted sharply with the more formalised practices I had observed among the nurses. This interaction, noted in my diary entry dated 28.03.22 in Section 7.3, disrupted my preconceived notions about professional hierarchies and the value traditionally placed on lived experience in mental health care. It prompted me to revisit my own identity as a professional, challenging how I understood concepts such as expertise and professional boundaries. In doing so, I became more aware of the emerging literature around clinicians and researchers having a dual identity - those shaped by both learned/laboured and loved/lived experience (Karbouniaris et al., 2020), and that therapeutic self-disclosure can support recovery (Riches et al., 2020). I realised that experiential knowledge could sometimes transcend formal training, offering insights and support I had previously overlooked or set aside in my nursing role. However, I found some comfort in recognising that integrating these experiences with clinical practice can be challenging (King et al., 2020, Zamir et al., 2022) and that frameworks for clinicians with dual identities are emerging (Dunlop et al., 2022). This moment reshaped my view of the PSW role and understanding of what it means to provide care.

These reflections deepened my understanding of the PSW role, not just as a relatively new role within the team but as a form of care that contrasted with and complemented traditional professional nursing practices. It forced me to consider how my professional background might have initially limited my appreciation for the nuances of PS and how being immersed in this field demanded that I continually challenge these ingrained assumptions. Engaging with these tensions through reflexivity allowed me to grasp better the complexities of 'expertise' and different forms of knowledge in mental health settings. It also highlighted the fluidity of my role as a researcher, navigating ethical dilemmas, emotional responses, and role conflicts.

Analysis

In this thesis, the richness and complexity of the setting generated a vast amount of data, making the analysis and interpretation both time-consuming and complex, a challenge highlighted in the literature (Pope, 2005). As a single-analyst ethnographer, the large volume and complexity of the data increased the risk of certain aspects being over or under-emphasised due to the influence of my identities. For instance, a key challenge during analysis arose from my professional identity as a nurse, which raised critical reflexive questions about how I interpreted the data.

Coming from a clinical nursing background, I realised that my initial interpretations were often filtered through that lens. At times, my 'nursing self' came to the forefront, I tended to frame the practices of the PSW or aspects of the field using language or assumptions rooted in nursing. An example of this was my use of 'nursing' shorthand, such as "ax" (abbreviation for assessment), in my observation notes, which inadvertently filtered my interpretation of PSW work through a clinical nursing

framework. This habit took me back to my experiences in the MDT. This inclination sometimes obscured the relational and distinctively non-clinical aspects of the PSW role. These moments of reflexive awareness underscored how my professional training could limit my ability to fully engage with the nuances of the PSW role. While this awareness was crucial, it highlighted the ongoing tension between my insider knowledge of healthcare systems and my outsider's perspective on exploring the contributions of PSWs.

In addition, interpreting the roles of psychiatrists, where I lack an insider perspective, required critical reflexivity. The distinct professional logics guiding these roles - compared to PSWs or my own experience as a nurse - highlighted the complexity of care delivery. The analysis revealed the risk of oversimplifying contrasts between structured, clinical approaches and recovery-oriented perspectives. Reflecting on my own background, I recalled previous experiences working alongside psychiatrists and the significant power and authority their roles entail. These interactions, which were both positive and, at times, challenging, shaped my understanding of how their decisions often carry substantial weight within the healthcare system. While my alignment with recovery-oriented principles might predispose me to favour certain approaches, this reflection made me confront how my experiences shape the lens through which I interpreted and analysed these specific roles.

To mitigate this, I adopted several strategies to maintain transparency and rigour in my analysis. I relied on reflexive memos to document and critically examine my reactions, interpretations and thought processes throughout the research process. Reflexive memos were essential in capturing and interrogating my reactions,

assumptions, and evolving interpretations through the research process. Writing these memos helped me identify patterns where my identities influenced my analysis. This process encouraged me to critically reflect on and revisit my interpretations, ensuring that I authentically represented the nuances of all perspectives while acknowledging the systemic pressures and responsibilities that influence them.

Supervision sessions further strengthened this reflexive process. Regular discussions with my supervisors provided critical external feedback, encouraging me to step outside my nursing perspective and consider alternative interpretations. These conversations helped me further reflect on my findings, offering alternative perspectives, questioning my interpretations, and sharpening my critical lens. This process demanded deliberate and ongoing reflection. I had to actively challenge ingrained ways of thinking, particularly where my professional training risked overshadowing the unique contributions of PSWs. This required ongoing, deliberate reflection, constantly unpacking and untangling how my nursing identity influenced my interpretations.

By reorienting my approach through reflective practice, I ensured I remained open to the distinct perspectives of the PSW, attempting to avoid reproducing familiar narratives from a nursing viewpoint. Despite these reflexive efforts, I acknowledge that the findings may still emphasise certain aspects of my positionality. Being transparent about how my identities shaped the research analysis is crucial to understanding how the study evolved and the nuances that influenced the final findings presented.

Reflexive summary

This reflexive section highlights the complex relationship between researcher positionality and the research process in ethnographic work. By critically reflecting on my multiple intersectional identities and their influence throughout the study, I aim to offer transparency about how my perspectives and experiences shaped the research journey and the subsequent findings. This ongoing reflexivity enhances the rigour and credibility of the ethnographic approach, ensuring that the study remains grounded in a self-aware and critical examination of my role in the field.

8.6 Strengths and limitations

This thesis offers four key strengths. First, it provides a descriptive, detailed, and contextual understanding of PSW role implementation within a community mental health team. It offers valuable theoretical insights into mental health service delivery and PSW role implementation. The use of triangulation enriched the data, allowing for a more nuanced understanding of how PSW roles are embedded in practice.

Second, ethnography is particularly illuminating in revealing the complex interplay between individual agency and organisational structures in healthcare settings (Reeves et al., 2008). This thesis employs a theoretical framework not previously applied to PSW roles and underutilised in mental health settings, offering a novel theoretical explanation for PSW role implementation.

Third, ethnographic sites are often chosen for their potential to generate meaningful theoretical contributions rather than for their typicality (Hammersley and Atkinson,

2019). The rich, in-depth findings offer theoretical transferability, providing insights that can inform the implementation of PSW roles in similar team configurations or settings. Theoretical transferability refers to the ability of research findings to resonate with and apply to other contexts despite the specificities of the original setting (Lincoln, 1985). Fourth, although this thesis is contextually tied to a particular community HTT, the theoretical insights generated may inform the integration of PSW roles in other complex mental healthcare environments. For example, the three processes by which an MDT navigate conflicting institutional logics may have relevance to other settings.

This thesis also has several limitations. First, the small sample size for interviews, combined with workplace demands and time constraints, may mean the study does not fully capture the diverse perspectives of all MDT workers regarding the PSW role. Additionally, relying on participants who were available and consented to interviews and observations may have excluded the views of workers with different experiences or work patterns.

Second, the fast-paced and complex nature of healthcare settings also posed challenges, as highlighted in previous research (Savage, 2000). Significant events or interactions may have been missed due to time limitations on observation, and formal and informal interviews were sometimes interrupted by clinical demands, such as when a worker had to return to practice addressing a clinical query (Wind, 2008). Consequently, the findings may not be directly transferable to other settings with different resources, team compositions, or service mandates.

The third limitation lies in the ability to capture the complexity of OC fully. Although refinements were made to interview questions to understand OC better, this aspect remains inherently challenging to document, as discussed in Section 4.7.

Fourth, institutional logics provided valuable insights but also presented limitations. The study did not encompass or capture all potential logics within the field, such as recovery, medical logics, economic, or market logics, making it challenging to identify dominant institutional logics in a setting as complex as mental health care. This challenge echoes broader debates in the literature about whether logics should be understood as practices and identities of groups or as narratives and scripts (Fincham and Forbes, 2015). Additionally, some marginal logics may have been deprioritised during the analysis, raising questions about whether dominant logics alone are sufficient to address the research question or if these lesser emphasised logics hold important explanatory power.

Fifth, the thesis gave limited attention to macro levels of analysis. Broader social, political, and systemic factors were not explored in depth, such as the role of activism (Arnaud and Gagné-Julien, 2024), the impact of politics on experience (Cohen, 2025), and the importance of social justice (Morrow, 2012), representing a notable gap. This oversight is significant, as recovery-oriented approaches to social inclusion emphasise the critical role of environmental and social aspects (Dell et al., 2021). To better understand the complexities of PSW implementation, future research should examine these macro level influences.

Finally, the POETIC study was conducted within a team with only one PSW. This limited the opportunity to explore how the role functions within teams that employ multiple PSWs. This raises questions about the extent to which the findings can be attributed to the PSW role itself, rather than the unique personal qualities of the individual in the role or their interpersonal relationships with colleagues. Similarly, the theoretical approach did not fully address the personal qualities of the PSW or manager, including their leadership styles and relational dynamics, which are likely critical to the successful integration and support of PSWs. Future research involving multiple PSWs across varied contexts is needed to better understand the interplay between role-specific expectations and personal characteristics in shaping the implementation, integration, and impact of PSWs.

8.7 Recommendations

Based on the data, the thesis recommendations address various aspects of PSW implementation. They are organised into policy, clinical practice, theoretical implications, and future research directions, offering a comprehensive approach to improving PSW implementation and effectiveness in mental health care.

Policy recommendations

The following policy recommendations are designed to enhance the recognition and support of PSWs within mental health services by addressing the broader institutional logics and constraints identified in this thesis:

1. **Recognise PSW role value**: policies should explicitly recognise and support the unique contributions and experiential knowledge that PSWs bring to community mental health teams, services, and systems. While PSWs hold great potential to address service gaps and enhance care quality, it is essential to ensure that policy development prioritises sustainability and the well-being of both PSWs and the broader team. This approach emphasises the need for frameworks that better integrate their roles in a way that mitigates the pressures of resource constraints and austerity contexts. Practical policy measures might include developing formal guidelines that articulate how the experiential knowledge of PSWs can directly contribute to addressing service gaps and how they may operate differently from other team members.

2. **Support integration**: develop and implement policies that actively support the integration of PSWs into all mental health teams. Some policies might include developing mandated targeted training to help PSWs effectively contribute to MDTs by leveraging their experiential knowledge, implementing team training on how to collaborate with PSWs to recognise their significant contributions, and/or workshops on collaboration and sharing lived experiences to enhance the understanding of PSW roles and potentially enhance overall care delivery.

3. **Invest in resources**: focus on dedicated resource allocation for PSW training, supervision, and ongoing role development. This investment should prioritise skills development for PSWs, particularly in navigating the complexities of mental health settings impacted by austerity. Policies should also consider fair remuneration, reflecting their significant contributions in providing care.

Importantly, teams should avoid employing sole PSWs to prevent the risk of overburdening and enhance peer-based support structures. Continuous PSW role development opportunities, such as training on navigating institutional complexity and working in resource-constrained environments, should be provided to meet the unique needs of PSWs. These measures will equip PSWs to carry out their roles effectively, maintain their well-being, and enhance their contributions within mental health teams.

Clinical practice recommendations

To improve the integration and impact of PSWs in mental health services, the following clinical practice recommendations are proposed:

1. **Clear PSW role description**: this is not a new recommendation but a reaffirmation of established best practices: clear role descriptions for PSWs should be established and effectively communicated to all team members. Clear articulation of the PSW role ensures that responsibilities and expectations are well understood, facilitating their implementation into the MDT. This clarity also highlights the unique and valuable contributions PSWs make, particularly in addressing risk and time constraints, thereby enhancing team collaboration and service delivery.

2. **Emphasise managerial support**: managers should be equipped to provide targeted support that enables PSWs to contribute effectively across teams by navigating and bridging different institutional logics, particularly those related to efficiency. Managerial support is pivotal in creating the flexibility and

understanding necessary for PSWs to fulfil their unique role in improving service user care and bolstering team capacities. To support this, training for managers should focus on the specific types of exceptions and accommodations that empower PSWs to thrive. This includes understanding when and how to adapt team processes to align with the experiential contributions of PSWs and fostering a collaborative environment that maximises their cross-team impact. Structured guidance on these adaptive practices would enhance the integration of PSWs while maintaining the overall functionality and goals of the team.

3. **Highlight PSWs as key MDT members**: recognise and reinforce the integrative and complementary role of PSWs within the MDT. To ensure their effective contribution to mental health care delivery, particularly in fragmented and resource-constrained systems, clear team-wide communication about the unique functions of PSWs is essential. This includes emphasising the exceptional nature of the PSW role: while they are valued as full team members, certain standard rules - such as prioritising immediate assessments - may not always apply to them. This distinction allows PSWs to focus on their primary strengths, such as addressing dimensions of risk and time through peer-based support and experiential insights. To implement this recommendation, organisations should develop clear guidelines specifying how and when PSWs may operate differently to preserve the integrity of their unique role, regularly evaluate team practices to ensure the PSW role is implemented in ways that maximise its benefits and incorporate role clarification into team preparedness activities.

4. **Continuity in teams**: prioritise continuity by minimising unnecessary rotations between teams. Consistent team placement allows PSWs to build trust, foster mutual respect, and strengthen relationships, enhancing the team's understanding and appreciation of their experiential contributions. Frequent rotations risk disrupting these dynamics, impeding relationship-building, and diminishing the integration of PSWs into team workflows. At the same time, addressing the career development needs of PSWs is essential. Instead of requiring movement between teams to achieve promotion, organisations should establish career development opportunities within teams. Creating roles that allow PSWs to advance professionally without relocation promotes both continuity and professional growth, enabling PSWs to deepen their contributions while building long-term relationships within their team. This dual approach supports stability in care delivery, reinforces the PSW's role within the MDT, and provides meaningful career pathways that align with the unique nature of PSW work.

Theoretical implications

This thesis contributes to theoretical understanding in several key areas:

1. **Empirical data in mental health settings**: the study contributes to institutional logics theory by demonstrating how logics are enacted and negotiated in mental healthcare settings. It provides empirical evidence of the dynamic intersections of logics and their impact on practice, particularly concerning time and risk. The observed conflicts related to time and risk present opportunities for further exploration in other areas of healthcare.

2. **Dynamic tendencies of logics**: the research highlights the evolving nature of institutional logics as they manifest in practice. This contributes to a deeper understanding of how logics shift and adapt in response to changing conditions within mental health care settings.

3. **Impact of austerity**: the findings offer valuable insights into how austerity-related policies and efficiency imperatives shape and reshape the daily practices of team members within mental health services. This contributes to a broader understanding of how economic pressures influence the implementation of roles and the interplay of dominant institutional logics in a mental health community team.

Future Research

Future research should build on the findings of this thesis by exploring the following areas:

1. **Observational cohort design studies** with multi-level modelling to analyse data across team, PSW, and service user levels, addressing an area not covered in this thesis. This approach would enable a deeper exploration of how OC and PSW roles influence service user outcomes, revealing the broader implications of PSW integration within mental health care delivery. By examining multiple levels, researchers can gain a nuanced understanding of how OC and PSW contributions impact service delivery and service user experiences. To assess service user recovery outcomes, validated measures such as the Brief INSPIRE (Moeller et al., 2024) and the Questionnaire on the

Process of Recovery (QPR) (Neil et al., 2009) could be utilised. This comprehensive, multi-level approach would clarify the impact of PSW roles and provide insight into their long-term impact on mental health care systems, offering valuable guidance for optimising PSW integration and improving service delivery across diverse mental health settings.

2. **Qualitative case series** across diverse community mental health teams that employ PSWs, such as early intervention and community mental health teams, could offer valuable insights into how teams implement recovery-oriented care by integrating PSWs into their practices. Unlike this study, which focused on a single team working with individuals in crisis, examining a broader range of teams would provide a more comprehensive understanding of the strategies and practices used to implement PSW across varied contexts (Yin, 2018). In addition, the extent to which time and risk feature prominently in other community mental health teams is unknown. Using interviews and observations, researchers can explore how teams utilise professional expertise and experiential knowledge to enhance care. A dual analytical approach, combining both framework and theoretical methods, could structure the identification of themes and uncover deeper underlying processes (Crowe et al., 2011). This approach would enable the examination of the different team dynamics and managerial styles, uncovering strategies that foster effective PSW integration and highlighting how PSWs contribute through their lived experiences and unique perspectives. Case studies are particularly useful for identifying counterexamples and best practices, demonstrating how successful teams adapt to and support the role of PSWs while maintaining a balance

between professional and experiential knowledge. They also might provide an in-depth understanding of how diverse approaches impact the overall implementation of recovery-oriented care.

3. **Participatory research methods** to explore the various forms of experiential knowledge that PSWs bring to their roles. The single-analyst ethnography employed in this thesis, while beneficial in capturing the context of PSW implementation, did not facilitate collaborative exploration of experiential knowledge with PSWs in navigating time and risk constraints. Visual mapping and/or photovoice could engage PSWs in a more interactive, reflective, co-creative process, allowing them to represent their experiences and contributions visually (Wang and Burris, 1997, Cochrane and Corbett, 2020). These participatory methods could uncover how PSWs enrich team dynamics, inform care strategies, and enhance service delivery through their unique lived experiences. By exploring different types of experiential knowledge, a deeper understanding of how PSWs leverage their personal histories and perspectives to influence the overall functioning of mental health teams will be highlighted.

4. **Comparative ethnographic studies** across two mental health teams situated in a Trust and third-sector organisation. This comparative design would provide valuable insights into how various institutional logics interact and shape the implementation of PSW roles in two different contexts (Simmons and Smith, 2019). This design, unlike the single-sited focus in this thesis, would enable researchers to identify key factors contributing to successful integration or highlight obstacles hindering PSW effectiveness. By comparing two settings,

researchers can uncover best practices, strategies for overcoming difficulties, and conditions that foster or hinder optimal PSW functioning. Such studies should also explore how PSWs navigate and potentially bridge gaps between different institutional logics. For instance, examining how PSWs integrate and reconcile diverse values, practices, and OC. By assessing the broader applicability of the findings of this thesis, researchers can determine how PSWs can contribute to cohesive care across different settings, expanding the current evidence base on their impact.

8.8 Conclusion

This thesis offers a nuanced and comprehensive understanding of the implementation of PSW roles within a community mental health team, especially in a pressured, resource-constrained environment shaped by austerity reforms and efficiency-driven demands. The findings elucidate how these constraints have reshaped the work of a community mental health team, underscoring the increasingly vital role of PSWs. It also identifies three key processes used to navigate competing institutional logics: eliminating, reframing, and reassigning.

The thesis advocates for both existing and new policy and practice adaptations. Key recommendations include prioritising the well-being of PSWs and the broader mental health team, improving PSW team integration, leveraging their experiential knowledge, and enhancing skills development, especially in austerity-affected settings. It emphasises equipping managers to help PSWs navigate institutional differences, ensuring clear role communication within teams, and minimising team

rotations for continuity. Additionally, the thesis calls for further research into PSWs contributions to cohesive care across different settings.

The incorporation of experiential knowledge has the power to revolutionise mental health services, making them more responsive, compassionate, and, ultimately, perhaps, more capable of meeting individuals' needs. This thesis underscores the profound impact of lived experience in reshaping the service landscape, offering a path toward a more inclusive and effective mental health care system. The findings suggest that this thesis is a catalyst for continued inquiry and development.

The journey of this PhD has been deeply inspiring on a personal and professional level, revealing a landscape rich with potential for future postdoctoral research and beyond. As this chapter concludes, I am filled with optimism and excitement for the future possibilities that this foundational work will unlock. This is just the beginning of a meaningful exploration into enhancing mental health care by integrating PSWs and harnessing the transformative power of experiential knowledge in practice.

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Appendix 1 - Participant information sheet and consent form

University of Nottingham
UK | CHINA | MALAYSIA

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Participant Information Sheet
(Final version 1.0)

IRAS Project ID: 304779

Title of Study: The POETIC Study

Name of Researcher: Ashleigh Charles

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The aim of this study is to explore how mental health peer support workers integrate and work with the wider mental health team where you are employed. The study involves three parts:

1. Observing peer support workers and other team members in the service setting in which they work. This will involve taking notes of the interactions, dynamics, language, actions and behaviours of team members that relate to peer support and engaging in informal conversations with all team members to understand certain aspects of peer support workers role within the team. The researcher will also observe peer support workers with non-participants such as other NHS staff, service users and family members.

2. The researcher will carry out semi-structured interviews with some (but not all) participants in order to further explore peer support worker and other team member perspectives on the peer support worker role. Some participants may be interviewed more than once.

3. Collecting documents relating to peer support work, which might include relevant policies, team minutes, leaflets, appraisal documents, etc. Documents will be collected in a range of ways, e.g., by printing or taking a photo.

This study is primarily educational for an Economic and Social Research Council (ESRC) funded Doctoral PhD study.

Why have I been invited?

You are being invited to take part because you are a mental health worker who is already a peer support worker or works alongside peer support worker(s).

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights and any decision you make will not impact on service user care or on your employment. If you decide not to take part, the study will continue but every effort will be made to minimise any observation involving you. This may not always be possible, for example in team meetings. In all cases, anything you say or do will not be used in the research.

What will happen to me if I take part?

The study has three parts: observation, semi-structured interview and document analysis.

If you decide to take part in this study, the researcher will observe the team for up to a period of four to six months. The focus of the observations is primarily on how peer support workers work with the wider mental health team. The researcher will take notes of interactions, language, behaviour and actions relating to peer support workers only. The researcher may also ask you a few questions in order to understand how particular things work in relation to peer support, or to gain further understanding on aspects of your work that relate to peer support. Your responses will be noted down in the researcher's field notes. The researcher will aim to minimise any disruption to usual clinical practice and will be sensitive and mindful of the team carrying out their duties. The observational part of the study will involve the researcher observing peer support workers interactions with service users, family members, and other stakeholders, and they will ask members interacting with peer support workers if they are happy for the researcher to be present. Observation will not require any additional time.

If you are asked to take part in the interview part of the study, you will be asked questions relating to the peer support worker role. This will require up to one hour of your time and will be recorded. Interviews will be arranged at a time convenient with yourself and the interviews will be conducted either online or at the service setting in which you are based.

The document analysis is unlikely to directly involve you, but it is possible that a document might be requested from you, such as meeting minutes or an appraisal document. It will be your choice whether to supply the document. Personal data will be redacted and pseudonymised by a study ID number before taken off site. The disclosure of personal or sensitive information is not expected as a result of participation but in such instances, this will be treated with sensitivity and understanding. The researcher will protect the rights of study participants to privacy and informed consent and will adhere to the Data Protection Act, 2018 and General Data Protection Regulation.

The time frame for this study is up to one year for data collection. After the study has been completed a report will be written and available to view. Efforts will be made to ensure no individual participant can be identified.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no expected or anticipated risks of taking part in the study. If you become distressed during the interview, this will be treated with sensitivity and understanding. If you are unable to continue, the interview will be stopped, and your service manager will be informed of your wellbeing.

What are the possible benefits of taking part?

We cannot promise the study will help you but the findings of this study are likely to generate new insights into PSW role implementation and be useful for Nottinghamshire Healthcare NHS Foundation Trust. For example, this research well be beneficial in informing the implementation strategy of new peer support workers roles in the trust and will highlight some of the barriers and facilitators which may support best use of this new emerging workforce

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Louise Sabir at fmhs-researchethics@nottingham.ac.uk.

In the event that something does go wrong, and you are harmed during the research, and this is due to someone's negligence then you may have grounds for a legal action for compensation against the

University of Nottingham, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, we will use information collected from you during the course of the research. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

Where possible information about you which leaves Nottinghamshire Healthcare NHS Foundation Trust will have your name and address removed and a unique code will be used so that you cannot be recognised from it. People will use this information to do the research or to check your records to make sure that the research is being done properly. Once we have finished the study. we will keep some of the data so we can check the results. We will write reports in a way that no-one can work out that you took part in the study. All other research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk and/or relates to the potential observance of poor practice we may feel it necessary to report this to the appropriate persons.

You can find out more about how we use your information at: www.hra.nhs.uk/information-about-patients/ or by contacting Ashleigh Charles by sending an e-mail or by ringing us.

What will happen if I don't want to carry on with the study?

Your participation in the study is voluntary, and you are free to withdraw at any time, without giving any reason. However, the information collected so far cannot be erased and may still be used in the project analysis. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still

be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Economic Social Research Council (ESRC) as part of a Doctoral PhD Research Study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by ****

Further information and contact details

For further information please contact:

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University of Nottingham
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E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Consent Form for Non-Participant Observation and Interviews
(Final version 1.0: 08/11/21)

Title of Study: The POETIC Study
IRAS Project ID: 304779
Name of Researcher: Ashleigh Charles
Name of Participant/Team:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.0 dated 01/10/21 for the above study and have had the opportunity to ask questions relating to non-participant observation. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group, and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the investigator will take notes during observations and may ask informal questions relating to peer support worker role only. ☐

5. (Optional) I consent that the investigator may conduct interviews and the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. YES ☐ NO ☐

6. I understand that the investigator will collect documents relating to peer support only within the service setting. ☐

7. I understand that the information collected in the study will be used to support other research in the future and may be shared anonymously with other researchers. ☐

8. I understand that there are limits to confidentiality including the disclosure of anything that puts you or others at risk and/or the observance of poor practice which may need to be reported to the appropriate persons. ☐

9. I agree to take part in the above study. ☐

Name of Participant	Date	Signature

Name of Participant	Date	Signature

2 copies: 1 for participant and 1 for the project notes

Appendix 2 - Letter of Health Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Mike Slade
School of Health Sciences
Faculty of Medicine and Health Sciences
University of Nottingham
NG7 2TUN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

04 February 2022

Dear Professor Slade

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Peer support Observational Ethnography – Theory in Context (POETIC) Study**
IRAS project ID:	**304779**
Protocol number:	**21075**
REC reference:	**21/NI/0192**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **304779**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Angela Shone*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [HRA Conditionally Supported Outcome letter - CAG]		07 January 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Certificate of insurance]		02 July 2021
HRA Schedule of Events [HRA Assessed Version]	1.0	24 November 2021
Interview schedules or topic guides for participants [Interview Guide]	1.0	08 November 2021
IRAS Application Form [IRAS_Form_11112021]		11 November 2021
Letter from sponsor [Sponsor Letter]		09 November 2021
Organisation Information Document [Organisation Information Document]	Version 1	18 November 2021
Other [Covering Email re HRA Conditionally Supported Outcome]		07 February 2022
Other [Observation Template]	1.0	08 November 2021
Other [Delegation Log]	1.0	08 November 2021
Other [DSPT reviews up to date]		13 October 2021
Other [Data Protection Register]		08 November 2021
Other [Professional Indemnity]		22 July 2021
Participant consent form [Participant Consent Form (TC)]	2.0	09 December 2021
Participant information sheet (PIS) [Participant Information Sheet]	2.0	09 December 2021
Research protocol or project proposal [Protocol]	1.0	08 November 2021
Summary CV for Chief Investigator (CI) [CI CV]		09 December 2021
Summary CV for student [Student CV]		09 December 2021

IRAS project ID	304779

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisation Information Document	It is expected that a Local Collaborator would be appointed at study sites	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 3 - Observation template

Observation Template

(Final version 1.0: 08/11/21)

Site	Observer	Date	Start time	Finish time	No. of hours

Description of field observation	**Description of setting/context**	**Description of activity** *(what is happening, who is there, purpose of activity)*
Behaviour *(what, by whom and with whom)*	**Conversation** *(What is going on in relation to the PSW?)*	**PSW involvement** *(how was the PSW involved, what was their role in the activity)*
Key insights and concepts	**Institutional logics** *(e.g. professional logic, managerial logic.)*	**New emerging institutional logics**
Reflexive comments		

Appendix 4 - Interview guide sheet

University of Nottingham
UK | CHINA | MALAYSIA

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Interview Guide Sheet
(Post pilot version)

Title of Study: The POETIC Study

IRAS Project ID: **304779**

Name of Researcher: Ashleigh Charles

Outline of Interview Guide

The interview process aims to be as open-ended as possible in order to bring new insight to light free from a strict framework. The interviewer will also use the non-participant observations as a further stimulus for constructing questions for the interviews guide.

"There are no right or wrong answers here. I am genuinely interested in hearing about your experiences and perspective on the peer support worker role, and it willl be anonymised".

Introductory questions

- What is your role in the team?
- What is your understanding of the peer support worker role?
- Can you tell me about your experiences of working with peer support workers/mental health workers in your team?
- What do peer support workers do within your team?
- Can you tell me how you (in your specific role) work with peer support workers/mental health workers?

Team questions

- Do PSWs work in the same model as the rest of the team?
- Do PSWs bring a different language? How?
- Are PSWs a colleague, an intervention or both?
- What does professional mean for the PSW and what does un-professional look like?
- Do the PSWs challenge the team?
- How much do the team/Trust support peer support workers?
- From your perspective what is the difference between a support worker and a peer support worker?

Team and organisational level questions

- From your perspective, are there any challenges working alongside peer support workers/mental health workers?
- Can you tell me about a time when it did work well? For example, when a PSW brought something valued and extra to the team?
- Can you tell me about a time when a peer support worker role didn't work out? Or didn't quite fit into the team?
- From your perspective, is or was there anything that could help peer support workers fit into the team more effectively
- How much does feedback matter within NHS culture?

- What would training for non-peers to work with PSWs look like?

Peer Support Worker specific questions

- How do you find working in the team?
- How do you access support?
- Can you tell me about any aspects of your role working you find particularly challenging?
- From your perspective, are there different ways of working within the team?

Distress protocol

If the participant becomes upset, treat such instances with sensitivity and understanding. If the participant is unable to continue, stop the interview, and inform the service manager of the participant's wellbeing. Following the interview, arrange a meeting with the Chief Investigator to discuss the occurrence and to check the wellbeing of the co-investigator.