The Consumer-employee as a New Actor in Industrial Relations: the case of peer support workers in UK NHS Mental Health Organisations

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Introduction

The recognition of consumers as organisational stakeholders has been gaining ground in response to international competition for customers in the private sector. Similar trends are apparent in the public sector with governments pledging to deliver high quality public services that meet the needs and choices of individual users. Further, at a time of growing financial constraint public sector service providers are subject to stringent accountability regimes and pressures to improve service quality and user satisfaction. In response to the latter imperative, some have introduced various mechanisms to secure the expertise of service users and give them greater representation and "voice" in decision making by including them in the monitoring, design, and co-production of services Observers of this expansion in end user involvement have suggested that the separation between the provider and user of services is becoming increasing blurred (Bellemare 2000), and such is their influence that the "consumer" could be seen as a new actor in the industrial relations system (Bellemare 2000; Kessler and Bach 2011). However, empirical evidence for such a contention is relatively sparse: studies of these new forms of user engagement have concentrated on service quality and patient outcomes, (Adame and Leitner 2008; Hodges 2007) and on the problems of transition from consumer to employee (Moll et al 2009) - but few have investigated the impact on employment relations (Kessler and Bach 2011). In this paper we seek to explore this proposition by reference to an empirical study of the employment of service users as peer support workers in mental health organisations in the UK.

In the UK there have been a growing number of innovations designed to harness service user expertise but involvement in the delivery of services has traditionally relied upon the work of volunteers: the paid employment of current service users appointed on the basis of their "lived experience" of managing a medical condition is a novel development Kessler and Bach 2011). This appears to be taking consumer engagement to a different level by creating a new occupational group with the potential to further the interests of the consumer at the point of service delivery. Thus the question as to whether such a group can be considered as representing a new actor in the work place is a pertinent one. However, it is not clear in the literature how an industrial relations actor may be identified, thus we commence the paper by considering how the term has been defined, and the necessary conditions to be met in order to justify this designation. After outlining the research methods we use the findings to assess role of the peer support workers and ask whether the introduction of this new occupational group has furthered the interests of the consumer, and to what extent it meets the conditions for identification as a new actor in the workplace. We end with some tentative conclusions about the future direction and of this role and its likely impact.

For those seeking to assess the role of the consumer as actor in industrial relations Bellemare (2000:386) provides a useful starting point by identifying "influence" (power) as its defining characteristic:

"An individual, group or an institution that has the capability to directly influence the industrial relations process, including the capability to influence the causal powers deployed by other actors in the environment (indirect action)"

"Actors" therefore have to demonstrate agency (action), and impact on process in terms of being able to influence the actions of others. Implied in this definition is that consumers have common interests which are distinct from those of other actors. Applying this definition to empirical studies of the workplace however, may be problematic- how much action and impact is required and over what period of time to justify designation as an actor? Further, individual action and influence alone would appear insufficient. Dickinson (2006:713) for example, concluded that the highly motivated HIV/AIDs peer support educators he studied while successfully exerting influence over individual's behaviour were not "actors" as they were not a conscious leadership group and did not have a constituency to draw on. It could be argued moreover that recognition of the group by other organisational actors and stakeholders as a legitimate player within the system should be added. Thus in assessing whether the emergence of a category of consumer/worker indicates the entry of a new actor in workplace industrial relations it appears that a number of conditions must be met. First, would be recognition of the group by other actors and stakeholders within the system. Second, members should have collective consciousness of belonging to a group and of having common interests. Third, are action, leadership and resources to further the group's interests. Fourth, is evidence of power in the workplace, either directly by action or indirectly by influence (Lukes 1974).

Research Context

The UK Department of health has demanded a radical change in the way in which care is delivered indicating a move towards self care and self management as a high priority (DH 2006a, 2008a, 2008b;). In the mental health sector national "Recovery" and "Social Inclusion" strategies entail greater involvement of patients in their care; recommend service user involvement in care planning, and the acquisition of self management skills (DH 2006b, 2006c, 2008c; Skills for Health 2006). These self care initiatives have been termed a 'cultural revolution' (Pietroni, Winkler and Graham 2003) and 'paradigm shift' (Wilson, Buck and Ham 2005) that challenge the traditional balance of power between patient and professional enshrined in the medical model of care. The implementation of the government's self care strategies therefore necessitates significant change for health and social care practitioners and organisations. The use of service users as peer support workers in the education of staff and service users and in service delivery is advocated as a primary mechanism for implementing this change. In order to further the self care agenda the department of health and local government funded pilot projects in order to demonstrate alternative methods of delivering care. Thirteen of these projects working with four NHS mental health Trusts were included in the study.

Research method

The research was based on our UK mental health NHS Trusts who have developed innovative interventions providing support for self care by mental health service users: a London MH Trust runs peer support groups for people experiencing personality disorder which are facilitated by peer support workers partnered with professionals.; a South of England MH Trust employs peer trainers who train staff and support service users in developing Wellness Recovery Action Plans (WRAP); two North of England Mental Trusts

work in partnership with community organisations providing arts projects co facilitated by peer workers. These peer support workers are referred to in the paper as PSWs. At the four Trusts semi-structured interviews were held with 21 senior managers with varying roles and responsibilities in relation to the projects: managers within nursing, governance, risk management, human resources, medicine, education and training, and PCT service commissioners, some of whom were interviewed more than once over the period of the research. 120 service users across were interviewed when they were referred to the self care support projects, and again nine months later. Qualitative interviews were also held with their informal carers (15), and staff teams working in the projects (including peer support workers) (30). In analysis of the interviews we coded data to a number of themes including, for example, 'new staff roles' and 'peer support'. A secondary analysis identified data specific to the aims of this paper. Documentary evidence on the Trust's organisational strategy and policies, performance and history of the projects was collected. The main study interviews were conducted between 2007 and 2009, with follow up interviews completed by end 2011.The research was funded by the UK National Institute of Health Research SDO programme. The "consumer" was engaged in every aspect of the research process: the core research team included current service user and carer researchers, NHS clinicians and managers, and further, a service user panel periodically reviewed and advised the team at each stage.

Findings

Our first question in assessing the role of the PSW relates to the recognition of the PSWs as an occupational group as this would appear to be a first step to exerting influence in the workplace. In the NHS occupational pay and status is based upon specialist technical skills gained through training, validated by professional qualifications, and enhanced by professional closure. The status of the peer support workers appointed solely on the basis of managing their own condition therefore depends upon the degree to which this expertise of "lived experience" is accepted as a "legitimate", valuable and non substitutable skill. We start by considering the degree to which the PSWs were seen as a distinctive occupation group and acceptance of their expertise by the main organisational stakeholders with whom they interact- managers, professionals, colleagues and service users.

Management

The shift in Government and NHS policy towards engaging and empowering consumers described would appear to validate the expertise and strengthen the position of PSWs. Certainly, the senior manager leading the Recovery strategy in the London Trust saw the introduction of PSWs as part of a national trend:

> *I see it as part of a major culture change not only in mental health therapy...but also to the relationships between citizens and services. This actually falls into a broader consideration of the whole of the welfare state that we're at the moment doing- a huge reshuffling of what we mean by a welfare state rather than a benevolent state telling people what to do. Actually, putting the power within the hands of citizens. (Senior manager London)*

The four Trusts were developing recovery and social inclusion strategies at the outset of the study, and the self care projects were seen by senior managers and the PCT commissioners to

be contributors to their implementation.   Trusts were also undergoing growing financial constraint, and there is cost saving potential in substituting PSWs for professional staff. The introduction of this new occupational group therefore was seen to contribute to meeting two major Department of Health targets for Trusts: to increase efficiency and to improve the quality of patient care.

As many organisational studies have shown, strategic alignment with goals at the top of the organisation does not necessarily guarantee recognition at the lower levels. Acceptance of the new Recovery culture, and of the role of PSWs in delivering it, was less uniform in management at middle and lower levels.

Most managers had experience of using patient "experts" to support the self-care on a voluntary basis but volunteers typically present difficulties for management control (Cnaan, and Cascio, 1999; Grossman and Furano (2000).Their formal employment would appear to be an opportunity for managers to secure this expertise in a more regulated manner. However, some managers still experienced problems associated with voluntary labour and complained about high dropout rates at the training stage, unreliability, sickness, the difficulty of performance managing a "patient", and the added responsibility of knowing when they were well enough to work:

> *I actually find them, as a manager, very hard to work with, … they try to hide always behind this blanket of you know, 'I am the patient' type of thing, but at the same time, we are paying them, ... Their sickness is high... when they don't want to do something, they don't want to do it (London Service Manager).*

> *For me the manager, there is a balance between supporting and helping staff develop to move on and also preventing them from sort of flight health... where they will just agree and they want to be doing well and they think they can cope and they go to sleep one night and they crash, and have…a personal crisis, so it's a very difficult"… (South service manager)*

Others however, saw the virtue of having a plentiful supply of labour with a wide range of skills:

The advantages are that ... you've got more people to do more things quite basically. You're drawing from a larger resource pool of skills as well because your staff are service users as well, so it's unlimited really. (Project manager South)

The employment of current service users was a major challenge for the HR departments: the role does not fit into formal pay bands or job specifications, the workers are self selected, unqualified, usually without recent employer references or Criminal Record Bureau clearance, and with restricted availability for work. They were in consequence only employed as temporary staff which gave them flexibility but placed them in a marginal position vis a vis core workers. Risk managers also had difficulty in developing acceptable procedures in this potentially dangerous environment and restricted the scope of the new role.
Thus acceptance of the role by managers outside the projects was variable. However, they received a great deal of support and protection from the project managers, and the Trust senior managers responsible for them. They put in considerable effort to protect the PSWs from hostility to the role, sort out the problems with employment contracts and deal with the tensions that arose.

Professionals

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The PSWs enjoyed the support of the majority of professional colleagues associated with the projects, but responses from other professionals ranged from being very supportive to downright hostility, especially clinicians:

> *we had two doctors on and they did challenge (professional colleague) quite a lot and me, like one of them asked me what medication I was on and that's absolutely inappropriate, and you know, "when's the last time I had a panic attack? . It was almost as if they were trying to demean me (PSW trainer London)*

> *[Recovery] challenges people in powerful positions, and traditionally psychiatrists have been very powerful. That's not to say that individual psychiatrists are not adopting this approach, because I know many that are. But organizationally, that's going to be difficult (North Senior manager).*

> *in the back of their mind there are always some people who are quite resentful. to be fair to some staff they feel very vulnerable and uncomfortable and I think the way they have been taught and trained and worked makes it feel very uncomfortable sharing it with the service user' (North team project member).*

Issues were not confined to clinical staff. PSW's in the London project also reported difficulty with social work staff they encountered in the community who resented intrusion into their territory:

> *I think you've got some staff who actively support me ...and you've got other staff who are quite resentful that I'm changing or trying to get them on board to change outside their 9 to 5 box ... you've got some staff who actively encourage clients ... to actually baulk against that change. And you can't prove it but it's fairly obvious what's going on* (North project service manager).

Colleagues

Project staff came from a range of backgrounds-clinical, occupational health and social work and joined the projects because they were fully committed to their objectives and to the PSW role. . For many of them working with the PSW was an essential and rewarding aspect of project work:

> *The success of the couple of people that have been facilitators is, has been really satisfying job wise. Working with people in a way that respects their experiences, it's not only empowering for them, but it's empowering for me, because I don't have to take on everything' (South team member).*

> *... people who're involved in the project, who also happen to be service users, I'm working alongside those individuals as my colleagues so I'm not working with them in any other capacity other than on an equal footing, and they're my colleagues (South team member)*

Even so, some reported difficulty in adapting to a different relationship with them:

> *It was challenging because you're in a role in a group where your role is a caring one...To then be in a situation where you're then someone's colleague, it is challenging to kind of shift to "you're not my patient, I'm not caring for you, and you're now my colleague' (South team member)*

> *I think it requires quite a big shift, because I think no matter how enlightened we think we are there is still a huge divide between service users and staff. And it's, yeah, particularly when you've got a service user running the group with you as well, they're in this sort of 'no-man's-land'. They're not quite staff, they are staff, but they're not quite the same, because you can't share certain information with the service users that you might with other staff. (London team member)*

Project team staff were responsible for training PSWs and for their wellbeing. There were issues about the rules preventing staff divulging personal information to service users, having access to patient records and working alone. These rules restricted the relationship with colleagues and their deployment, and imposed a significant additional workload which had prompted some team members to leave.

Other colleagues not directly recruited to the projects, varied in response: some found it difficult to accept working with service users as colleagues, and staff response to training delivered by them was not always favourable:

> *In the back of their mind there are always some people who are quite resentful... to be fair to some staff they feel very vulnerable and uncomfortable and I think the way they have been taught and trained and worked makes it feel very uncomfortable sharing it with the service user' (North team project member).*

> *'You definitely need to be very open and very clear that this is the service user that runs the show with you, and that is quite a change. And there are a lot of staff I think, that aren't particularly comfortable with that' (South team member).*

> *There's a bit of conflict between the project] and [Community Mental Health Teams... they've got this slight power thing ... they're not working together ... they won't liaise together ... I think the project] are a bit of a pain to them (London service user).*

Colleagues working within the projects fully accepted the PSW role and its contribution to the new approach to care. Acceptance by other colleagues, including some in the social services, was less certain.

Service Users

Service users identified with the PSWs and felt that when PSWs disclosed their own mental health issues this gave their advice and guidance credibility. However, service users were not

always sure what the PSW's role was and were anxious whether they would have the clinical competence necessary if they were in crisis. Thus while they generally valued the PSW support role they did not see it as a substitute for professional expertise. There was some indication that carers felt their own role as the "life expert" was being usurped by the PSW and question whether they might not have "their own agenda ":

> *It's a hearts and minds situation in relation to other users and carers and their concerns ..... if asked what do you think about peer support workers they would probably say ' I want somebody who actually knows what they're doing, I don't want somebody else who's got mental health problems to help, I need somebody who's a doctor or a nurse to kind of help me move forward in life'. Carers feel the same."* *(Senior manager London)*

> *'... they are not judgemental ... it feels less formal than with doctors or therapists ... it just seems more of a genuine relationship. Service user London '*

Generally, service users saw PSWs as a valuable enhancement to their care and accepted the role. However, they did not see it as a credible substitute for professional staff.

PSWs

Thus recognition of the PSW role by the key stakeholders was not uniform, except by senior management and staff within the confines of the projects. The second question to be addressed therefore was whether the PSWs identified themselves as a distinctive group with common interests. Motivation for the PSWs to take on the role varied. Some saw it as providing the experience, references and confidence necessary to get back into the labour market, others, as way of assisting their own recovery, and only a few as a possible career within mental health services.

> *I think that the experience I've been through can be of help to others who are going through it. And that's what I want to concentrate on now is helping others through their illness. (South PSW*

> *My true motive for doing what I'm doing is to help out and my benefit, and that in itself is a really good medicine 'cos it's helping me. I'm getting through quite healthily (North PSW)*

> *I'm thinking of going back into the classroom as a learning support assistant. ...so I could take my um, experience into the workplace. I'll probably be able to work better with children than I could before. Because I'm more flexible; I've learned to be more flexible (PSW South)*

> *with having a nursing background I thought well I'd like to become a team member again, and I was very interested in people having a say and the ability to have a voice and I thought the project gives a voice to people like us and I think that's amazing (London PSW)*

Thus the PSW's interests in terms of what they hoped to gain from the role were not uniform, and most saw it as a temporary stage on the road to recovery. The last quote was from the only PSW who saw herself as some kind of service user representative. The majority said

they felt cut off or distanced from service uses, having stepped over some invisible line. They were therefore deprived of the support of other service users that they have formerly enjoyed. This also made them dependent on professional colleagues who were the main source of support for the PSWs:

> *A he's working with people who are fellow service users and he was a bit apprehensive of how people would take to that because he's now a worker as well ….it very difficult for him to actually have to go into the area where everyone knew and he was like on the other side of the fence (team member North)*

> *From becoming a service user to part of the team, you have to change your attitudes and values completely (London PSW)*

There was some confusion in terms of identity and difficulty in making the transition from service user to staff. It was acknowledged that that shift in identity – from service user to staff member – was neither easy, and nor was the dual identity as a service user lost. The PSW was often left in a difficult dual role, described by one project manager as a 'no-man's-land' between service user and staff identity:

> *It's quite a hard place to be in that middle ground and being not quite professional, not a service user (London Peer Worker)*

> *I wouldn't say that I feel completely like I'm a member of the team, who are liaison workers. I guess I'd still feel somewhat inferior , I don't know, how I'm seen by the team or by members... I don't let it affect me too much (London PSW)*

Some however, embraced this new identity with enthusiasm:

> *When ... you're presenting there is a degree obviously to which you have to be professional ... how much do you disclose about yourself, and how you conduct yourself? But service users, in my experience, fall quite easily into that role. And professional conduct is something that is covered in the training ... I do feel like a professional when I'm up there (South PSW)*

Despite some variation there was little indication of a common PSW identity and set of interests, except a desire to help others and to maintain their own recovery. Beyond this, they did not see themselves as some kind of formal patient representative - activities of this kind were performed by the permanent professional staff rather than the PSWs. Leadership in terms of progressing the interests of service users was clearly in the hands of the project managers who worked tirelessly for radical change in the service user- professional relationship (see Gillard, Edwards et al 2010).

Impact

Finally, we turn to the question of impact in the workplace and how far PSW's directly or indirectly influenced other actors. At first sight, they appear to have few resources to draw on. Employees who are also service users are particularly vulnerable owing to a dual dependence on the organisation as both an employer and provider of care. The PSW role still has to be fully integrated into the organisations with standardised terms and conditions of employment, career structures and formal training. They are also very dependent on co-

workers for training and support, and they have yet to be fully accepted by professionals, middle managers and service users. They are not union members in a highly unionised environment and rely on project managers for leadership and action to resolve problems for them. Their value to middle and lower managers is also far from clear: problems with duty of care, managing risk and performance management were apparent. Furthermore, the skills PSWs possess are in plentiful supply. Thus their position in the workplace at this stage would appear to be that of a marginal group of workers with no leadership and collective identity, who were easily substituted, and had little status - a theoretically weak position from which to exercise power or influence in the workplace. Nonetheless, there were aspects of the context that enhanced their position and discernable outcomes that can be attributed to their role.

First, there is evidence from the longitudinal study of service users that the projects were succeeding in improving patient satisfaction and outcomes with this new approach, and that the PSWs were a contributory factor (Gillard Edwards et al 2010). Second, evidence of influence on staff was also found. Project staff explained that PSWs brought insight into the needs of service users that would otherwise be lacking:

> *We've certainly found it helpful having a service user, a service who is also a member of staff because it's, you know it's given us quite a lot of insight into how it feels to be on the other, on the receiving end really (North team member)*

> *The PSWs are very good in pointing that out because they don't have a professional background, so they tell us off, and they will say 'why did you contact Dr such and such? Was that really necessary?' and 'you're doing your risk thing' ... I really struggled last week because I wanted to contact somebody's care coordinator because she was quite suicidal in group and they said 'Were you doing that just to make yourself feel better?' (London project manager)*

Positive impact then was evident on both project staff and service users. However, at the time of the study the effect on mainstream services was limited. Nonetheless, the senior Trust and commissioning managers who had sponsored the projects were in no doubt of the beneficial impact on service users, and the contribution this made to implementing Recovery strategies. In consequence, some projects won financial that secure their future and consolidated the experimental role of the PSW as a permanent one . Enthusiasm for the use of PSWs was most marked in the London Trust where Recovery strategy implementation was most advanced. By 2011 the culture of mental health care had shifted considerably, and the benefits of "self-care" were more generally accepted. Government pressure for culture change and efficiency was also growing. In 2011 the London trust extended PSW delivered recovery training to all staff and was planning to substitute up to 50% of mainstream professional staff with PSWs. The cost saving potential of this move was explained by a senior manager:'

> *We are wasting the resources, wasting expensive professionals. It costs an awful lot to train a nurse or a psychologist or a psychiatrist. And if they spend chunks of their time helping people to wash their socks or filling DLA forms, both of which they're ill equipped to do, we are actually wasting money. (Senior manager London)*

The PSW role there was seen to contribute to meeting two key Government targets. Thus a combination of change in the culture of mental health care, Department of Health policy, and the strategic response of the Trusts to it enhanced the potential position of the Peer support role.

Conclusion

The introduction of the PSWs can be seen both as a consequence of a change in the culture of mental health care and a means of pushing it forward. At the national level the influence of the end user is clearly visible with the NHS issuing strong strategy directives to health and Social care organisations in relation to the personalisation of services and consumer empowerment. There were also external pressures to improve efficiency whist maintaining quality of care. . The projects using PSWs were seen by senior managers as an important contribution to meeting these externally set targets. Strategic alignment with organisational goals therefore was their main potential source of power. However, the need for change in culture of mental health care had not been accepted by all professional staff and managers at the Trusts. Nor did they accept the PSWs were necessarily the best way to achieve it. However, the projects were successful and by the end of our study were beginning to make a wider impact on the Trusts that employed them.

Currently, the PSW role does not satisfy the criteria for designation as an actor identified at the start of the paper. However, as acceptance of the Recovery culture and approach grows so the factors that we have found impeding the impact of the PSWs might be expected to diminish. The introduction of University accredited qualifications and training schemes promises to validate the expertise, and clarify the identity and boundaries of the role. The scope and numbers employed in such roles is expanding and thus may be a target for unionisation. Nonetheless, several factors may constrain expansion. First, is resistance amongst service users against the substitution of PSW's for professional workers. Second, is the vulnerability and dependence of the PSW on these colleagues who may withdraw support in the face of increasing workload and reduced job opportunities as the numbers of PSWs grow. Fourth, is the question as to whether this group will develop a common identity and interests associated with a long term commitment to the role. Finally, if they do develop as a distinct occupational group, will they take on leadership to further the interests of consumers, or, pursue diverse personal goals and remain just one mechanism for delivering a service user orientated approach to mental health care?

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