Final report

November 2017

Innovating for Improvement

Peer Supported Open Dialogue

Kent and Medway NHS and Social Care Partnership Trust

The Health Foundation

Project title: Peer Supported Open Dialogue

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Part 1: Abstract

Open Dialogue is a novel approach to mental health care that derived in Finland in the 1980s, and has been adapted for the NHS by the inclusion of peer support workers. Current treatment models often see high hospital admissions and use of psychiatric medication. Adult mental health care is predominantly individualised treatment and often means seeing a number of different clinicians and services. Open Dialogue [1] asserts that people and their family or social networks are seen within the first 24 hours of crisis, and see the same clinicians throughout their care; hasty treatment decisions are avoided and all discussions are held in their presence. Research from Finland shows that this approach can lead to reduced relapse rates, lower medication use and increase the chance of employment.

In Kent we launched the first Peer Supported Open Dialogue POD service into the NHS on 1st February 2017 and sought to evaluate its effectiveness. To date we have seen over eighty clients and their networks. Despite initial low research uptake, we are beginning to see encouraging results, particularly in terms of satisfaction of care and low hospital admissions.

A challenge to launching this service has been gaining agreement to staff the service from within existing resources, without clear UK outcome evidence or national benchmarks. Board and executive level commitment, along with amazing staff dedication, led to the launch, and produced growth and development which have begun to yield results. This sets us on track to embed POD as mainstream in Mental Health care.

Part 2: Progress and outcomes

The aim of this project was to implement and evaluate a Peer Supported Open Dialogue (POD) service [2] in the NHS. POD is a UK adaption of Open Dialogue which originated in Finland in the 1980s. It combines a specific organisational structure and a distinct form of therapeutic conversation and produced impressive results around hospital admissions, medication use and return to work. The UK adaption includes the involvement of peer support workers as integral to the team.

The seven key principles of Open Dialogue are:

- **Immediate Help** – first meeting within 24 hours
- **Social network perspective** – family and others in network
- **Flexibility and mobility** – e.g. allowing possibility of daily meetings during acute crisis
- **Responsibility** – first person to respond to referral takes overall responsibility of treatment process
- **Psychological continuity** – for as long as is needed – can involve other forms of treatment e.g. individual therapy
- **Tolerance of uncertainty** – hasty treatment decisions are avoided including medication and hospitalization
- **Dialogue** – all voices are equally heard without direction

To be faithful to the model the service redesign was to have a standalone team that straddles the current treatment pathways of Crisis Resolution Home Treatment (CRHT) and Community Mental Health Treatment (CMHT).

Prior to the project 35 staff in Kent and Medway Partnership Trust (KMPT) had been trained in POD. The POD service was successfully launched on 1st February 2017 with 9 clinicians and has currently treated over 80 clients.

We have monitored model fidelity and quality from the start and launched an NIHR portfolio research study (CPMS ID 31831, IRAS No. 211010). We set out to recruit 50 clients but this required following the research consent process at the point of crisis and due to low number of recruited participants we changed the research protocol to enable a later consenting process. A cohort of 20 participants were recruited prior to the protocol change. We will continue to recruit a further 30 using the amended version (Appendix 2).

Significant adjustments to original project proposal

It is important to note that it was originally our intention to operationalise a team in two localities, Canterbury and Medway. The major challenge of the project has been to transfer trained POD clinicians out of their role into a POD team without extra funding and relying on our ability to evidence innovation and sufficient clinical activity. As a result we managed only to operationalise a team in the Canterbury locality. This in turn also had an impact on the recruitment of research participants.

Extension to project

Given the slow early recruitment of numbers to the research we requested an extension from The Health Foundation with no implication of funding. This was granted on 26th July 2017 (see appendix 3). Health Research Authority have also granted an extension to the study (see appendix 3). As a 6 month follow up is required a final updated report will be provided to the Health Foundation in June 2018.

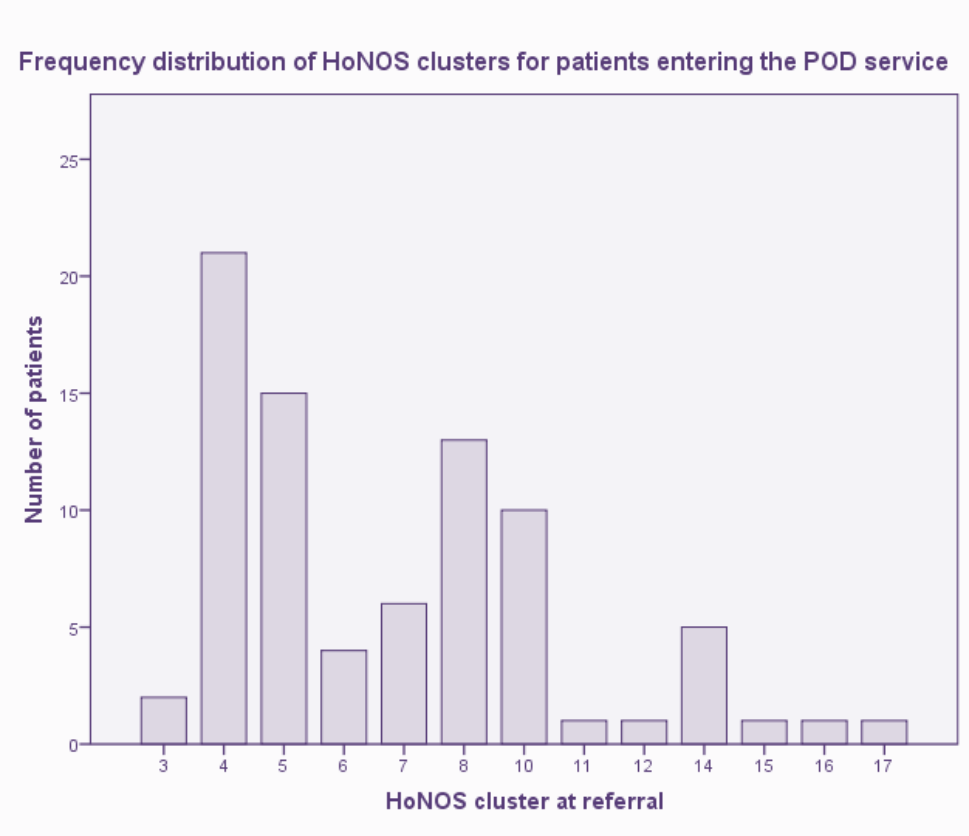
Results

At this early stage the results have been very encouraging. Mental and social wellbeing improve significantly with this service, along with the support that carers receive. Using the standardised Community Mental Health Survey the POD service is rated higher than both the local NHS Trust services and the National average.

Demographics

As part of the internal service evaluation we have examined the illness severity and hospitalisation rate of everyone entering the service, shown below. The Health of the Nation Outcome Scales (HoNOS) [3] are used routinely to evaluate symptoms.

Table 2.1: HoNOS Clusters for POD clients



From table 2.1 above we can see that the most common HoNOS clusters for patients entering the service are 4 and 5, followed by 8,10, 7 and 14; explained in Table 2.1.1.

Table 2.1.1: Explanation of HoNOS clusters

Most common HoNOS clusters within the POD service		
cluster	**type**	**definition**
4	Non-Psychotic (severe)	Severe depression, anxiety or other disorder. Increasing complexity of needs. Unlikely to improve without treatment and may deteriorate.
5	Non-Psychotic (very severe)	Severe depression or anxiety or other disorder. Including recurrent depressive disorders. May have strong unreasonable beliefs.
8	Non-Psychotic chaotic and challenging disorders	Wide range of symptoms, chaotic and challenging life styles. May include diagnosis of Personality Disorder.
10	First Episode Psychosis	Presenting to service for first time with mild to severe psychotic phenomena. May have anxiety/depressed mood and/or other behaviours.
7	Enduring NonPsychotic disorders (high disability)	Moderate/severe disorders thatare very disabling. Problems are enduring, chronic and complex.
14	Psychotic Crisis	Service users experiencing an acute psychotic episode, cognitive problems may be present. May be vulnerable and a risk to themselves or others.

Primary outcome: overall hospitalisation data

In the 24 months prior to referral to the POD service 19% (16 out of 84) of the patients were in hospital for a total of 362 days.

Following referral to the service 7.1% (4 out of 84) of the patients were in hospital for a total of 183 days.

Secondary outcomes: consenting research participants

The first cohort of 20 participants was split equally across gender (10M, 10F) with an age range from 18 to 61 years with the average age being 30. Participants completed questionnaires on mental wellbeing [4], social impairment [5], experiences of mental health services [6] and carer support [7].

Table 2.2 : Mental and social wellbeing of clients plus carer support

	Baseline		3 months		6 months	
	mean	SD	mean	SD	mean	SD
Mental Wellbeing	18.00	4.63	23.75	5.71	26.00	2.94
Work and Social Impairment	23.10	10.65	15.27	8.92	13.00	7.44
Carer support scale	43.09	5.72	48.33	3.08	50.25	0.96

The above numbers are indicative of the success of the service but are not conclusive due to the ongoing data collection.

Community Mental Health Survey results

One of the simplest ways to compare the service to other mental health services is to look at the results of the National Community Mental Health Survey.

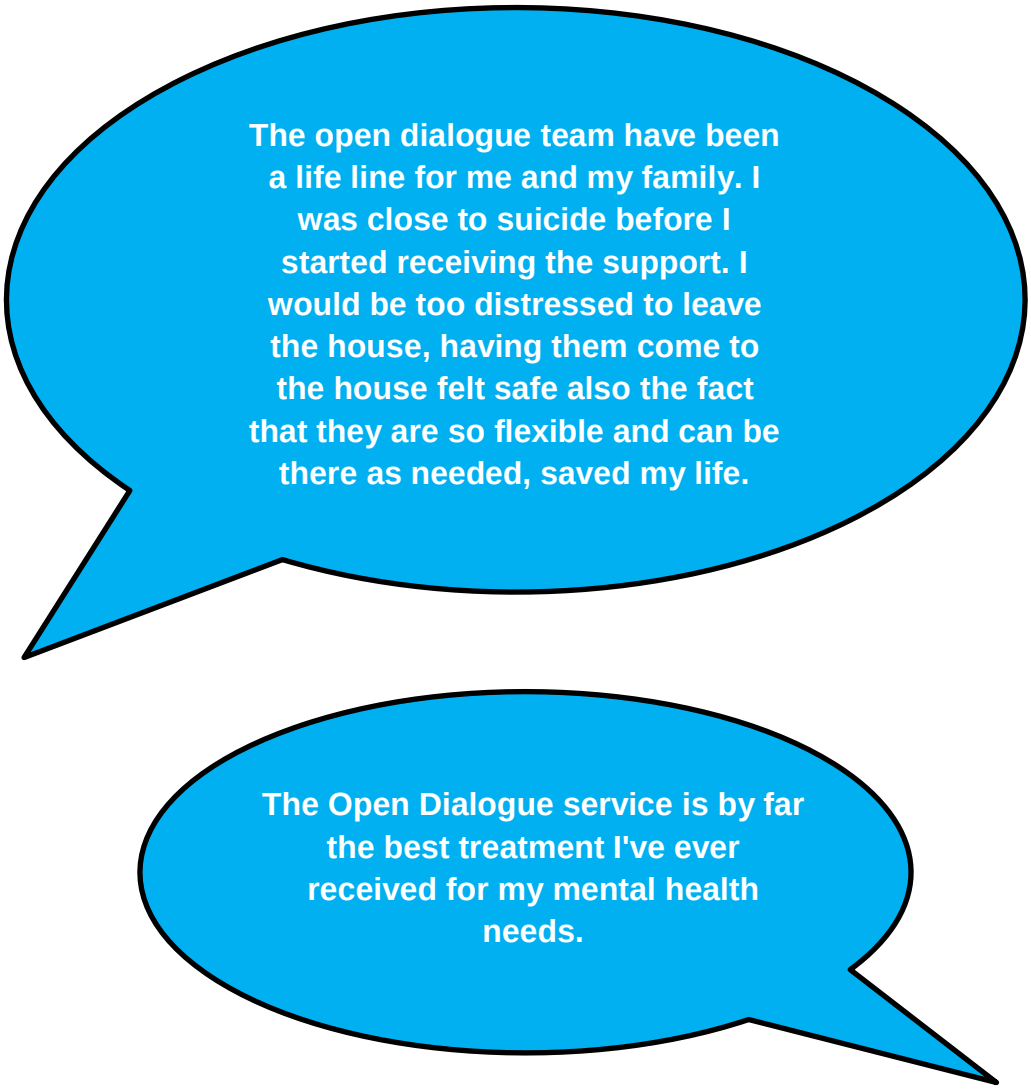
Table 2.4: Community Mental Health Survey comparisons

	Question from the Community Mental Health Survey	2016 National score	2016 KMPT score	2017 POD score at baseline
Overall	Overall, on a scale of 0 (I had a poor experience) to 10 (I had a good experience)	6.97	6.45	8.90
Contact	In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	6.19	5.27	7.75
Family	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	6.77	6.70	9.71
Listening	Did the person or people you saw listen carefully to you?	8.15	7.30	9.50
Help	Do the people you see through NHS mental health services help you with what is important to you?	6.44	5.64	9.00
Time	Were you given enough time to discuss your treatment and needs?	7.59	6.95	9.75

Views from service users

The comments from service users revealed themes of previous unsuccessful or unhappy experiences with mental health services and the incredible contrast

that Open Dialogue was. Another recurring theme was their happiness and surprise that the team would come to them in their own houses as needed.



Ongoing work

A series of focus groups have also been conducted examining the thoughts, feelings and opinions of clinicians and managers regarding the implementation of the POD service a full qualitative thematic analysis of these will be conducted. A few early messages that emerge from these however are:

- **Tensions between POD and established services.**

"I've always seen this as a balancing act between developing the service and trying to incorporate it within an existing service."

"It's about that tightrope walk to try and ensure that the Open Dialogue is developing whereas at the same time making sure the other service is there as a safety net."

- **Role of Peers**

"Meetings have opened up and trusts have been built when people realise that you've struggled yourselves."

- **Clinician's experience of working in POD**

"It feels the most authentic way of working that I've ever done professionally."

"From what I've seen people really like this, people feel heard and they feel like active participants in what's taking place."

Further quotes can be found in Appendix 4

Part 3: Cost impact

The POD service is internally commissioned and paid for by KMPT, through an agreed Business case. A financial evaluation of the project has not formally been conducted but yet remains a difficult but hot topic. The three key challenges to financial evaluations are:

a) There are no national benchmarks for Open Dialogue in the UK

b) The specific organisational structure of the model seeks to seamlessly overlap two distinct services provisions; namely crisis mental health care (Crisis resolution home treatment Team - CRHTs) and Recovery mental Health care (Community Mental Health teams – CMHTs). Therefore to financially evaluate this project with current treatment models requires either a longer period of evidence to gather data on full treatments or to clinically, but relatively arbitrarily, section up the aspects of Open Dialogue Care

c) Our hypothesis remains that clinical and financial benefits are multi layered and wide (e.g. Extending to family or social network mental, physical and social care). Full financial implications therefore require both longevity of treatment model and a broad reaching health economic analysis. We are aware that the national RCT will conduct a fully commissioned heath economic analysis.

Notwithstanding these points it has been important for us to attempt to financially evaluate this project as best we can.

Implementation costs

Implementing the service has involved training of current clinical staff (£4250 per person) and negotiating the moving of staff from their roles to the new service. This has saved on recruitment costs directly incurred by this service but passed these on to their old services to replace them.

Team costs

Current team (total caseload – 120) - £321,526 for 7.58 whole time equivalent (wte) staff however this does not include other clinical staff currently inputting into the service as additions to their other roles. Due to the overlap of roles (eg. for the CRHT Consultant Psychiatrist) it is difficult to be clear what these extra costs are.

Fully funded team (total caseload – 150) – £569,950 for 13.20wte. We recognise however that with spread we would benefit from some economies of scale.

High level review

From our clinical experience obtained since the launch we believe that if we remove training costs, the service is more expensive than existing pathways in both the early stages of implementation and treatment. This is mainly due to the need for two clinicians to be so flexible in the early crisis phase which leads to lower capacity than teams operating traditional models of care. Furthermore, the length of sessions can be extended early on in line with the model.

We remain confident however that a broad look at financial costs could indicate that in the medium and long term it will be more cost effective than existing pathways. This is based on an early clinical sense that hospital admissions and medication use are indeed reduced compared to traditional models of care.

Despite initial high training costs during the 'spread' phase we would greatly reduce costs by commissioning shorter training or providing in-house training.

Part 4: Learning from your project

Undertaking a project of this type and size has produced a great number of lessons for us to take forward. At the start of the project we hoped to operationalise a standalone POD service and evaluate it. The size and coverage of the service has changed since the project started in November 2016 due to organisational and financial challenges. Thus the initial vision of the service being developed in two distinct areas was changed to one operational team in Canterbury. In terms of evaluation we have only partially achieved what we hoped as described above.

Important Individual or Group Contributions

For us the main enabler was organisational support through all layers of the organisation, from the CEO and Trust Board to frontline operational staff, but it is difficult to envisage the project achieving as much as we have without the steadfast commitment and support of the Executive Medical Director.

Client buy-in has been maintained through carer and peer support worker leads engagement with 'service user groups'. The commitment of staff has been helped by the fact that it was a self-selecting staff group and momentum between training and operational team was assisted by POD clinicians carrying 'training' cases to maintain skills.

We started our steering group for this project approximately 3 years ago and it has been a critical communication link between different parts of the organisation and also for the governance of the work. We have ensured that the make-up of the group has also included the voice of the service user/peer worker and carer/family to help us keep closely aligned to the principle of co-productive development. Commitment and cohesion in this small group of people has played a hugely significant role in ensuring momentum, visibility and strategic planning.

Policy that helped

The national Five year forward view (FYFV) and development of the Sustainability Transformation Plan (STP) in Kent have been key policies that have helped us. We sought to promote Open Dialogue as a new model of care that contributes to the overall transformation of care within the Kent health and social care economy. We have been keen to show how the family/ social network approach to mental health promotes inclusivity, shared decision making, collaborative partnership working and a normalising of difficult emotional states.

The service user and carer forums in Kent have been supportive of this innovation and have helped us consider ways in which families/networks are assets to the delivery of care and support.

What proved tough?

Predictable Risks

We were aware that with no new money, transferring staff out of stretched services to a new service without concrete assurance that like for like activity being achieved was a predicted risk. We attempted to mitigate against this with robust business cases with different information and returned to the clinical benefits of the model, using clients and their family networks to describe their experiences to key audiences. One Board member during a presentation to the Trust Board said “it certainly passes the pinch test”.

Unexpected challenges

The changing picture of the workforce and financial challenge could not have easily been predicted in advance although we were always aware that this innovation was being launched during difficult organisational times both in the NHS and for KMPT.

In order to overcome these challenges we took opportunities where appropriate to present and negotiate a new position, accepting that it was not what had been originally envisioned. This led to an organisational agreement in October 2017 to fund the existing service for a period of another 12 months with the expectation that there will be good qualitative and quantitative outcomes in a year’s time to justify the continuation of the project.

Culture that served as a barrier

The culture of existing services that are under pressure and with staffing challenges has meant that questions have been asked about whether this is the right time for this kind of innovation. Thus we have ensured that engagement with teams or services that interface with the project have been maintained to continue an atmosphere of collaboration and focus on best outcomes for service users and their families.

Feedback that surprised us

On reflection perhaps it shouldn't have been a surprise to learn that there were pockets of dissent, scepticism and envy across the Trust from frontline staff through to care group directors. This came in terms of both the efficacy of the model and the notion of a new service with 'protected' or capped caseloads.

What we will take away?

What we take away is that for an innovation to be accepted there needs to be clear rationale as to why here and why now. I am not sure we thought this through sufficiently at the beginning and instead the work grew incrementally. This can be seen as good in terms of evolving organically but takes greater communication to keep all parties involved and remaining supportive.

We also learned that despite the existence of specific commonly understood processes in the organisation to be followed for innovation to occur, the underlying politics of the organisation mean that commitment from key individuals and positions ultimately lead to success. This commitment has predominantly revolved around a keenness on the part of the Executive medical director and Chief Executive Officer to argue for this innovation in Executive and Board level meetings, despite at times strong opposition due to lack of UK evidence of the model.

If only we knew

One important 'carrot' which helped to establish the training and service was the promise of the national, multi-site RCT in Open Dialogue. On reflection we were naive as to the length of time it takes to bring such a major trial to bear. Knowing the length of time this and other aspects of innovation take would have helped manage expectations both at a staff level but also for the organisation.

What others would need to know?

We would list the following things that others would need to put in place to implement a similar project:

- Ensure full commitment of clinical and managerial experts
- Have the championing voice and commitment of an Executive board member preferably medical or nursing.
- Train good staff well and ensure model fidelity remains upper most

Part 5: Sustainability and spread

The POD service will be sustained beyond the funding period. Support for this came from a collective Trust wide decision to invest in this innovation for the forth coming year. The Trust recognise that this model of care meets both the strategic direction of the Kent Sustainability Plan (STP) and meets the Trust objectives to carry out innovative research in the form of the national NIHR Randomised Control Trial (RCT). Aware of the risks and the benefits, a commitment was made in October for one year of funding for the team on the condition that internal evidence will be produced within that period and now awaits the RCT research evidence.

External interest and Recognition

External interest and recognition have come in the following ways:

AWARDS:

- Positive Practice Mental Health Awards (13/10/16) – Highly commended in the Crisis Care Pathway award
- Social Worker of the Year Award – Yasmin Ishaq – Creativity and Innovation (Open Dialogue) 25/11/16
- Finalists in Kent, Surrey & Sussex Leadership awards – 1/3/17
- Parliamentary Reception at Westminster for Social Work Award winners 16/3/17

CONFERENCES:

- 'Best practice event' for all staff across Kent, Surrey and Sussex funded by Health Education England (20/3/17)
- Present at national Open Dialogue conference (22/3/17)
- Presented two workshops at the International society for psychological and social approaches to psychosis (ISPS) international conference 28/8/17 to 2/9/17
- Presentation to the Approved mental health professional service for the North West region – 13/7/17

- Presentation to the National Welsh Early intervention for psychosis (EIPS) conference – 18/10/17
- Visits to the Kent team from Australian clinicians (6/6/17 and 2/7/17)
- Visit from Hackney EIPS – 6/17
- Learning Event hosted in Kent for Camden and Islington, Barnet, Enfield and Haringey and NELFT. 11/10/17

PUBLICATIONS:

- Two journal articles accepted in 'Context Magazine'. 1st published - 8/17
- Media/ FILMING:
- Open Dialogue in Kent in Kent STP launch video
- Member of POD team featured in BBC 2 documentary on hearing voices. Publicity for this lead to Kent POD team mentioned in credits and on breakfast television
- Filming completed for promotional videos, editing in progress. Link to supervision video to be used at the ISPS conference - https://www.youtube.com/embed/4DIDWkfiS6Q

Community and networks targeted

We have targeted local MPs, Clinical Commissioning Groups, GPs, Mental Health Action groups, Rethink and Mind groups. This has involved either individual meetings or short presentations. Our carer lead, Annie Jeffrey, who has long established relationships with many of these groups, has been instrumental in gaining access to meeting agenda both around Canterbury and in Kent.

Spread beyond the Innovating for Improvement site

Scaling up and spreading this model is a key work stream of the national RCT trial. This includes developing accessible and cost effective training in the model. As the first UK service here in Kent we will provide significant input and expertise into this. Locally we have plans to spread this model to other sites across Kent, and the potential to bring training in house. However, these will be

largely dependent upon good RCT evidence as well as local clinical and financial evidence.

We have also developed close links with Health Education Kent, Surrey and Sussex, and with the support of some training money we have offered a 'best practice event' to all three trusts. We are also expected to provide some training directly to these Trusts, including the specifics of how to operationalise this change in an NHS context.

Additional resources required:

- To achieve our plans to spread this innovation we will need dedicated business informatics to focus not just on clinical effectiveness in our immediate vision but also to evidence the potential savings to the wider health economy. This will be sought from our Trust initially and form part of discussions with our Clinical Commission Groups.

- We will need to fund dedicated clinical leaders to explain and train staff and external stakeholders on the model and most importantly monitor the fidelity to the model as scale is achieved. We are passionate about the elements of the model not being lost as size and scale grows. This will be sought from our discussion with Clinical Commissioning Groups.

- We are very mindful of the fact that, as the focus of the model is on family and social networks, we are part of a national and international 'family' network of open dialogue initiatives. We therefore will require some time and financial resources to connect with national and international partners whether through conferences, skype meetings or journal publication.

- We have benefitted greatly from publicity and marketing of our innovation including conference presentations, national awards, media coverage and journal publication. We will therefore require additional resource to develop this as we seek to spread the model both within our organisation and to other organisations.

- We have also greatly valued our partnership with The Health Foundation and Springfield Consultancy in guiding us through this journey. We will therefore be seeking to continue this connection by applying for further support in spreading this exciting innovation.

Appendix 1: References

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Appendix 2: Focus group quotes

1. Senior staff and service managers (POD Steering Group)

Preliminary emerging themes:

Operationalising the team was not a concern at first.
"Initially we had the focus on the training without really much idea of how we were going to operationalise."
"We didn't know what the issues were likely to be until we'd got partway into the training."
"I don't think we did know at the end of the training what the operation would look like."

There are tensions between OD and established services.
"I've always seen this as a balancing act between developing the service and trying to incorporate it within an existing service."
"It's about that tightrope walk to try and ensure that the Open Dialogue is developing whereas at the same time making sure the other service is there as a safety net."
"I would see this as a paradigm shift in the provision of mental health care in psychiatry… you are really testing the stability of the psychiatry model and really challenging that. At times that's opened doors and at other times it's had doors shut for us."
"In order to transform you have to let go of some of what you're trying to sustain at the same time and it's a real tension. For this innovation to gain traction some of what we, as an organisation, want to sustain has to shift and maybe that is the tension of transformation?"

There is no evidence base for OD.
"There isn't a robust evidence base."
"Innovation requires the operational directors to hand over some money to do something that we don't have an evidence base for."
"This is all based on a punt isn't it, there is no hard research evidence that says that this will give you wonderful outcomes."

Staff wellbeing is important and a concern.
"We're dealing with some really difficult feelings in clinical supervision which I had never seen dealt with in clinical supervision in the way that we're doing it now."

Creating the OD service was difficult.
"I don't think we would have created the service if there wasn't this core group of very committed clinicians and staff."
"I don't think we'd have got this far if we hadn't won our Health Foundation bid."

There are financial issues.
"How much resources can get allocated to Open Dialogue as opposed to traditional service is a big discussion that's still being had."
"There is no additional money to innovate."
"It's been a really tricky time within the health economy in the last twelve to eighteen months, there's nothing to spare anywhere, so the fact that it's kept going has really been an achievement."
"We do have a small team but we don't have the budget for that, we're relying on an overspend in another budget to have that small team."

There are both threats and facilitators to sustainability.
"Any threats to the continuation of this service are held by how embodied the service already is in the organisation… that's what will keep it safe."
"I've worried about the sustainability of it because it's such a small service and all you need is a couple of key people gone and I think we'd really struggle."
"There are some risks to sustainability but I've started to comfort myself in going over a tipping point when I think the organisation took Open Dialogue as their flagship, kudos building thing to shout about."

"It meets what patients and carers need and it meets what staff need so it's being used as something to shout about in the midst of this despair."
"We're beyond the tipping point now so that's where my confidence in the sustainability is."
"It is good but it is fragile I think, the whole thing, and it does worry me at times."

POD is different to other services.
"I think it takes a different type of confidence as a clinician to work in an Open Dialogue model than it does if you're working in a system whereby you take responsibility for service users more."
"This model promotes a much more genuine shared responsibility… what we try and do is maintain holding the shared responsibility to a much higher level,"
"Some of the people who were working in the Crisis team previously have struggled within the Open Dialogue team because there hasn't been the systems and processes that are within the Crisis team."

The service's support from the Trust is unclear in the event of an SI.
"If there are concerns or things don't go as planned will the support be there for people, on an individual level are the clinicians going to be supported?"
"I was thinking, if there was a high profile death whether people would run scared."
"At the point of an SI, what will be brought into sharp focus is how we are supported by the wider organisation."

Appendix 3: Focus group quotes (cont'd)

2. Clinical team
Preliminary emerging themes:

Training
"Even though I've known other colleagues for years and they might be personal friends, there's something about this training that you know a bit more emotionally about someone."
"The training prepared me adequately for doing network meetings but it didn't prepare me for working in this service."

Experiences
"I think it's been an incredibly rewarding experience but one that's been very challenging."
"It feels the most authentic way of working that I've ever done professionally."
"This is the way I want to be working, and that's not to say that at times I question whether it's being effective – it's important to be critically reflective."
"From what I've seen people really like this, people feel heard and they feel like active participants in what's taking place."
"It's a great team to work with; everyone has the same kind of thinking."
"I'm always shocked about how effective clients feel it is, because I have my own doubts and I've always been very open about them. But then you get feedback and it's like wow, that's not feedback I've had before."
"I find that sitting in some of the meetings makes me very emotional and sitting just with uncertainty and a lot of emotion is quite challenging."

Barriers/facilitators
"It was really hard when we were first setting up, not knowing if we were in the team, if you were going to be released after you'd invested so much in this training – and I still hear that now from colleagues who haven't fully come over yet."
"It's made it easier being involved in a team where people are here because they want to be here."
"There are a lot of people here who are really passionate about it and everyone seems to be trying their best, and that's really refreshing."

Professional impact
"I've learnt to be more patient and just sit still and not problem solve, not out loud anyway although that still happens in my own head but I won't share it and I remind myself that that's my solution, it doesn't mean it will work for other people."
"I feel that this approach just completely changes the whole dynamics of the way meetings are held and my experience before was just much of the meeting was about medication and I reflect on just how little that is sometimes included in some of the meetings I go to and I think that just changes the whole thing, trying to get away from the medical model that people are working to and opens up many topics."
"We're not pathologising as in labelling but trying to go, 'What's going on here? What's the problem?' and for me that's such a human thing."

Personal impact
"POD has changed my personal life massively in that I'm less inclined to second-guess what people are thinking, I'm a lot more open to listening to people."
"For me it's been about reminding myself of the benefit of dialogism within my family, and how difficult that can be in a very pressured, busy, time-limited family life."
"It's more at the forefront of my mind to stop and listen and be patient because problem solving isn't just in my role, it's in me."

Families
"Families bring us opportunities to understand things differently; you get multitudes of understandings of what's happened rather than one person's narrative and then a professional opinion on that narrative, there's actually a multitude of voices."

Peers
"What I'm finding is that this model lends itself to everybody sharing parts of themselves, whether it's experience of mental distress, or being a parent, or being an athlete or whatever – there is much more sharing of who we are as people."
"I hope that my role brings more to the team and helps, offers reassurance and other good things."
"Meetings have opened up and trusts have been built when people realise that you've struggled yourselves."
"I still struggle with the concept (of peer support)."
"I think it's really important to have peer workers. I think having as many valuable voices as you can have in that network meeting is very important and brings hope to many people."

Risk
"I did have a concern that supervision wasn't frequent enough but what I found is we're informally supervising each other all of the time now – it feels a lot safer and a lot more contained."

Motivation and stress
"I think this way of working can have additional challenges to our emotional wellbeing."
"Everyone has come into this team with a level of enthusiasm about the model… at some point the enthusiasm will wear off and it can be really tiring and really stressful."
"I feel I can talk to anyone in the team about anything that's bothering me, that's really refreshing, I haven't really felt that previously."
"I think we're struggling, not as a team but with our own personal health. I think our sickness is higher than what it would have been in our previous jobs."
"I've never heard anyone say, 'I hate my job', and I've heard that before in other teams."

Anything else?
“For innovation to thrive and develop there has to be a giving up of the existing organisation and I think there’s a tension there at the moment.”
“Everyone wants to innovate but nobody wants to change, it is such an enormous change within mental health services that it provides big challenges.”