



CREATE

Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

<http://create.canterbury.ac.uk>

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. Gieniusz, Barbara (2014) Being a pioneer: mental health service users' experiences of peer brokerage. D.Clin.Psych. thesis, Canterbury Christ Church University.

Contact: create.library@canterbury.ac.uk



BARBARA GIENIUSZ MA

BEING A PIONEER: MENTAL HEALTH SERVICE
USERS' EXPERIENCES OF PEER BROKERAGE

Section A: Experiences of peer workers in mental health
services, benefits, challenges and impact on own recovery

Word Count: 7426

Section B: Being a Pioneer: mental health service users'
experiences of peer brokerage

Word Count: 8081

Overall Word Count:

15507

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JUNE 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

!

AUTHOR'S DECLARATION

No conflicting interests

ACKNOWLEDGEMENTS

I would like to thank organisations that helped me with recruitment and peer brokers who took part in my research. Thank you for your openness, inspiring stories and encouraging others to participate in the study.

I would also like to thank my supervisors Dr Sue Holttum and Rayya Ghul for their guidance and feedback with special thanks to Sue for her help with data analysis. Thank you, Mark Kilbey, for reviewing my interview schedule and analysis and spending hours helping me understand peer organisations, peer support and my own bias in relation to service users.

I would like to thank other trainees, especially – Noveed, Sanna and Mark for support and sense of humour. Finally, thank you Gwyn for talking through my ideas and help with the editing.

SUMMARY OF THE MRP PORTFOLIO

Experiences of peer workers in mental health services, benefits, challenges and impact on own recovery

In recent years, mental health services in the UK started employing peer workers. Studies shown that employing peers can have a beneficial effect on service users.

The current review was aimed at examining the experiences of peer workers in mental health settings. A number of databases were searched and 21 studies were identified. Overall, peer workers reported benefits related to their own recovery, feeling valued, having increased self-esteem and an opportunity to gain employment. Difficulties included prejudice from staff, unclear work structure and difficult feelings related to work with clients. There is a shortage of UK-based studies as evidence comes almost exclusively from studies in other countries.

Being a Pioneer: mental health service users' experiences of peer brokerage

The study aimed at understanding the experiences of mental health service users and working as peer brokers – advising other service users on personal budgets. Six peer brokers were interviewed and the data were analysed using Interpretative Phenomenological Analysis. Five main themes were identified in the interviews: changing and growing; rewarding and challenging aspects of the role; client-centred approach to peer brokerage; importance of peer-relationships; and the pioneering nature of the role. Participants emphasised that this is a new idea in mental health services requiring commitment and determination in facing obstacles.

More UK-based studies are needed to understand peer workers' experiences and their partnership with services.

LIST OF CONTENTS

<u>SECTION A</u>	1
<u>ABSTRACT</u>	2
<u>INTRODUCTION</u>	3
DEFINITION AND DEVELOPMENT OF PEER SUPPORT	3
PEER SUPPORT AND RECOVERY	5
<u>EFFECTIVENESS OF PEER LED SERVICES AND CHANGES IN ORGANISATIONS EMPLOYING MENTAL HEALTH WORKERS</u>	8
PEER SUPPORT'S IMPACT ON SERVICE USERS' OUTCOMES	8
EFFECTS ON ORGANISATIONS EMPLOYING PEER WORKERS	9
<u>EXPERIENCES OF PEER WORKERS</u>	9
<u>EXISTING REVIEWS</u>	10
<u>CURRENT REVIEW</u>	11
METHOD	11
MOTIVATION TO DO PEER WORK (N = 3)	12
BENEFITS EXPERIENCED BY PEER WORKERS (N = 17)	13
CHALLENGES ASSOCIATED WITH THE ROLE OF PEER WORKERS (N = 18)	17
RELATIONSHIP WITH STAFF AND CLIENTS (N = 9)	20
QUALITY AND LIMITATION OF EXISTING PAPERS	21
<u>DISCUSSION</u>	23
EFFECTS ON RECOVERY	23
IMPORTANCE OF SUPPORTING OTHERS	24

STIGMA AND PEER SUPPORT	24
ORGANISATIONAL ISSUES	25
COMPARISON WITH EXPERIENCES OF PROFESSIONALS	26
<u>IMPLICATIONS FOR FUTURE RESEARCH</u>	<u>27</u>
<u>REFERENCES</u>	<u>28</u>
<u>SECTION B: EMPIRICAL PAPER</u>	<u>1</u>
<u>ABSTRACT</u>	<u>2</u>
<u>REVIEW OF THE LITERATURE</u>	<u>3</u>
EFFECT OF PEER SUPPORT ON SERVICE USERS	3
EXPERIENCE OF PEER WORKERS	4
PEER-LED ORGANISATIONS	5
DIVERSIFICATION OF PEER ROLES AND PEER BROKERAGE	6
<u>RATIONALE FOR THE STUDY</u>	<u>6</u>
<u>RESEARCH QUESTIONS</u>	<u>6</u>
<u>METHOD</u>	<u>7</u>
DESIGN	7
PARTICIPANTS	7
ETHICS	8
MATERIALS/MEASURES	8
PROCEDURE	8
DATA ANALYSIS	9
QUALITY ASSURANCE	9

<u>RESULTS</u>	10
CHANGING AND GROWING	10
REWARDING AND CHALLENGING ASPECTS OF THE ROLE	13
CHALLENGES.	14
REWARDS.	15
CLIENT-CENTRED APPROACH TO PEER-BROKERAGE	17
IMPORTANCE OF PEER-RELATIONSHIPS	20
PIONEERING NATURE OF PEER BROKERAGE	23
<u>DISCUSSION</u>	26
THE REWARDS, CHALLENGES AND PERSONAL GROWTH	26
MUTUAL SUPPORT	27
CLIENT-CENTRED WORK	27
PIONEERING ASPECTS OF WORK	28
LIMITATIONS	28
IMPLICATIONS FOR FUTURE RESEARCH	29
IMPLICATIONS FOR CLINICAL PRACTICE	29
<u>CONCLUSION</u>	30
<u>REFERENCES</u>	32

LIST OF TABLES

Table 1 (Section B) Participants' demographic information.....	8
Table 2 (Section B) Subthemes of theme 1 Changing and growing.....	10
Table 3 (Section B) Subthemes of theme 2 Rewarding and challenging aspects of the role..	13
Table 4 (Section B) Subthemes of theme 3 Client-centred approach to peer brokerage.....	17
Table 5 (Section B) Subthemes of theme 4 Importance of peer relationships.....	20
Table 6 (Section B) Subthemes of theme 5 Pioneering nature of peer-brokerage.....	23

LIST OF APPENDICES

Appendix 1 Flow chart of literature search and search criteria
Appendix 2 Table summarising reviewed research
Appendix 3 Journal's submission criteria
Appendix 4 Consent form
Appendix 5 University letter granting ethics approval
Appendix 6 Interview Schedule
Appendix 7 Sample of an interview with annotations
Appendix 8 Reflective diary
Appendix 9 Bracketing interview summary

Section A

Experiences of peer workers in mental health
services, benefits, challenges and impact on own
recovery

Word count: 6880 (546)

Abstract

In recent years, mental health services in the UK started employing peer workers. This was partly as a result of studies showing that peer-led services and employing peers can have beneficial effects on service users. Additionally, there was a need for role models demonstrating recovery and providing hope for service users.

The current review was aimed at examining the experiences of peer workers in mental health settings. A number of databases were searched and 21 studies were identified. Overall, peer workers reported benefits related to their own recovery, feeling valued, having increased self-esteem and an opportunity to gain employment. Difficulties included prejudice from staff, unclear work structure and difficult feelings related to work with clients. A very small number of studies focused exclusively on the experience of peer workers, most examined it as part of broader studies trying to identify employment issues related to the roles. There is a shortage of UK-based studies as evidence comes almost exclusively from studies in other countries.

Keywords: Peer Support, Peer Workers, Mental Health, Recovery

Introduction

In the UK, since the 1990s, mental health service users have been increasingly involved in the design and provision of their care (Lawton-Smith, 2013). The development of peer-run services and formal employment of peer support workers was initially developed in the USA, New Zealand, Canada and Australia. In recent years the UK has built upon this work and increased formal peer support provision (Mental Health Foundation [MHF], 2012). A number of Government papers have recommended the importance of peer support in mental health provision strategy. The “Putting People First” paper recognises that “the availability of effective peer support is essential in the transformation of adult social care and in enabling people using services to have greater choice and control” (Department of Health [DoH], 2010, p.2).

Definition and Development of Peer Support

“Peer support” can be defined as social and emotional support, often accompanied by instrumental support, 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 & Riessman, 1982, p. 632).

Bradstreet (2006) distinguishes three types of peer support:

- informal/unintentional and naturally occurring peer support
- participation in consumer or peer-run groups/programmes, and
- use of service users as paid providers of services – formal or intentional peer support. (p. 34)

The first type – informal peer support – has been recognised for a long time but perhaps more on the basis of anecdotal evidence and theory. For example, group therapists

mentioned mutual support as an important element of therapeutic change more than half a century ago (e.g. Dickoff & Lakin, 1963).

Consumer-run services were developed as an alternative to the traditional mental health system as part of a wider service user movement (Rogers & Pilgrim, 1991). At that time user dissatisfaction had reached such a point that it constituted a ‘new social movement’ (Pilgrim, 2005). A recent survey in the USA found a higher number of consumer-run services than professional-run services (Goldstrom et al., 2006). Consumer-run services have been defined as organisations in which the paid staff and most of the governing board are themselves users of mental health services (Mowbray, Holter, Stark, Pfeffer & Bybee, 2005). Goldstrom et al. (2006) included in the scope of consumer-run services: mental health support groups, self-help organisations for mental health service users and their families and services operated by mental health service users.

The latest development in the field has been mental health services employing users as care providers arising from the need to involve consumers in the provision of services and as a response to dissatisfaction with traditional mental health services (Bracken & Thomas 2001). It is worth mentioning that, outside of physical health, development of peer support in its current form is mostly connected with people who are described as having ‘severe and enduring mental health problems’ and that the service user movement so far has been focused on a human rights agenda for the group of people experiencing the greatest stigma and discrimination (Perkins & Slade, 2012; Pilgrim, 2005). Alongside the changes and rapid development of peer support, a number of research papers have been published examining the evidence for its use (Davidson & Guy, 2012). Not all peer-related roles may fit into the three categories mentioned above and many people with a history of mental illness might have experienced more than one form of peer support.

Peer Support and Recovery

Employing peer workers has a particularly valuable role from the point of view of a recovery approach, which arguably took mental health by storm in recent years. Recovery focuses on the well-being of service users and the understanding of individual needs, goals and dreams and goes beyond management of symptoms and medication (Mead & Copeland, 2000).

Development of recovery in mental health services. Emergence of recovery ideology is connected with personal stories of hope, contradicting previous opinions of inevitable decline associated with severe mental health diagnoses (Anthony, 1993). Longitudinal studies showed that people with a diagnosis of serious mental illness such as schizophrenia had a chance of a fulfilling life (Strauss & Breier, 1987). Unlike recovery in physical health, which is focused on eliminating symptoms, recovery in mental health was understood 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” (Anthony, 1993, p. 17). Andresen, Caputi and Oades (2003) reviewed stories of services users that spoke of recovery after a diagnosis of schizophrenia. They found that most service users focused on rebuilding their sense of identity and valued social roles. Faulkner and Layzell (2000) found that service users’ aims in recovery are often quite different from clinicians who used the word ‘recovery’ more in relation to symptom reduction and risk management goals. Positive and meaningful aspects of life were more important in personal narratives, such as acceptance, shared experience, emotional support, reason for living, peace of mind, taking control, having choices, security, safety and pleasure. Since the word ‘recovery’ was not always clearly defined, Leamy, Bird, Le Boutillier, Williams & Slade (2011) reviewed all papers examining

the concept of recovery. They found that recovery consisted of five processes: connectedness; hope and optimism about the future, identity, meaning in life and empowerment.

Need for role models in recovery. Ralph (2000) defined the main tasks of recovery as internal, for example insight, determination and self-managed care. But those need to be combined with external factors, especially related to connecting with others who experience hope (ibid). It has been argued based on evidence from physical health research that access to people with similar difficulties who manage to live a fulfilling life may have a greater potential to install hope in service users (Dennis, 2003). Providing hope has been suggested as one of the important aspects of promoting recovery (Jacobson & Greenley, 2001). Service users' accounts confirm the importance of role models who could show that recovery was possible, as described by Deegan, quoted by Davidson et al. (1999).

It would have been good to have role models – people I could look up to who had experienced what I was going through – people who found a good job, or who were in love, or who had an apartment or a house on their own, or who were making a valuable contribution to society. (p. 116)

Mead and Copeland (2000) described how, from service users' perspective, mutually supportive relationships nourish recovery:

Support, in a recovery-based environment, is never a crutch or a situation in which one person defines or dictates the outcome. Mutual support is a process in which the people in the relationship strive to use the relationship to become fuller richer human beings. Although we all come to relationships with some assumptions, support works best when both people are willing to grow and change. (p. 323)

Is becoming a peer worker a final stage of recovery? Spaniol, Gagne and Koehler (1997) found that the main problems relating to serious mental illness, from the point of view of service users, were: loss of sense of self, loss of power, loss of meaning and loss of hope. A new role of being a peer worker allows to gain employment and help others, so it might bring a meaningful change in all the areas mentioned above. In particular, involvement in peer support might facilitate a new sense of self, considered by some as a crucial element of recovery after hospitalisation, i.e. seeing oneself as more than a patient (Davidson & Strauss, 1992). Dunn, Wewiorski and Rogers (2008) found that employment is considered crucial by service users in recovery from serious mental illness: it “fosters pride and self-esteem” (p. 60) and was central to their identity. Financial benefits were also important for participants of that study.

Andresen et al. (2003) developed a five-stage model of recovery based on interviews with people who experienced institutional psychiatric care. The five stages are: moratorium, awareness, preparation, rebuilding and growth. The rebuilding stage is characterised by rebuilding identity and self-worth, learning to deal with setbacks and finding own goals. The growth stage can be described as having a sense of purpose. People at this stage may not be symptom-free but they know how to manage their symptoms. They will also have found in what way their experience enriched them as a person and feel that their life is meaningful. Perhaps being a peer worker could help to move a person from the “rebuilding” stage by finding fulfilling goals and helping them to move towards the “growth” stage.

It is however possible that at a later stage of recovery the role of peer worker could also reduce opportunities to create an identity totally independent from the experience of mental health difficulties, if this is what is sought. Therefore it is helpful to examine the evidence.

Effectiveness of Peer Led Services and Changes in Organisations Employing Mental Health Workers

Peer Support's Impact on Service Users' Outcomes

A number of studies in recent years confirmed that peer-led services can bring desirable changes for people with mental health diagnoses. Castelein et al. (2008) compared in a randomised controlled trial (RCT) of a peer support group for psychosis with treatment as usual. The experimental group showed positive effects on the social network. High attendees showed more improvements including increased social support, self efficacy and quality of life. Davidson et al. (1999) reviewed studies related to peer support and found evidence that people with severe mental illness who engaged in mutual support benefited by increased self-esteem and social functioning. The engagement also correlated with educational goals and finding employment.

Pfeiffer, Heisler, Piette, Rogers and Valenstein (2011), in a meta-analysis, reviewed the evidence of using peer support with people diagnosed with depression. Overall peer interventions were superior to usual care based on seven RCTs and their effectiveness was not statistically different from group cognitive-behavioural therapy. Doughty and Tse (2011) reviewed controlled studies related to consumer-led mental health services and concluded that they are as effective as traditional services and with better outcomes related to employment and reducing hospitalisation.

Davidson and Guy (2012) reviewed current evidence for using peer support for severe mental illness. They found that engaging peer staff in mental health services can be effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with co-occurring substance use disorders. Peer support that involves positive self-disclosure, role modelling and friendly approach was

found to increase service users' sense of hope, control, and ability to effect changes in their lives. It also increased their self-care, sense of community belonging and decreased service users' level of depression and psychosis (Davidson & Guy, 2012).

Effects on Organisations Employing Peer Workers

A small number of qualitative studies have explored the effects of employing peer workers on the organisations and non-peer staff. Some challenges were highlighted in relation to role ambiguity and other staff not knowing how to approach their peer colleagues. This was mostly observed in services that were new to a recovery way of working (Bradstreet & Pratt, 2010). Overall shifts in services were also observed, such as increased recovery-orientation of the teams or peer workers, which eased the communication between professionals and clients (Miyamoto & Sono, 2012). Other organisational issues were used as lessons about the importance of role clarity and good quality supervision. These were found to be crucial for the organisations to involve peer-employees successfully (McLean, Biggs, & Whitehead, 2013).

Experiences of Peer Workers

Members of self-help groups experience a sharing of feelings and/or greater control over their lives (Hatzidimitriadou, 2002). Peer workers encounter challenges, such as lack of clarity about their role, setting boundaries with colleagues, isolation as other colleagues do not understand the role (Kemp & Henderson, 2012). Repper and Carter (2011) reported evidence that, despite many obstacles such as appropriate training and supervision, peer support positively impacts the wellbeing of mental health patients and supports their recovery.

However, the Mental Health Foundation (2012) acknowledged concerns about formalising peer support as it: "may 'steal' it away from service users who simply see it as a

natural and spontaneous response to someone who has shared their own experience” (p. 4). The aspect of advocacy and political activism related to peer-run services might be lost and peer workers would be faced with having to accept a more medical way of thinking about mental illness to fit in with their professional colleagues. Repper, Aldridge and Gilfoyle (2013) in the paper about implementation of peer work in the UK highlight importance of understanding unique role and contributions of peer workers so they are working with service users in a different way than professionals.

Additionally, with development of service users’ involvement in service provision, a greater variety of peer roles are available. For example: activity coordinators, working in in-patient settings, on outreach teams, case management, substance misuse services or peer-brokerage. A number of skills, independent from their own experience of services, may be required from those peer workers. Very little is known about how specific aspects of a peer role affect the workers.

Existing Reviews

Apart from reviews focused on the effectiveness of employing peer workers in traditional mental health services or of peer-run services, there are a number of reviews that touch upon the experiences of peer workers. Repper and Carter (2011) reviewed research related to peer support and included a short summary of experiences of peer workers. Miyamoto and Sono (2012) looked at lessons and challenges related to peer support from the perspective of service managers, other professionals and peer workers. Walker and Bryant (2013) conducted a meta-synthesis of qualitative findings related to peer-support, summarising all themes that were brought up by peer workers, other staff, managers and patients in previous studies. This paper provides an interesting opportunity to compare the

thoughts of different parties involved in peer support and shows how organisational issues such as supervision and training affected the experiences of people in the services.

Current Review

The current review will focus on the experiences of peer workers in mental health services. None of the previous reviews focused solely on peer workers experiences rather than as a small section as part of a larger topic. The review will explore all aspects of the peer workers' experiences including their recovery, benefits and challenges and social network. The main body of the research focused on symptom reduction and other outcomes for the service users who are on the receiving end of peer support. A smaller number of studies explored the experience of peer workers. Additionally, the current review encompasses all aspects of peer worker experience, including being involved in training to become a peer worker.

Method

Search strategy. Jstor, MedLine, PsychInfo and Google Scholar were searched for relevant articles relating to peer workers.

The search included other terms used to describe 'peer workers' employed by mental health services, some examples being: 'peer support', 'experts by experience', 'survivor consumers', 'peer support specialists', 'service user employees', 'consumers-providers' or 'consumer staff'.

The flow chart with all search terms and papers can be found in Appendix 1. The articles were manually searched to verify if they were related to the experience of peer workers or if they examined only the effects on people on the receiving end of peer support. Additionally, references were cross-checked.

Exclusion and inclusion criteria. All the studies examining the experience of peer workers being employed by mental health services were included. Some studies focused mainly on service users' experiences or the effect on services, but peer workers were still interviewed as a part of the research. For these studies, only the aspect of research focused on peer workers was analysed. Other studies examining the effects of training to become peer workers were also included. A total of 21 studies were examined. One of the studies was published in more than one paper but focused on different aspects of the peer workers' experiences (Moran, Russinova, Gidugu, Yim & Sprague, 2012; Moran, Russinova, Stepas, 2012; Moran, Russinova, Yim & Sprague, 2013). Another study was published in two papers, focusing on different data analysis (Nelson, Ochocka, Janzen & Trainor, 2006; Ochocka, Nelson, Janzen & Trainor, 2006). A summary of all studies with the number of participants and the main findings has been provided in Appendix 2. This review is aimed at synthesising information from different studies and considers the quality of the findings. Each section is given a number in brackets (n) which indicates the number of studies that discussed each theme in their results.

Motivation to do Peer Work (n = 3)

Moran et al. (2013) analysed the motivation of 31 peer workers using a grounded theory approach. Most commonly mentioned were internal sources of motivation, which corresponds with Self Determination Theory (Ryan & Deci, 2000):

- autonomy needs – having the freedom to disclose and work in accordance with personal values;
- competence needs - using personal experience as a resource to help others;
- relatedness met-needs – the opportunity to connect and reciprocate with consumers.

External motivations included:

- generic occupational goals;
- getting away from negative work experiences.

This study provided a thorough analysis of the possible motivations that lead service users to become peer workers. This topic was not analysed in depth by other studies and Moran et al. (2013) showed how many different functions being a peer worker can serve for those who choose this role. Clear examples and quotes from participants contribute to the reliability of the study.

Benefits Experienced by Peer Workers (n = 17)

Managing symptoms (n = 2). Salzer et al. (2013) used data from a state-wide survey (n = 154) to measure the use of services by peer workers working across Pennsylvania, USA. Significantly more workers reported a reduction in the use of emergency services, case management, crisis services and hospitalisation days in comparison with those who reported similar or increased use. The survey did not provide specific data as to the nature of service use reduction (i.e. reduced number of hospital days, frequency of A&E visits etc.). The survey also suggested that a small number of peer workers reported increased use of services and it remained unexplored if that was related to their role in mental health services or to other factors. The survey however, gives an indication that the majority of workers felt that their use of various types of services was less frequent since they started their peer worker employment.

Own recovery (n = 3) Nelson et al. (2006), in their longitudinal study of the consumer provider initiative, compared active and inactive members. Active membership was related to greater benefits at 18 months follow-up. The same benefits were not found in non-active members. Initial interviews suggested a similar level of problems in both groups at

the start of the study. The study used mixed methods and showed improvements in social support, reduced hospitalisation and on a quality of life measure. No improvements were noted in the inactive group, but this group significantly dropped on measures of employment and education outside of the initiative. Interviews at baseline, after nine months and 18 months in the initiative, allowed greater understanding of what was happening for the participants. The inactive group spoke mostly of distress and challenges including struggles with mental health difficulties and suicidal thoughts. Active members spoke less of mental health problems, brought more hopeful themes in the second and third interviews and spoke more of feeling normal, feeling healthier and stronger. This suggests that staying within the peer-run project, and being an active member, is associated with greater benefit than being only at the receiving end of support. Active members had more opportunities to provide support to others and be “role models”. They probably also received increased levels of support from others, but the exact nature of the support provided and received were not measured. Using a longitudinal design, this study seems to suggest that participation in support groups brings positive results and that active involvement is needed to sustain benefits. However, it is unclear how much of a role may have been played by initial motivation or individual differences in problems that the participants were experiencing. It would be difficult to test these kinds of issues with randomisation, because researchers would not be able to easily manipulate variables such as motivation to play an active role in an organisation and provide informal support.

Moran et al. (2012a) looked at the process of peer worker recovery in detail. They found five domains of recovery emerging from the interviews with 31 peer workers: foundational, emotional, spiritual, social, and occupational:

- Foundational wellness included aspects such as learning about one's own illness, asking for help, managing symptoms and, in general, being more self-aware.
- Emotional wellness included experiencing positive emotions, self-acceptance, having a sense of humour related to their experiences, increased belief in own abilities and empowerment – feeling like they could stand up for themselves.
- Spiritual wellness consisted of finding meaning in suffering, developing personal virtues such as compassion and working on personal goals such as better communication.
- Social wellness reflected mostly improved relationships and social networks and an increased sense of bonding and connectedness.
- Occupational wellness included benefits developing a career, an increased ability to function at work and feeling respected as a professional.

In addition, analysis revealed mechanisms of beneficial impact. The role of sharing one's personal story was highlighted as contributing to the positive re-authoring of one's self-narrative. Additionally peer networking, listening to others' stories and educating oneself were seen as important aspects of the role that supported the recovery process. This was a very detailed account of benefits associated with peer worker roles. The term "recovery" was used in a broad way and any positive change was seen as a form of recovery. That way of defining the term might be useful in highlighting how meaningful peer work can be. On the other hand, it would be helpful to clarify which benefits in particular helped participants reduce problems arising from their experiences of mental health difficulties.

Self-esteem and self-efficacy (n = 7) Ratzlaff, McDarmid, Marty and Rapp (2006) evaluated a 15 week training for peer workers, including an 8 week placement of shadowing staff at a community mental health centre. A statistically significant difference on the

measure of hope and self-esteem was found when comparing participants' scores before and after the training. It was not clear if any peer staff were involved in the training or supervision of participants. This and the topics covered by the training such as recovery, ethics, helping skills, documentation, confidentiality and strengths-oriented practice suggest that the programme might have been more similar to basic training for mental health workers. Therefore, the improvement might be associated with finding employment rather than specifically with becoming a peer worker. Additionally, a statistically significant difference on pre-test and retrospective pre-test ("where do you think you were before this training on the measure") regarding one's own recovery, suggests that participants' understanding of the meaning of their own recovery changed as a result of the training. There was no control group, so it is not clear whether the changes were a result of the training or other factors.

Strong evidence that providing support may enhance self-efficacy and grant a feeling of mastery for people with mental health problems was provided by Bracke, Christiaens and Verhaeghe (2008) who compared the amount of support provided and received by 590 service users attending day therapy centres in Belgium. The association with self-esteem and self-efficacy was measured. Receiving and giving support was correlated. Good quality measures with high internal consistency were used in the study ($\alpha = 0.80$ for self-efficacy and $\alpha = 0.82$ for the self-esteem measure). However, this was a cross-sectional, correlation study, not a predictive one, so it does not answer the question of whether providing or receiving support increases self-esteem and self-efficacy, it only identifies a link between those qualities.

Self-esteem was associated with total support, so the highest self-esteem was linked with a balanced high amount of giving and receiving support. This suggests that receiving and giving support are part of a strong social network that provides the most benefits to the

person and hence improves their self-esteem. Self-efficacy was correlated with total support and with support inequity – providing more support than receiving. The relationship was stronger for men than for women. In women, self-esteem correlated with received support while there was no relationship between those variables in the men's case. The authors suggested that this might be a result of a different understanding of receiving support by different genders: men understand support more in terms of agency and women as a way of connecting with other people (Helgeson, 1994). This was an interesting conclusion since other studies did not include gender comparisons in relation to peer support.

Other studies based on surveys (McLean et al., 2013) and interviews (Salzer & Shear, 2002) showed an increase in self-reported self-esteem in peer workers; and increased confidence (Salzer et al., 2009) and increased self-esteem after attending training to become a peer worker (Ratzlaff et al., 2006).

Other benefits (n=10). One of the most commonly mentioned benefits in Salzer and Shear's study (2002) was related to professional growth such as building skills and experience and social approval. This was similar to the occupational recovery theme in Moran et al.'s study (2012b). Peer workers valued an opportunity to progress in their careers. Doherty et al. (2004) found that peer workers saw their role as a step towards finding another job rather than seeing their role as an ultimate aim.

Other benefits also included feeling respected and the experience of having their role valued (Salzer et al., 2009; Yuen & Fossey, 2003) and seeing the value of what they do (Meehan, Bergen, Coveney, Thornton, 2002; Lawn, Smith & Hunter, 2008).

Challenges Associated with the Role of Peer Workers (n = 18)

Moran et al. (2013a) focused on challenging aspects of peer support. The study provided an in-depth understanding of possible challenges and the context in which those

occur; difficult aspects of the role were discussed in more detail compared to other studies. Quotes and examples provided sufficient context to be reliable and to help understand how similar challenges could arise for peer workers in other situations. Most challenges related to occupational path and work environment. Working in conventional mental health settings was related to having to deal with direct and indirect expressions of prejudice, such as colleagues making fun of clients outside of appointments or other professionals being 'less open' with them once they found out about a peer worker's past. Other challenges included feeling that services were not recovery oriented – participants struggled when discovering that services were mostly interested in symptom reduction or not involving service users in their treatment plans. The problems were escalated for some by having supervisors who did not know much about, or believe in, recovery. Being the only peer in the service was harder for some, contributing to feeling as if they were “placed to challenge the whole system”.

Difficulties in relationships with staff and other clients were also discussed. Some of the peers gave examples of negative reactions from clients in response to their disclosure, e.g. “What? You are crazy and you think you can help me?” (p. 286). This posed a dilemma in relation to how to use personal experience, when to disclose and how to be the most beneficial to the client and not to “set standards too high or scare them”. Especially difficult experiences with clients were described when they were not improving or in crisis, which evoked feelings of helplessness in peer workers. A small number of peer workers found that the peer identity could be limiting at times, that they felt “pigeon-holed”. The study clearly shows that individual factors related to each person, the role or service context could affect peer workers' experiences.

A recurrence of symptoms was mentioned by a small number of peers (four out of 31) and feeling over-worked was a common experience (nine workers). This included taking

worries home, emotional reactions to hearing about very difficult experiences of others, or listening to experiences similar to their own. Being reminded of past experience was mentioned as a theme in other studies (Meehan et al., 2002, Biggs, Whitehead, 2013).

Doherty, Craig, Attafua, Boocock and Jamieson-Craig (2004), in the only England-based study, interviewed two peer workers from an assertive outreach team. Other team members were also interviewed. This study highlighted difficulties such as feeling too protected, for example peer workers feeling as if they were “wrapped in cotton wool”, while sometimes they wanted to “be just like everybody else” (p. 76). One of the peer workers spoke of difficulties with feeling “too attached to the clients”. Another area of difficulty was related to fulfilling job requirements such as getting up in the morning, concerns about return of symptoms, and the need for “proving themselves”.

One of the studies suggested that more difficulties are experienced at the start of involvement as a peer worker (Chinman et al., 2008). In this case, focus groups enquired about the experience of the team and included questions regarding the experience of peer workers. This was conducted in a veterans organisation in the USA. More problems were mentioned at the time of peer workers joining teams: trying to prove their worth to the organisation and anxiety about the work as the role was ambiguous. Interestingly, similar anxiety and unclear ideas about involving peer workers in the team was shared by other staff members. The experience was easier when more than one peer worker was joining the team. The difficulties were mostly resolved with time and eventually most peer workers felt that they ‘fitted in’ with teams and were valued by others. This study highlights that the experiences of peer workers can be linked with the experiences of the wider team. The limitation of the study was that non-peer staff were recruited at a recovery conference, so their answers could have included a positive bias towards peer workers.

Role related strains (n = 6). Slade (2009) in his book about recovery quoted a very interesting study from New Zealand published by Wells in 2003. Based on interviews with five peer workers, six categories of strain were identified:

- Super cool – limited range of emotions that could be shown i.e. trying to be cool at all times, hiding anger or feeling sad.
- Super normal – need for being conservative in behaviour and appearance.
- Super person – feeling a need to be an expert in all areas of mental health.
- Voyeurism – staff wanting to know the details of mental illness and admission but not the other parts of the story or what the lessons were.
- Remuneration – difficulties with pay due to lack of pay scales for peer workers. (p. 107)

Unfortunately the original article was not available online and it is unclear if this was due to a temporary or permanent removal, but the quality of the study and details could not be verified. However, themes related to each of the categories appeared in other studies and the names and descriptions give a brief yet informative idea about the difficulties that can be experienced by peer workers.

Relationship with Staff and Clients (n = 9)

Setting boundaries in work relationships was not a main theme in the reviewed studies, however it was touched upon by some workers in many of the papers. None of the studies focused specifically on relationships with staff and negotiating boundaries. Some studies revealed negative attitudes from non-peer staff, facing prejudice (Mowbray, Moxley & Collins, 1998; Moran et al., 2013a), feeling overprotected (Doherty et al., 2004) being treated 'like a patient' (Chinman et al., 2008).

Participants mentioned difficulties arising from working with people they knew socially or from previous admissions, and an unclear distinction between a peer worker and a friend (Mowbray et al., 1998) and new tensions arising from peer role such as envy by former fellow patients (Chinman et al., 2008) or feeling that the new role could be too restrictive in peer relationships (Moll, Holmes, Geronimo & Sherman, 2008). Some peer workers also struggled when working with new clients who seemed to desire friendship rather than support (Colson & Francis, 2009). Relationships at work seem to present with complex issues and it would be interesting to compare those issues with the dilemmas on non-peer staff.

Quality and Limitation of Existing Papers

Quantitative studies. Reviewed studies were of a varied quality, some being surveys or training evaluation using very basic methodology such as descriptive statistics (e.g. percentages). Two studies used pre- and post-designs and one showed no statistically significant differences (Tse, Tsoi, Wong, Kan & Kwok, 2013) but the number of participants was only 18. The other was able to show the difference with this design as more participants took part (Ratzlaff et al., 2006). Salzer et al. (2013) chose Chi square analysis, comparing people who improved with those who did not. Since hospitalisation time and the use of services were analysed, more robust and objective measures could have been used such as counting the actual number of bed days. The more rigorous quantitative designs were present in two studies based on peer support occurring in day centres and a peer-run service (Bracke et al., 2008; Nelson et al., 2006). Even though these were not studies of peer workers in mental health services, the findings suggest the value of active involvement in peer support for people with mental health problems and direct benefits from providing support to peers.

Qualitative studies. Mays and Pope (2000) suggested that criteria such as credibility, development of theory, consistency, sufficient amount of detail, grounding in context and

reflexivity could be used to evaluate qualitative studies. The most common design of reviewed studies was thematic analysis, which is useful to obtain an overview of themes but does not assign as important a role to understanding the researcher's influence as other qualitative approaches such as phenomenology (Smith et al., 2009, p. 34-37). Ochocka et al. (2006) and all analyses related to Moran et al.'s research (2012a) had sufficient detail to assess the rigour of their data analysis. Interviews were also detailed enough to gain more in-depth understanding. Even though some other studies followed the process of quality assurance (Doherty et al., 2004; Chinman et al., 2008), their studies did not cover the entirety of peer workers' experiences, since interviewing peer workers was only a part of the research. The focus was on the collaboration between peer and non-peer staff and the functioning of the service. This means that more personal experiences unrelated to the main research questions were often left unexplored. Additionally, some studies were conducted using ethnographic or case study approaches and the experience of peer workers and other staff was not separated well enough to draw salient conclusions about those (Moll et al., 2008; Colson & Francis, 2009).

The studies also had geographical limitations. Apart from one service pilot evaluation from Scotland (McLean et al., 2013) and a study that included two peer workers from an assertive outreach team (Doherty et al., 2004), all the studies were conducted outside of the UK. The healthcare system in Canada, where some of the studies were conducted, is financed from public taxes similarly to the NHS (Roe & Liberman, 2007). The system in the United States is quite different and based on an entrepreneurial model of the purchase of health insurance by private individuals or employers. Differences in health-system organisation can also be found between individual states and some services, such as veteran's healthcare, are provided by the government. Other countries such as New Zealand or

Australia have mixed systems that combine elements of tax-funded services and private healthcare (ibid). These differing health systems, in addition to cultural differences, make it difficult to estimate to what extent the experiences of peer workers in the UK would be similar.

Discussion

Effects on Recovery

The reviewed studies suggest that peer workers experience a wide range of benefits, including improved skills, value of their work and better managing their own difficulties. Moran (2012b) in their study showed how broadly recovery can be understood and that peer workers can experience varied benefits enhancing their wellbeing encompassing: managing symptoms, expanding their social network, experiencing positive emotions, personal growth and skills development. This holistic view of personal wellness is similar to descriptions of the later stages of recovery in service users' narratives (Weeks, Slade & Hayward, 2013). Apart from the above study, peers did not participate in conducting interviews. It is possible that studies showed positive bias and reported more benefits than challenges as peer workers might have found it difficult to express critical views related to their role when talking to professionals. Presence of a peer when collecting feedback about services was correlated in other research with expressing more negative views (Simpson & House, 2002).

Certain benefits reported by peer workers could be associated with obtaining employment rather than with specific aspects of the peer role. The value of finding work after serious mental illness and hospitalisation is high as mental health problems were found to be associated with the loss of valued social roles (Spaniol et al., 1997). Service users voiced in previous studies how finding employment was central to their recovery and moving away from a "patient identity" (Dunn et al., 2008).

Importance of Supporting Others

The reviewed studies contribute to evidence that the opportunity to provide help to others is important for personal wellbeing. The study by Bracke et al. (2008) suggested that some benefits of providing support are even greater than benefits of being on the receiving end of it. This study is unique in its methodology and brings attention to important limitations of receiving support as it might foster a sense of inferiority and helplessness. The idea that the balance of social support is important for wellbeing has been noted before (Barrera, 1986). The study analysed naturally occurring support amongst people diagnosed with serious mental illness so it is not entirely clear how the same aspects of sense of self would be affected in professional peer workers, when providing support is a part of their role.

Nelson et al. (2006) also found that active engagement in a peer-run service, which includes being a role model for others, is associated with more benefits than being only on the receiving end of support. This is consistent with the “helper therapy principle”: a positive, therapeutic effect of providing assistance that increases sense of competency and allows one to occupy a socially valuable role (Roberts et al., 1991). Similar effects of providing support were found in physical health research. Peer support to people with similar physical health difficulties was found to involve a “dramatic shift” including increased self-esteem, confidence and self-awareness (Schwartz & Sendor, 1999).

Stigma and Peer Support

One of the issues that peer workers needed to deal with was external and internal stigma. In one interesting piece of research Ilic et al. (2012) identified different strategies for dealing with mental health stigma. Community involvement, humour and positive in-group stereotyping were linked with higher self-esteem. Secrecy, selective disclosure and attempts at overcompensation or disproving stereotypes were related to lower self-esteem. Strategies

helpful for reducing stigma can be promoted by peer work. An improved social network, humour and appreciating lived experiences were all mentioned as benefits in reviewed papers. Disclosure of past difficulties could have a positive effect of re-authoring own narrative (Moran et al., 2012a) and the burdening effect of secrecy is avoided in peer workers. From this point of view, peer workers might have an advantage over mental health professionals who do not disclose their own difficulties. Corrigan, Kosyluk and Rüsck (2013) found that contact with people who are open about their mental health difficulties is up to three times more effective in reducing self-stigma than health information-based campaigns. This can be another argument supporting the idea of involving peer workers in services but it suggests that peer workers might benefit from continued contact with their peer network. It is also worth remembering that peer workers deal with very real stigma and prejudice from other professionals. Mental health professionals were found to be more negative about the future of people with mental health problems than the general population (Lawrence, 2004).

Organisational Issues

Participants of reviewed studies mentioned how recovery orientation of the services and other staff's attitudes can affect their experience. This highlights the importance of the context in which peer workers function, that is why so much of the research in this area provides lessons for services or is focussed on organisational issues (e.g Gates & Akabas 2007, Manning & Suire, 2009; McLean et al., 2013). Formal peer support is a relatively new way of working in mental health and it is not fully clear what could improve the experiences of peer workers.

Research highlighted that training and supervision are important for the success of a peer-support role. This was a recommendation arising from 44% of qualitative studies

related to peer support (Walker & Bryant, 2013). Some authors argued that training interferes with the advantages of being a peer (Dixon, Krauss & Lehman, 1994). This is, however, based on the assumption that training includes knowledge of mental health models. If training is organised by peers and helps to use personal stories to aid recovery, working with non-peer professionals and managing own distress then this should enhance the skills without losing the unique perspective arising from lived experience of using mental health services.

Studies showed that the training in itself might be beneficial for peer workers (Tse et al., 2013; Ratzlaff et al., 2006) although it is not clear if benefits could be sustained if training is not followed by peer work employment.

When analysing organisational factors affecting peer work, a risk exists of under-estimating other individual factors. One of the non-peer participants in Doherty et al. (2004) noted that in a close-knit team everyone affects how the team functions: “People bring their own personalities into the job, so everybody does alter the dynamics of the team, but I don’t think that there was any difference in the dynamics in the team purely because they had mental health problems” (p. 79)

Comparison with Experiences of Professionals

Some of the difficult aspects of peer experience, for example hearing distressing life stories, or working with people who are stuck or in crisis are similar to those experienced by mental health professionals. Perhaps in this case peer workers give us an opportunity to once again see the challenges related to work in mental health. High levels of stress have been found before in mental health professionals (Prosser et al., 1997). Amongst many positive effects of peer workers on teams Doherty et al. (2004) found that assertive outreach teams

became more caring and understanding of each other's limitations as they worked alongside people more open about their distress.

Implications for Future Research

More research is needed, especially since new policies recommend inclusion of service users as a part of good practice (DoH, 2006) and the number of peer workers employed in the UK is on the rise. Local studies are important to be able to say whether experiences of peer workers in the UK are similar to other countries. Since a greater variety of peer roles are now implemented, for example peer brokerage (DoH, 2007a), it is important to find out how those roles are different and who can benefit the most from applying for them. In some way peer workers' satisfaction can be a measure of recovery orientation in services as peer workers found it the hardest to work in non-recovery oriented environments. This review suggests that the impact on workers should be considered and that a peer role can be a step to enhancing wellness and a way of the service contributing to the recovery of not only service users but also peer workers. More research on ways of supporting peer workers is also needed as their role has a potential for a wide variety of challenges.

As for implications for clinical psychology, due to our role in reflective practice and understanding of team processes, we could play a role in integrating peer workers in teams of professionals. Being sensitive to issues of communication, partnership and discrimination we could help with negotiating the boundaries of the role and finding the best way to include peer workers into the team of professionals. Psychology contributions into better team functioning is consistent with The New Ways of Working implemented by the Department of Health (2007b). The role of psychology and reflective practice in relation to peer work also needs to be explored in further research.

References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australasian Psychiatry*, 37(5), 586-594. Retrieved on 12 May 2012, from : <http://www.catalystbreakthru.com/wp-content/uploads/2012/02/2.The-experience-of-recovery.pdf>
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal*, 16(4), 11-23.
- Armstrong, M. L., Korba, A. M., & Emard, R. (1995). Of mutual benefit: The reciprocal relationship between consumer volunteers and the clients they serve. *Psychiatric Rehabilitation Journal*, 19(2), 45-49.
- Barrera Jr, M. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology*, 14(4), 413-445.
- Bracken, P., & Thomas, P. (2001). Postpsychiatry: a new direction for mental health. *BMJ*, 322(7288), 724-727.
- Befesfor, P. (2003). *It's our lives. A short theory of knowledge, distance and experience*. London: Citizen Press.
- Bracke, P., Christiaens, W., & Verhaeghe, M. (2008). Self-Esteem, self-Efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal of Applied Social Psychology*, 38(2), 436-459. doi: 10.1111/j.1559-1816.2008.00312.x

- Bradstreet, S. (2006). Harnessing the ‘lived experience’: Formalising peer support approaches to promote recovery. *The Mental Health Review, 11*, 33-37. doi: 10.1108/13619322200600019
- Bradstreet, S., & Pratt, R. (2010). Developing peer support worker roles: reflecting on experiences in Scotland. *Mental Health and Social Inclusion, 14*(3), 36-41.
- Castelein, S., Bruggeman, R., Van Busschbach, J. T., Van Der Gaag, M., Stant, A. D., Knegtering, H., & Wiersma, D. (2008). The effectiveness of peer support groups in psychosis: A randomized controlled trial. *Acta Psychiatrica Scandinavica, 118*(1), 64-72. doi: 10.1111/j.1600-0447.2008.01216.x
- Chinman, M., Lucksted, A., Gresen, R., Davis, M., Losonczy, M., Sussner, B., & Martone, L. (2008). Early experiences of employing consumer-providers in the VA. *Psychiatric Services, 59*(11), 1315-1321. doi: 10.1176/appi.ps.59.11.1315
- Colson, P. W., & Francis, L. E. (2009). Consumer staff and the role of personal experience in mental health services. *Social Work in Mental Health, 7*(4), 385-401. doi: 10.1080/15332980802237735
- Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103*(5), 794-800. doi: 10.2105/AJPH.2012.301037
- Cribb, A., Owens, J. (2010). Whatever suits you: Unpicking personalisation for the NHS. *Journal of Evaluation in Clinical Practice, 16*, 310–314. doi: 10.1111/j.1365-2753.2010.01390

- Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6(2), 165-187. doi: 10.1093/clipsy.6.2.165
- Davidson, L., & Guy, K. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, 11(2), 123-128. doi: 10.1016/j.wpsyc.2012.05.009
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65: 131–145. doi: 10.1111/j.2044-8341.1992.tb01693.
- Dennis, C. L. (2003). Peer support within a health care context: a concept analysis. *International journal of nursing studies*, 40(3), 321-332. doi:10.1016/S0020-7489(02)00092-5
- Department of Health (2006). *Direct payments for people with mental health problems: A guide to action*. London: Department of Health. Retrieved on 4 April 2012, from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndguidance/dH_4131060
- Department of Health (2007a). *Putting people first: A shared vision and commitment to the transformation of adult social care*. London: Department of Health. Retrieved on 4 April 2012, from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081119.pdf
- Department of Health (2007b). *Mental health: New ways of working for everyone. Developing and sustaining a capable and flexible workforce*. London: Department of

Health. Retrieved on 13 March 2014, from

http://www.spn.org.uk/fileadmin/SPN_uploads/Documents/progressreportpdfapril2007.pdf

Department of Health (2008). *Good practice in support planning and brokerage*. London:

Department of Health. Retrieved on 20 April 2012, from:

http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/Good_Practice_in_Support_Planning_and_Brokerage.pdf

Department of Health (2010) *Putting people first: Planning together – peer support and self-directed support*. London: Department of Health. Retrieved on 12 January 2014,

from: <http://www.groundswellpartnership.co.uk>

Dickoff, H., & Lakin, M. (1963). Patients' views of group therapy: Retrospections and interpretations. *International Journal of Group Psychotherapy*, 13, 61-73.

Dixon, L., Krauss, N., & Lehman, A. (1994). Consumers as service providers: The promise and challenge. *Community Mental Health Journal*, 30(6), 615-625.

Dixon, L., Hackman, A., & Lehman, A. (1997). Consumers as staff in assertive community treatment programs. *Administration and Policy in Mental Health and Mental Health Services Research*, 25(2), 199-208.

Doherty, I., Craig, T., Attafua, G., Boocock, A., & Jamieson-Craig, R. (2004). The consumer-employee as a member of a mental health assertive outreach team. II. Impressions of consumer-employees and other team members. *Journal of Mental Health*, 13(1), 71-81. doi:10.1080/09638230410001654576

Doughty, C., Tse, S. (2011). Can consumer-led mental health services be equally effective? An integrative review of CLMH services in high-income countries. *Community Mental Health Journal*, 47 (3), 252-266. doi: 10.1007/s10597-010-9321-5

- Druss, B. G., Zhao, L., von Esenwein, S. A., Bona, J. R., Fricks, L., Jenkins-Tucker, S., ... & Lorig, K. (2010). The Health and Recovery Peer (HARP) Program: a peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophrenia Research*, *118*(1), 264-270. doi: 10.1016/j.schres.2010.01.026
- Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric Rehabilitation Journal*, *32*(1), 59-62. doi: 10.2975/32.1.2008.59.62
- Faulkner, A., & Layzell, S. (2000). *Strategies for living: a report of user-led research into people's strategies for living with mental distress*. London: Mental Health Foundation.
- Gartner, A., & Riessman, F. (1982). Self-help and mental health. *Hospital & Community Psychiatry*, *33*, 631-635.
- Gates, L. B., & Akabas, S. H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*(3), 293-306. doi: 10.1007/s10488-006-0109-4
- Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., & Manderscheid, R. W. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(1), 92-103. doi: 10.1007/s10488-005-0019-x
- Hatzidimitriadou, E. (2002), Political ideology, helping mechanisms and empowerment of mental health self-help/mutual aid groups. *Journal of Community and Applied Social Psychology*, *12*, 271-285. doi: 10.1002/casp.681

- Helgeson, V. S. (1994). Relation of agency and communion to well-being: Evidence and potential explanations. *Psychological Bulletin*, *116*(3), 412.
- Ilic, M., Reinecke, J., Bohner, G., Hans-Onno, R., Beblo, T., Driessen, M., ... & Corrigan, P. W. (2012). Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. *International Journal of Social Psychiatry*, *58*(3), 246-257. doi: 10.1177/0020764010392058
- Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*(4), 482-485. doi: 10.1176/appi.ps.52.4.482
- Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, *35*(4), 337. doi: 10.2975/35.4.2012.337.340
- Lawn, S., Smith, A., & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*, *17*(5), 498-508.
- Lawrence, J. (2004). Mental health survivors: your colleagues. *International Journal of Mental Health Nursing*, *13*(3), 185-190. doi: 10.1111/j.1440-0979.2004.0331.x
- Lawton-Smith, S. (2013). Peer support in mental health: where are we today? *Journal of Mental Health Training, Education and Practice*, *8*(3), 152-158. doi: 10.1108/JMHTEP-03-2013-0009
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452. doi: 10.1192/bjp.bp.110.083733

- Manning, S. S., & Suire, B. (1996). Consumers as employees in mental health: Bridges and roadblocks. *Psychiatric Services, 47*, 939-943.
- Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal, 320*(7226), 50-52.
- McLean, J., Biggs, H., & Whitehead, I. (2013). *Evaluation of the delivering for mental health peer support worker pilot scheme*. Retrieved on 24 November 2013, from:
<http://scotland.gov.uk/Resource/Doc/291860/0089932.pdf>
- Mead, S., & Copeland, M. E. (2000). What recovery means to us: consumers' perspectives. *Community Mental Health Journal, 36*(3), 315-328. doi: 10.1023/A:1001917516869
- Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal, 25*(2), 134. doi: 10.1037/h0095032
- Meehan, T., Bergen, H., Coveney, C., & Thornton, R. (2002). Development and evaluation of a training program in peer support for former consumers. *International Journal of Mental Health Nursing, 11*(1), 34-39. doi: 10.1046/j.1440-0979.2002.00223.x
- Mental Health Foundation (2012). *Peer Support in Mental Health and Learning Disability*. London: Mental Health Foundation. Retrieved on 12 January 2014, from:
http://www.mentalhealth.org.uk/content/assets/PDF/publications/need_2_know_peer_support1.pdf
- Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: a review of the literature. *Clinical Practice and Epidemiology in Mental Health: CP & EMH, 8*, 22. doi: 10.2174/1745017901208010022
- Moll, S., Holmes, J., Geronimo, J., & Sherman, D. (2009). Work transitions for peer support providers in traditional mental health programs: unique challenges and opportunities.

- Work: A Journal of Prevention, Assessment and Rehabilitation*, 33(4), 449-458. doi: 10.3233/WOR-2009-0893
- Moran, G. S., Russinova, Z., Gidugu, V., & Gagne, C. (2013a). Challenges experienced by paid peer providers in mental health recovery: a qualitative study. *Community Mental Health Journal*, 49(3), 281-291. doi: 10.1007/s10597-012-9541-y
- Moran, G. S., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012a). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. *Qualitative Health Research*, 22(3), 304-319. doi: 10.1177/1049732311420578
- Moran, G. S., Russinova, Z., & Stepas, K. (2012b). Toward understanding the impact of occupational characteristics on the recovery and growth processes of peer providers. *Psychiatric Rehabilitation Journal*, 35(5), 376. doi: 10.1037/h0094496
- Moran, G. S., Russinova, Z., Yim, J. Y., & Sprague, C. (2013b). Motivations of persons with psychiatric disabilities to work in mental health peer services: A qualitative study using self-determination theory. *Journal of Occupational Rehabilitation*, 1-10. doi: 10.1007/s10926-013-9440-2
- Mowbray, C. T., Holter, M. C., Stark, L., Pfeffer, C., & Bybee, D. (2005). A fidelity rating instrument for consumer-run drop-in centers (FRI-CRDI). *Research on Social Work Practice*, 15(4), 278-290.
- Mowbray, C. T., Moxley, D. P., & Collins, M. E. (1998). Consumers as mental health providers: First-person accounts of benefits and limitations. *The Journal of Behavioral Health Services & Research*, 25(4), 397-411. doi: 10.1007/BF02287510
- Nelson, G., Ochocka, J., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 1—Literature review and overview of the study. *Journal of Community Psychology*, 34(3), 247-260. doi: 10.1002/jcop.20097

- Nelson, G., Ochocka, J., Janzen, R., Trainor, J., Goering, P., & Lomotey, J. (2007). A longitudinal study of mental health consumer/survivor initiatives: Part V—Outcomes at 3-year follow-up. *Journal of Community Psychology, 35*(5), 655-665. doi: 10.1002/jcop.20171
- Ochocka, J., Nelson, G., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members. *Journal of Community Psychology, 34*(3), 273-283. doi: 10.1002/jcop.20099
- Oyserman, D., Markus, H., R (1990). Possible selves and delinquency. *Journal of Personality and Social Psychology, 59*(1), 112-125. doi: 10.1037/0022-3514.59.1.112
- Perkins, R., & Slade, M. (2012). Recovery in England: transforming statutory services? *International Review of Psychiatry, 24*(1), 29-39. doi:10.3109/09540261.2011.645025
- Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: a meta-analysis. *General Hospital Psychiatry, 33*(1), 29-36. doi: 10.1016/j.genhosppsych.2010.10.002
- Pilgrim, D. (2005). Protest and co-option—the voice of mental health service users. In: A. Bell and P. Lindley (Eds.) *Beyond the water towers: The unfinished revolution in mental health services 1985–2005* (p.17-26). London: The Sainsbury Centre for Mental Health.
- Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., & Thornicroft, G. (1997). Perceived sources of work stress and satisfaction among hospital and community mental health staff, and their relation to mental health, burnout and job satisfaction. *Journal of Psychosomatic Research, 43*(1), 51-59.

- Ralph, R. O. (2000). Recovery. *Psychiatric Rehabilitation Skills*, 4(3), 480-517. doi: 10.1080/10973430008408634
- Ratzlaff, S., McDiarmid, D., Marty, D., & Rapp, C. (2006). The Kansas consumer as provider program: Measuring the effects of a supported education initiative. *Psychiatric Rehabilitation Journal*, 29(3), 174. doi: 10.2975/29.2006.174.182
- Repper, J., Aldridge, B., & Gilfoyle, S. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health & Mental Health Network, NHS Confederation. Retrieved on 13 January 2014, from: http://www.recoverydevon.co.uk/download/ImROC_briefing_5-Peer_Support_Workers_Theory_and_Practice.pdf
- Repper, J., Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411. doi:10.3109/09638237.2011.583947
- Repper, J., Perkins, R. (2006) *Social inclusion and recovery: A model for mental health practice*. London: Bailliere Tindall.
- Roberts, L. J., Luke, D. A., Rappaport, J., Seidman, E., Toro, P. A., & Reischl, T. M. (1991). Charting uncharted terrain: A behavioral observation system for mutual help groups. *American Journal of Community Psychology*, 19(5), 715-737.
- Rogers, A., & Pilgrim, D. (1991). 'Pulling down churches': accounting for the British mental health users' movement. *Sociology of Health & Illness*, 13(2), 129-148.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68, doi: 10.1037/0003-066X.55.1.68

- Salzer, M. S., Darr, N., Calhoun, G., Boyer, W., Loss, R. E., Goessel, J., ... & Brusilovskiy, E. (2013). Benefits of working as a certified peer specialist: Results from a statewide survey. *Psychiatric Rehabilitation Journal*, 36(3), 219-221. doi: 10.1037/prj0000016
- Salzer, M. S., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania certified peer specialist initiative: Training, employment and work satisfaction outcomes. *Psychiatric Rehabilitation Journal*, 32(4), 301-305. doi: 10.2975/32.4.2009.301.305
- Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*, 25(3), 281-288. doi: 10.1037/h0095014
- Slade, M. (2009). *Personal recovery and mental illness: a guide for mental health professionals* (Vol. 34). Cambridge: Cambridge University Press.
- Schwartz, C. E., & Sendor, R. M. (1999). Helping others helps oneself: response shift effects in peer support. *Social Science & Medicine*, 48(11), 1563-1575.
- Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *BMJ*, 325(7375), 1265. doi: 10.1136/bmj.325.7375.1265
- Spaniol, L., Gagne, C., Koehler, M. (1997) Recovery from serious mental illness: what it is and how to assist people in their recovery. *Continuum*, 4, 3-15.
- Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: Methodology, study sample, and overall status 32 years later. *Am J Psychiatry*, 144(6), 718-726.
- Tse, S., Tsoi, E. W. S., Wong, S., Kan, A., & Kwok, C. F. Y. (2013). Training of mental health peer support workers in a non-western high-income city: Preliminary

evaluation and experience. *International Journal of Social Psychiatry*. doi:
10.1177/0020764013481427

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A
metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*, 36(1), 28
doi: 10.1037/h0094744

Weeks, G., Slade, M., Hayward, M. (In press). A UK validation of the stages of recovery
instrument. *International Journal of Social Psychiatry*. Retrieved on 1 May 2012,
from
[http://www.uow.edu.au/content/groups/public/@web/@health/@iimh/documents/do
c/uow077374.pdf](http://www.uow.edu.au/content/groups/public/@web/@health/@iimh/documents/doc/uow077374.pdf)

Willig, S. (2008) *Introducing qualitative research in psychology: Adventures in theory and
method*. Maidenhead: McGraw-Hill, Open University Press.

Yuen, M. S., & Fossey, E. M. (2003). Working in a community recreation program: A study
of consumer-staff perspectives. *Australian Occupational Therapy Journal*, 50(2), 54-
63. doi: 10.1046/j.1440-1630.2003.00306.x

Section B: Empirical Paper

Being a pioneer: experiences of mental health service users providing
peer brokerage

For submission to Journal of Mental Health

Word count: 8000 (86)

Abstract

Background: In recent years in the UK, services introduced personalisation, allowing mental health service users to be in charge of the budgets given to them by social care. Peer brokerage is based on advice regarding the best use of personal budgets.

Aims: To understand the experiences of mental health service users being trained and working as peer brokers, and any role of those experiences in their recovery and identity.

Method: Six peer brokers were interviewed and the data were analysed using Interpretative Phenomenological Analysis.

Results: Five main themes were identified in the interviews: changing and growing; rewarding and challenging aspects of the role; client-centred approach to peer brokerage; importance of peer-relationships; and the pioneering nature of the role. Participants emphasised that this is a new idea in mental health services requiring commitment and determination in facing obstacles.

Conclusions: Similarly to previous research on the experiences of peer workers, participants spoke of challenging and rewarding aspects, including learning and benefits from helping others. New themes highlighted by this study show the importance of support from other peers and a humanistic approach to helping others. More UK-based studies are needed to understand peer workers' experiences and their partnership with services.

Declaration of interest: none

Review of the Literature

The Department of Health (DH, 2007) is in the process of giving users more control over the services they receive. As part of this agenda aimed at personalised care, service users are able to manage a budget, which was recently available only to private providers. The aim is to support social inclusion and service user choice. Where options are available, support should be provided to help with these (Department of Health [DoH], 2007). It has been recognised in “Good Practice in Support Planning and Brokerage” (DoH, 2008) that in the pilot of personalised services the support in using personal budgets, i.e. brokerage, was crucial to success. It also suggests that, where possible, the option of receiving advice from peer-led organisations should be available, but in 2009 only 22% of people with personal budgets across all disabilities had access to that form of support (DoH, 2010).

Peer brokerage is a new form of support available from other peers. It is part of a wider trend of increased employment of peer workers in mental health services in the UK. Repper (2013), in her briefing paper on peer work implementation, states: “The widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services” (p. 1).

Effect of Peer Support on Service Users

Doughty and Tse (2011) reviewed controlled studies related to consumer-led mental health services and concluded that they are as effective as traditional services, with better outcomes related to employment and reduced hospitalisation. Repper and Carter (2011) found that peer support positively impacts the wellbeing of mental health patients and supports their recovery. Even more informal peer support was found to be beneficial.

Members of self-help groups experience sharing of feelings and/or greater control over their lives (Hatzidimitriadou, 2002).

Experience of Peer Workers

The shift from mental health service users to a professional capacity could be beneficial. It has been noted that employment and community involvement aids recovery since mental illness diagnoses are associated with a loss of important social roles (Repper & Perkins, 2006; Spaniol, Gagne & Koehler, 1997). Recovery in those studies was understood as a return to “a satisfying, hopeful, and contributing life even with limitations caused by illness” (Anthony, 1993; p. 17). Being part of a peer-led service can itself add to the process of an individual’s recovery and re-evaluation of their own experience. Based on research of service users’ experiences Andresen, Caputi and Oades (2003) created a five-stage theory of recovery where the last stage is characterised by growth beyond the life before diagnosis of the illness.

Despite increased numbers of peer worker within the NHS, a very limited number of studies focused on their experience of the role. The main body of research comes from the United States, Australia and New Zealand. Only one study looked at an introduction of peer workers into mental health teams in Scotland (McLean, Biggs & Whitehead, 2013) and another study of a London-based assertive outreach team analysed interviews of two peer workers and other team members about the peer-non-peer partnership at work (Doherty, Craig, Attafua, Boocock & Jamieson-Craig, 2004). This suggests there is a shortage of good quality UK-based studies in this area.

Studies from abroad suggest that a number of benefits can be experienced by peer workers, including better symptom management (Salzer et al., 2013), enhanced recovery broadly defined in terms of social, emotional, occupational and spiritual benefits (Moran,

Russinova, Gidugu, Yim & Sprague, 2012) and increase in self-esteem (Salzer & Shear, 2002). Some benefits, including increased self-esteem, occur after just attending training to become a peer worker (Ratzlaff, McDiarmid, Marty & Rapp, 2006).

Moran, Russinova, Gidugu and Gagne (2013) analysed challenges associated with peer work. Most related to occupational path and development, but additionally dealing with prejudice and non-recovery oriented services was seen as a challenge. Work with clients was occasionally associated with recurrence of symptoms, emotional reactions to hearing about very difficult experiences of others or listening to experiences similar to their own. Being reminded of past experiences was also mentioned as a theme in other studies (Meehan, Bergen, Coveney & Thornton, 2002; McLean et al., 2009).

Peer-led Organisations

Literature published on recovery from mental health problems using user-led interventions outside of the medical mental health system is even more scarce. This is despite service user-led organisations outnumbering professional-led organisations in the USA in recent years (Goldstrom et al., 2006). Recovery from addiction using peer-led organisations and self-help groups were shown to be equal or superior to professional services (Pistrang & Baker, 2008; Kelly, Magill & Stout, 2009). Benefits are assigned to involvement in helping others in addiction programmes (Zemore & Kaskutas, 2004). Little is known about what are the most beneficial aspects of those groups. Bracke, Christiaens and Verhaeghe (2008) in a large quantitative study explored naturally-occurring support between mental health service users and suggested that some benefits of providing support (e.g. self-efficacy are greater than the benefits of being on the receiving end of support).

Diversification of Peer Roles and Peer Brokerage

The increased number of peer workers in mental health services and new peer roles also raises new questions. Are the requirements of each peer role similar or do they differ substantially? Should the benefit for service users or peer workers be considered when offering the role?

Peer brokerage is an interesting mix of peer-run and professional support. Peer brokers are usually a part of a peer organisation that supports them, while also having contact with clients using professional-run services and working as partners with service providers. In this case, peer brokers might also give advice on personal budgets to people with physical or learning disabilities. Peer workers within NHS mental health services are meant to be, amongst other things, “recovery role-models” showing that good life despite the diagnosis is possible (Repper, Aldridge, & Gilfoyle; 2013). This would not translate easily into work with someone with physical health problems.

Rationale for the Study

Research into peer brokerage for mental health service users has particular importance due to current policies (e.g. DH, 2007) and services looking for the best options to implement the personalisation agenda within NHS trusts. Research is needed to fill the gap related to lack of UK studies on any type of peer work.

Research Questions

This study aimed to answer questions of what is a sample of mental health service users’ experience of training and work in peer brokerage, how they make sense of their experience and how, if at all, they link it with their recovery and view of themselves.

Method

Design

A qualitative approach was chosen as this is a new area of exploration, and a small number of service users are currently involved in peer brokerage. A phenomenological approach (Smith, Flowers & Larkin, 2009) seemed the most suitable as it allowed an in-depth investigation into the perspectives of people involved in peer brokerage and their views on whether and how it affected their lives. Qualitative research will allow exploration of the new area of mental health related to personal budgets, when practice is more established quantitative research can add to the evidence.

Participants

Six mental health service users currently working as peer brokers took part in interviews. All participants had a history of contact with mental health services including inpatient admissions (mental health or addiction-related) and diagnosis of either bi-polar disorder or psychosis related difficulties. The recruitment was arranged through two peer-run organisations providing peer brokerage for people who were in the process of receiving a personal budget. Four participants were members of a mental health organisation and two of a peer organisation that includes people with physical, learning and mental health disabilities.

Initially the intention was to recruit eight to ten participants following advice by Smith et al. (2009). Due to high drop-out rates (eight out of 12 brokers left one of the projects within few months), only six mental health service users who trained as peer brokers were available. This might imply that the participants were particularly resilient and committed to the idea of peer brokerage, or perhaps more skilled and resourceful than others since they managed to overcome problems that prompted others to leave. Table 1 presents basic demographic information on participants.

Table 1

Participants' demographic information

<u>Demographic category</u>		<u>Number of participants</u>
Gender	Male	2
	Female	4
Age (years)	Range	43-53
	Mean	49
Ethnicity	White British	6

Ethics

This research received ethical approval from Canterbury Christ Church University. NHS ethics approval was not required as all participants were approached through non-NHS organisations. Applications and approval letters can be found in Appendices 4 and 5.

Materials/Measures

Semi-structured interview questions were guided by the study aims (Appendix 6). Open questions were used to minimise suggestions regarding what content was expected (Smith et al., 2009). The focus was on the participants' experience of training, preparation and providing peer brokerage. The other topics covered were links with other areas of participants' life and view of themselves. Additional questions were asked following up from the experiences described by participants.

Procedure

Participants were invited to take part in the research through the organisations providing peer brokerage. Those who were interested contacted the researcher. Written informed consent was taken from all participants (Appendix 6).

Semi-structured interviews were conducted at the offices of the organisations they work for. All participants were given an opportunity for subsequent contact if they wanted to add anything to the interview. One person met with the researcher for the second time as the first interview was conducted just before she started work as a peer broker and she felt that much had changed for her within the first few months that was relevant to this study.

All interviews took between 45 minutes and 1 hour 20 minutes. On average interviews lasted for 1 hour. Interviews were transcribed and anonymised for analysis. Participants had a further opportunity to discuss and comment on the group themes.

Data Analysis

Analysis followed a structure suggested by Smith et al. (2009). Each participant's data were analysed separately, initially noting comments related to the content, linguistic style and conceptual associations relevant to each section of the text. This analysis was then used to establish themes relevant for each participant. (See Appendix 7 for annotated interviews). Finally, the themes were re-organised and master themes were developed to synthesise information from all six interviews.

Quality Assurance

A number of measures were taken to help reduce and understand the researcher's own bias. A reflexive diary was used during the interview process to help analyse assumptions (see Appendix 8). A bracketing interview was used at the stage of consolidating themes to reflect on the process of data collection and analysis (see Appendix 9 for the interview summary). The supervisor's notes on interpretative commentary and themes from one of the interviews were used as an audit of data coding. Finally, a service users' representative involved in creating peer brokerage training read through one of the anonymised interviews

with the interpretative commentary to help highlight possible assumptions arising from the present author being a mental health professional.

Results

The results for each participant were organised into five master themes: changing and growing; rewarding and challenging aspects of the role; client-centred approach to peer-brokerage; importance of peer relationships and the pioneering nature of peer-brokerage. All the themes are presented below. Each section includes a table with subthemes and the number of participants who spoke of those subthemes in their interviews. Names used in the presentation of results are pseudonyms.

Changing and Growing

Table 2 *Subthemes of theme 1: Changing and growing*

<u>Subthemes</u>	<u>Alice</u>	<u>Beth</u>	<u>Colin</u>	<u>Daisy</u>	<u>Elle</u>	<u>Frank</u>	<u>More than half?</u>
a. Realising own value and worth	Y	Y	Y	Y	N	Y	Y
b. Improving skills	Y	Y	Y	Y	N	N	Y
c. Better management of own problems	N	Y	Y	N	Y	Y	Y
d: Fuller life	Y	Y	N	N	Y	Y	Y
e: Establishing a new value system	N	N	N	N	N	Y	N

Y-Yes, subthemes present; N-Not present

Realising their own value and worth. Part of the process of changing and growing included finding how valuable their own experience could be when it was shared with others. Alice recalled how her interest in peer support started from meeting someone who had been through similar problems to hers: “She... said ‘oh, Alice I’m so glad I’ve met you... it’s made such a difference to meet someone who’s actually been through it.’ ...hmmm... And that really reinforced doing it.” (Alice)

The opportunity to help others made Colin feel resourceful: “I’m also quite good at finding resources for people.[...] I know a lot of the people around and if I haven’t got the answer myself I usually know where to go.” (Colin). In Colin’s case his confidence did not necessarily stem from peer brokerage, but from giving him the opportunity to use the skills that he already knew he had. For Frank, this role was more clearly a source of feeling valued:

I think the word I used is... was: ‘esteem’, it’s esteem-able stuff, it’s great. You know... it’s estimable in... in a spiritual sense it’s, you know... I mean, I know I talked to you about it... is just, you know, feel valued.. [...] it’s not the area, you know, to be for the money but... it’s kind of, in terms of, you know.... fulfilment.
(Frank)

Improving skills. The sense of change and growing didn’t only come from the peer brokers realising their own worth. Participants also spoke of tangible improvements in their skills. For Beth, those changes and sense of growth made her feel good: “Even on the computer I was rubbish and now... (pause) you know I’m doing the reports and everything and I, just, I don’t know... it just makes you feel good, doesn’t it?” (Beth)

Peer brokerage might be an opportunity but Colin noticed that it also met his desire to learn, he saw himself as an active recipient who affected the process of growth: “the whole thing was, you know, beneficial. I’m just one of these people, when I go on something like that I wanna get the most out of it.” (Colin)

Better management of their own problems. Beth, like others, found that being a peer broker didn’t mean that all her personal problems needed to be resolved. She managed to overcome some difficulties when she started work:

...I think the biggest thing for me is confidence, because when I initially went out, even my husband said ‘you shouldn’t be doing this job’, because I was shaking so

much, and I was just so nervous and, I knew, that, because I'd done the training that (pause) I knew I could do it (Beth)

Other difficulties, such as self-harm, remained on-going and Beth needed to manage them while working as a peer broker:

I have little blips of self-harming, which... I just have to make sure I don't beat myself up more about it and go through the stage where I think 'oh stupid woman'.

Yeah, I'm still in recovery, I think (Beth)

Fuller life. Changes and growth characterised participants' lives not just in areas directly connected to peer-brokerage. For example, Beth expressed a wish for her life to be about more than using services: "You want to move on and do other stuff so, hmm... I say... I do a lot of other bits and pieces so yeah, really starting to move on." (Beth) Elle gave an example of her personal life that recently changed and how this became very important for the way she saw herself.

You need something to do in life, a purpose. I am a mum as well and I have been able to have a child, which I didn't think would happen. I was 41 when I had my girl. So I am a mother and I like to look after people. (Elle)

Establishing a new value system. Frank chose a different way of talking about change and growth in his life. Starting with his recovery he described a journey of establishing a new value system:

Oh (pause) I feel quite emotional now. I told you [...] the kind of work I used to do, you know... I mean - it was all based on money, you know, kind of sales and money.

I don't know how I used to... it's now... it's based on making a difference. (Frank)

Frank contrasted his old values with his current values to show how much more meaningful he found his life to be. This meaningfulness was also reflected in his emotional

reaction when he spoke. He then compared the new value of ‘asking for help’ with messages from his family and wider culture: “these are the kind of ideals, you know, that you’re not encouraged to do... You’re encouraged to ‘grin and bear it’ you know ‘stiff upper lip’ you know.” (Frank) Those ideas were very different to Frank’s answer about how he saw himself. “Honest, passionate, loving, vulnerable... and it’s ok to be vulnerable”. (Frank)

Overall, the idea of changing and growing did not seem to be a linear representation of changes caused by the experience of training and work as peer brokers. Some changes were affected more or less by this role, some were perhaps totally independent to the role such as changes in the families and friendships.

Rewarding and Challenging Aspects of the Role

Table 3 *Subthemes of theme 2: Rewarding and challenging aspects of the role*

<u>Subthemes</u>	<u>Alice</u>	<u>Beth</u>	<u>Colin</u>	<u>Daisy</u>	<u>Elle</u>	<u>Frank</u>	<u>More than half?</u>
a. Feeling for the client	Y	Y	N	Y	Y	Y	Y
b. Feeling challenged by client’s behaviour	Y	Y	N	N	Y	Y	Y
c. Work triggering own difficulties	N	Y	N	N	Y	Y	N
d: Work satisfaction and appreciation	Y	Y	Y	N	N	Y	Y
e: Valuable knowledge of local resources	Y	Y	N	N	Y	N	N
f: Flexibility of time and workload	Y	Y	Y	Y	N	Y	Y
g: Importance of paid work	Y	Y	Y	Y	Y	Y	Y

Y-Yes, subthemes present; N-Not present

The theme of rewarding and challenging aspects of the role and learning to overcome them focused on what participants liked about peer brokerage and what made this role difficult.

Challenges.

Feeling for the client. Participants sometimes found it difficult to work with clients, especially those who seemed to be ‘stuck’: “I always find really annoying that I can’t do anything, I keep thinking: ‘couldn’t I do this?’, ‘couldn’t I do that?’ but it’s so difficult, you know” (Alice). This challenge was as much about empathy as about accepting their own limitations. Elle found it difficult not to take full responsibility for the clients: “When you work with people one to one intensively, even though it is a short intervention, brokerage, I have problems where I feel so responsible for that person that it overwhelms me.” (Elle)

Seeing people whose lives are not going well and who experience a lot of suffering can itself be a great challenge. Frank gave the example of visiting his second client: “I left there in tears. Just this... this... this man’s life and you know, and it really affect... hmm... I mean I’ll tell you, really - it’s affected me, actually... I was so so sad” (Frank)

Feeling challenged by clients’ behaviour. Sometimes a client’s behaviour was also difficult to manage for the participants, an example could be someone who seemed too passive to benefit from peer-brokerage: “I knew whatever I did find wouldn’t be good enough because he was that sort of mind set you know... He was lonely and isolated but he didn’t like groups and he didn’t wanna go out”. (Alice)

Work triggering their own difficulties. Participants found that contact with clients occasionally brought back unpleasant experiences from the past.

My father was very ill [...] I was looking after him and things were extremely frightening. So possibly the child carer of an ill person... there is something that is very specific to me as to why I become overwhelmed with a feeling of responsibility. (Elle)

Rewards.

Work satisfaction and appreciation. One of the most rewarding experiences described by the participants was feeling valued and appreciated by others: “everything in the plan she wanted so that was good... and they [care team] were really pleased with it so that was good” (Alice). The way Alice described the rewards showed that others being happy equalled in her mind with work being well done. Not only clients expressed appreciation, some came from the family of the client and even professionals. “I did encourage, you know, encourage him... more socialisation, you know - getting out more and... and... you know I got, really... you know, in fact, I got really good feedback from the family” (Frank). Alice was pleasantly surprised at being treated as an equal by professionals, seeing it as a sign of being valued: “they said they would be interested to hear my views, which, I thought: ‘that’s great’, ‘that’s a psychiatrist and a care-coordinator done their assessments and asking me what I think’.” (Alice)

Valuable knowledge of local resources. One aspect of peer brokerage is to find local resources that can be recommended when advising on personal budgets. This process itself was seen by some as a good thing. Alice found herself to be someone known for her resourcefulness:

All the service users know I’m a peer broker and, you know, they ring my house, one rang me the other week, you know... they’d ring me with their problems, you know, people say: ‘why don’t you ring Alice and ask her?’ (Alice)

Beth found that the knowledge of the local area was useful in finding activities for herself and getting more involved in different things: “I do a lot of research. It even helped me in that front, cause I didn’t know, how much was out there, really”.

Flexibility of time and workload. The participants saw peer brokerage as a flexible role which appealed to them. Some found that this allowed accounting for times when they did not feel up for the task: “if I am having a bad day, I can move things around and, you know, change it and find something suitable for that day... I then get back onto it another day”. (Colin)

Importance of paid work. One of the issues raised by all participants related to the importance of getting paid: “getting paid for it shows that it is taken seriously” (Beth). The goal of earning money seemed unachievable to Beth in the past: “Because I haven’t worked for so long I just thought, you know: ‘what can I go back into?’ And... because I am not always well myself... I can get this, you know, fitted into my life.”

Interviewees noted that most peer support in services is done on a voluntary basis so peer brokerage stood out as a better opportunity: “volunteers get exploited. I haven’t found that, I found the complete opposite... you know it, you know this is [organisation]. It is not... you know, we get acknowledged.” (Frank). Frank contrasted voluntary work which seemed exploitative with the paid work that meant to him that he was being acknowledged. Being paid also seemed to him a personal achievement: “I’ve been on benefits since... 2003 something like and last year I came off benefits, that’s the you know... fantastic feeling you know, not in that just kind of, you know, it was yeah... great one.”

Client-Centred Approach to Peer-Brokerage

Table 4 *Subthemes of theme 3: Client-centred approach to peer brokerage*

<u>Subthemes</u>	<u>Alice</u>	<u>Beth</u>	<u>Colin</u>	<u>Daisy</u>	<u>Elle</u>	<u>Frank</u>	<u>More than half?</u>
a. Motivation to help others	Y	Y	Y	Y	Y	Y	Y
b. Importance of listening and empathy	Y	Y	Y	N	Y	Y	Y
c. Tailoring a budget to client's needs	Y	Y	Y	N	Y	Y	Y
e: Disclosure based on what helps clients	Y	Y	N	N	Y	Y	Y

Y-Yes, subthemes present; N-Not present

Motivation to help others. Helping others was a motivator to get into peer-brokerage. This motivation was described as a strong drive in participants' lives that went beyond this specific role:

It's based on making a difference, you know... I'm trying to make a difference to try to empower somebody, who perhaps in the past, you know, hasn't had the opportunity... you know, so making a difference, you know, in other people's lives is... kind of... really important. (Frank)

Importance of listening and empathy. Experience taught peer brokers that listening and empathy play a crucial part in their work with clients: "I've learnt not to talk. I think nerves... (pause) at first I used to talk a lot and, I think now, it's easier to, sort of... like... take a little step back and let them do the talking" (Beth). Beth also found that using her own experience helped her to understand better what can be useful for others: "I think recently, when I've started to feel really so much better, I've looked at the things that have really helped me and then tried to sort of, like... put it onto others." (Beth)

Colin found that sharing and opening up is directly related to how much he is able to help in his role: "And it really will be up to them how much they wanna get out of it, how

much they wanna divulge and tell you about themselves. The more they tell you the more you'll be able to help." (Colin)

Tailoring a budget to client's needs. Alice described the process of creating a budget and the effort she put into finding the right activities for people she worked with:

I don't just put it on a bit of paper [...] I actually speak to them and actually go along when I can and see what the groups do, and how they work, and what the people are like. And then I can see whether... if you walk in as someone on your own, how you're gonna be treated. (Alice)

It is clear from what Alice said that she made the effort to put herself in her client's shoes to understand what problems they might be faced with. Colin spoke of a client who did not have a personal budget, but he still managed to find something for the person: "I've managed to get her some help... for nothing... so hmmm... whether she comes under personalisation or not doesn't bloody well matter, because it's free so I can give that to anybody." (Colin) The way Colin described the situation suggested irritation with the financial limitations. His response was that being helpful to the client was the most important thing, even if he was to do something beyond what was expected of his role.

Disclosure based on what helps clients. Disclosure in the case of peer brokers is not as clearly defined within the role as in other peer roles: the main task is to advise clients about activities, not necessarily to share the story of their own recovery. This prompted participants to find their own ideas about what and when to disclose stories regarding their personal difficulties. The guiding principle became helpfulness to the client. Frank found that disclosure did not always seem appropriate: "if I feel a connection with somebody and I feel it's right, then I will disclose... you know, it's my own stuff... So I did that, where it went really well".

Disclosure became more clearly a dilemma in cases of working with clients who had a budget due to physical disability:

You see people with mental health difficulties and physical stuff with [peer brokerage organisation], but very, very often... they may be in denial about mental health aspects of it, so it is completely inappropriate to be explicit about mental health difficulties. (Elle)

Beth found that the most useful way to share her personal story was with clients who had similar problems to hers in the past:

[client] was a really bad self-harmer. And I could see that she was, you know, pulling her sleeves down and everything and I said... 'look, can I just say something to you?', I said, [...] 'look, I used to self-harm, I know what it's like' and I showed her my arm... and she said 'oh, thank you so much for sharing that' [...]. 'I know', I said to her 'I know how you feel... I really do'. (Beth)

In this example Beth did not even choose to say much, showing the scars was symbolic of having been through similar problems and therefore being able to understand the client.

Importance of Peer-Relationships

Table 5 *Subthemes of theme 4: Importance of peer relationships*

<u>Subthemes</u>	<u>Alice</u>	<u>Beth</u>	<u>Colin</u>	<u>Daisy</u>	<u>Elle</u>	<u>Frank</u>	<u>More than half?</u>
a. Acceptance and mutual support	Y	Y	Y	Y	N	Y	Y
b. Learning from other peers	Y	Y	Y	Y	Y	N	Y
c: Preference of peer over professional support	Y	Y	Y	Y	Y	Y	Y
d: Need for peer-supervision	Y	N	N	N	Y	Y	N
e: Does 'peer' include other disabilities?	N	N	N	N	Y	Y	N

Y-Yes, subthemes present; N-Not present

Acceptance and mutual support. Participants' belief in helping other service users often came from personal experience of forming peer relationships. Participants found it crucial to have mutual support between peer workers: "We might be peer brokers helping people with personalisation but we also need to... to be peer brokers helping out each other to move forward, as well." (Colin)

One element of peer support that was important for participants was acceptance: being able to open up and not having to hide their difficulties. Alice talked about how she felt around the peers she worked with: "you can tell them everything... you're not sort of thinking 'oh god I can't say that, they'll think I'm completely mad' I mean (pause) they all know we're mad, so it's ok. (laughing)" (Alice) Here Alice used the usually pejorative term in a humorous way reflecting how she could feel at ease with whatever label might be given to her while she was with people who have been through the same difficulties. Daisy also spoke of use of humour as a part of peer bonding: "So the informal networks... we just accept each other as we are. We have had our bizarre, I mean [one of the peer-brokerage trainers]'s sense of humour, has me pissing myself... (both laughing)... sorry." (Daisy) It

seems as if Daisy's narrative in this quote slipped into a very informal way of talking that she was used to in her peer group. Shared laughter brought this sense of fun into the interview. The exchange ended with a withdrawal and return to the interview format. Saying 'sorry' might mean a return to a more formal conversation, a reminder that the interview was with a non-peer.

Learning from other peers. Other peers not only provided support, they were also seen as role-models and some interactions were seen as a learning opportunity. This included more successful learning from peer trainers who could lead by example, as participants found peer trainers to be more approachable than the usual interactions within educational settings. Beth described meeting peer brokerage trainers for the first time: "you don't feel like you need to be put on the spot, like in 'them and us' situation. And then you can, sort of, pass that down. I think that just helps people feel more relaxed". (Beth)

Preference of peer over professional support. Seeing the benefits of peer support gave participants belief that it works well and was superior to professional support:

It gives [service users] a little bit of confidence in what's happening because, you know, they feel somebody else is likely to understand the sort of things they're going through. (Colin)

Frank spoke of his experience of volunteering as a peer worker in an addiction service where he suspected that professionals felt threatened by peer workers:

[Peer workers] clearly had something which they didn't have, you know... and that was empathy, you know... this is understanding of, you know, of where our clients have been, you know, you could, you know, completely understand their situation. (Frank)

Need for peer-supervision. Elle noted that increased support from other peers was needed to meet demands of the role: “I think working with peers... I think there is a necessity for increased supervision. It isn’t because people’s work is going to be problematic... it is because of the emotional demand of the work.” (Elle) Frank used support from his wife, who is also a peer worker, to help him with the challenges of the role:

Once in a while you need support. Again, you know... I mean having your, you know... having my wife, you know, as my ‘in-house supervisor’ (laughing) isn’t, you know... isn’t really ideal to be honest. But it’s, you know... she’s really helped me, again... you know, she knows me very well. (Frank)

Does ‘peer’ include other disabilities? The need for peer supervision came from two participants who did not work in a mental health organisation, therefore some of their colleagues were people with other disabilities. Perhaps this meant that the level of understanding between peers was not as good due to different difficulties they were facing. Spontaneous mutual support was not as frequent, leading to a need for more formalised supervision. Elle explained:

To be a peer here, it is a broader understanding of the term ‘peer’. [...] You could have physical and sensory impairment, learning difficulty or mental health. The peer intervention at the mental health services... you have to have used secondary mental health services, so you have to have more severe mental health difficulties and it is narrower... (Elle)

When discussing the emerging themes with Elle and Frank they added that this wider understanding of the term ‘peer’ led, in their view, to a need to oversee the process, that they met peers who had a quite medical view of mental health problems. They wondered if this view was a result of spending time with professionals and losing some of their identity, or if

they did not see themselves as similar to people with mental health problems so needed to use other ways of understanding.

Pioneering Nature of Peer Brokerage

Table 6 *Subthemes of theme 5: Pioneering nature of peer-brokerage*

<u>Subthemes</u>	<u>Alice</u>	<u>Beth</u>	<u>Colin</u>	<u>Daisy</u>	<u>Elle</u>	<u>Frank</u>	<u>More than half?</u>
a. Belief in personalisation and excitement about the role	N	Y	Y	N	Y	Y	Y
b. Pioneering work is bound to be difficult	N	Y	Y	Y	Y	Y	Y
c: Need to promote the idea	Y	Y	Y	Y	Y	Y	Y
d: Being ‘too rebellious’ for the role	N	N	N	Y	N	N	N

Y-Yes, subthemes present; N-Not present

Belief in personalisation and excitement about the role. Peer brokers saw themselves as pioneers in their field, doing something that was new and not well known by many people within mental health. This pioneer status then required dedication from them and the belief that they are introducing something important and worthwhile. Frank spoke of it as something that was an exciting opportunity to make a difference in other people’s lives: “I can make a difference in... you know... to somebody else’s life [...] I do believe that personalisation is... you know, kind of... you know... is the way forward. It really is really... it’s really important.” (Frank) The repetition of ‘really’ seemed to reflect Frank’s commitment to the idea and his faith in personalisation.

Pioneering work is bound to be difficult. Pioneering work also meant that things didn’t always go smoothly. Some peer brokers experienced long delays between the training and getting work:

Initially I was really really excited, then we went through a sort of a low... and I thought “this is never going to get off the ground”... and it went like that for a while and... and I started to lose confidence in what I’ve learnt. (Beth)

Beth emphasised how good she felt about the work, even though she was enthusiastic the delay in starting work turned out being very difficult to manage. Others saw change that was being introduced to the mental health system as difficult to accept and challenging the status quo. Elle reflected: “the whole concept of self-directed support... mental health services aren’t ready for it.” (Elle) Frank described the process of implementing change as a struggle: “We’re talking about these great huge... great clunking, kind of... you know (pause) council dinosaurs. You know, there’s like... there’s... and within these, you know... these organisations - there’s all sorts of resistance.” (Frank) Frank gave a vivid image representing how he felt as peer broker, showing how the structure that he tried to change seemed much bigger than him and beyond his power to affect. This feeling might have been related to an experience he had with one of the councils who asked for peer brokerage but ultimately did not approve the budgets or changed the recommendations made by peer brokers:

It took a year to actually work out that, you know... that in many cases the council were ignoring our support plans and do, you know... and, you know... and kind of doing their own, which is... you know, like: ‘what’s the point?’ (Frank)

Similar to Beth’s experience with delays, Frank found himself struggling with maintaining motivation when faced with such difficulties.

Need to promote the idea. Because many professionals were not aware of what peer brokers did, especially when it came to work with clients with mental health problems, there was sometimes a need to introduce the idea to teams of professionals. Alice found that using

her marketing knowledge from her past career was the best way to do this. She approached mental health professionals by letting them know how they would benefit from peer brokerage: “it’s really just going out and getting the work, really. But because I’ve run two of my own businesses so I’m used to doing that I’m used... to marketing.” (Alice) She also found that persistence was crucial:

You’ve gotta keep going there... and plugging away [...] because they’re so busy, they forget or, you know, they’re doing other things and they haven’t really thought... ‘oh that could be brokerage’... (Alice)

When the themes were reviewed with Elle she added that the pioneering aspect of the role was crucial for her, she felt that to be a peer broker it was important to be ‘a crusader’ and be driven to change the mental health system.

Being ‘too rebellious’ for the role. Daisy’s experience after the training differed from other participants. She experienced an involuntary hospital admission that she found harmful rather than helpful. This made her see the professional mental health system in a more negative light than before. When she took part in the study she was not sure if she wasn’t ‘too rebellious’ to be able to work with services:

It is like ‘oh will you let me be empowered today?’ That is the psychology. And I hate that and that is why I am the rebellious one out there, do you know what I mean? [...] they say ‘just have another pill’, ‘have another pill’ and that is all there is to it. It is that simple... and it is not that simple, because people are in shit social conditions, in many circumstances, they have had shit things happen to them... and it is not the answer! It doesn’t solve anything. You are just stuck in a box. I would have been stuck as well if I hadn’t taken my own steps. (Daisy)

Daisy disagreed with professionals' decision to put her on antipsychotic medication, which she felt was seen as an ultimate rejection of professional help: "I was off medication for 4 years at that point. I had been off it for a year before a previous hospitalisation. I am off it again now. Now... the shrinks don't like that."

Interestingly, even though other peers had negative experiences in services, for example Elle chose not to work in the area where she was initially admitted to a hospital, other peers spoke of taking psychiatric medication as a part of keeping well. This highlighted how being angry at the professional mental health system might contribute to change but also can become a great obstacle to getting involved.

Discussion

The Rewards, Challenges and Personal Growth

This area of the study was the most consistent with previous findings related to experiences of peer workers. Challenges, including feeling helpless when working with people who do not get better and being reminded of one's own problems, were reported by Moran et al. (2013). Benefits to peer workers from helping others have also been found previously, including increased skills and self-esteem (Salzer & Shear, 2002) and better symptom management (Salzer et al., 2013). The importance of employment and getting paid, with its positive consequences on self-esteem, has previously been highlighted by Dunn, Wewiorski and Rogers (2008) as crucial for service users in recovery from serious mental health problems.

The theme of living a fuller life is similar to the last stage of recovery of Andresen et al. (2003), characterised by growth beyond the illness-related identity. This did not however mean to the participants that their problems disappeared. Also, changing and growing was

not always a result of being a peer broker. Some changes appeared independent of the role, and some might have been catalysed by it but were initiated beforehand.

Mutual Support

Many positive changes were ascribed to support between peer brokers and from peers that they met in other roles, not just from work with clients. The importance of working with other peers was not mentioned in studies that included interviews with peer workers employed by mental health services. This finding might be related to the fact that peer brokers in the present study were involved in peer-led organisations, allowing them to receive and give support to other peers in similar roles. Bracke et al. (2008) found that exchange of support between mental health service users, rather than only giving or receiving support, was associated with the highest scores on wellbeing measures. The findings are also consistent with research on self-stigma reduction by Corrigan, Kosyluk and Rüschi (2013) showing that contact with other peers helped to reduce self-stigma and improve self-esteem.

Client-Centred Work

The theme of client-centred work showed that peer brokers saw as most important in their roles the humanistic values of listening, connection, and finding things based on the person's interests. Previous research found that service users understand their recovery in a wider sense than professionals and are less concerned with symptom reduction (Davidson, O'Connell, Tondora, Staeheli & Evans, 2005). Kogstad, Ekeland and Hummelvoll (2011) analysed turning-point stories of 347 people with severe mental illness and found that one of the important factors for service users were dialogue, respect, care and understanding. It seems that peer brokers are able to apply this lived knowledge into working with clients.

Pioneering Aspects of Work

Participants seeing themselves as pioneers might mean that peer brokerage attracted people dissatisfied with the system and wanting to change it; some aspects of the role require resilience and determination. Previous studies of challenges in peer work pointed to environmental and occupational factors as being the most difficult to manage (Moran et al., 2013). Perhaps peer brokerage as being provided by peer-led organisations to different teams results in seeing the greater picture rather than concentrating on work with individual clients alone. Some of the participants' ideas were similar to planning for social and organisational change (i.e. promoting the idea, assessing the environment, support, professionals' attitudes and readiness of the system). This is similar to what experts consider in implementing innovation in healthcare (Fleuren, Wiefferink, & Paulussen, 2004).

Limitations

The research was conducted by a trainee clinical psychologist who participants might have perceived as a representative of mental health services. This could have led participants to be uncomfortable discussing their own difficulties in the peer role. Negative experiences with professionals and services might have been downplayed. Research involving service user interviewers would be potentially valuable as this might prompt some additional insights and perspectives. Research suggests that the presence of other peers helps in expressing more negative opinions of services (Simpson & House, 2002).

Since peer brokerage is an ongoing experience, it would be helpful to interview participants at different time points to see what changes over time and how their understanding of the role develops. If possible, reaching those who dropped out of peer brokerage training could help to understand what difficulties were faced by those who chose to leave.

The study was on a very small scale, however, very few mental health service users work as peer brokers in the UK. The study expands on the current knowledge in the area of peer work within NHS mental health services.

Implications for Future Research

Scarce research in the area of peer support provided both within the NHS and in peer-led organisations has been conducted in the UK. A better understanding is needed of common and specific factors of the roles affecting the experiences of peer workers. An understanding of the experiences of different age groups and in varied services is needed to support the implementation of peer work in mental health services, to find the best way for professionals to aid peer support, and to help service users transition into peer work.

A further question is the extent to which the organisational context enables peer workers to feel fully valued and part of the team, as this appeared to be variable in people's experience. Since listening and empathy are held very highly by peer workers, this raises a question as to whether organisations would value listening and empathy more as peer work becomes more common. Some changes, such as being more supportive towards staff after integrating peer support within the teams, were already noted in previous studies (e.g. Doherty et al., 2004).

Implications for Clinical Practice

This study adds to the body of research showing the importance of peer relationships, in this case extending it to peer support for peer workers, not just service users. It also shows that peer brokers relate to clients through listening and shared connection, and bring the nurturing aspect of human relationships into their intervention. The peer position might make it easier to use this approach. The emphasis placed on empathy and listening reminds us of the reports of service users' experience of its insufficient presence in many mainstream

mental health service interactions. Research suggests that bringing these kind of qualities into a medical-model oriented practice by professionals is very difficult (Benjamin, 2011). Despite evidence of the positive effect of peer support on service users, many professionals are unsure of the available options, their value, and do not make referrals to peer-led organisations (Hardiman, 2007). This study, by examining experiences of peer brokers, allows a better understanding of how the approach differs from the professional approach and the unique value it offers to service users. Applied psychology expressed commitment to increased wellbeing by focusing on social rather than medical formulations (British Psychological Society, 2009), therefore peer support can be considered as an important avenue to increased wellbeing.

Conclusion

This study explored for the first time in the UK a new area within mental health of peer brokerage. This is an important research since the number of peer workers within the NHS is increasing and majority of studies that inform the changes were conducted in other countries. Personal benefits, challenges and rewards in presented study were similar to previous research on peer work from United States, Canada and New Zealand. Aspects unexplored in previous studies were: importance of humanistic values such as empathy and listening, and the pioneering aspect of the work – wanting to change and improve the mental health system. Great value was also placed on mutual support in peer organisations, and more clearly than in previous research the benefits of a peer-network for wellbeing of peer workers were highlighted. The study shows that great determination to help others, thoughtfulness and resilience is required in peer brokerage as it is a new role that includes facing many barriers within mental health services.

The ideas of the participants could be helpful in further implementation of personalisation within mental health, which is an important part of the agenda within the NHS. Alongside other UK-based research, this study will allow a greater understanding of the complexities of involving service users in providing paid support to others.

References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australasian Psychiatry*, 37(5), 586-594. Retrieved on 12 May 2012, from : <http://www.catalystbreakthru.com/wp-content/uploads/2012/02/2.The-experience-of-recovery.pdf>
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23. doi: 10.1037/h0095655
- Benjamin, E. (2011). Humanistic psychology and the mental health worker. *Journal of Humanistic Psychology*, 51(1), 82-111. doi: 10.1177/0022167810363918
- Bracke, P., Christiaens, W., & Verhaeghe, M. (2008). Self-Esteem, self-Efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal of Applied Social Psychology*, 38(2), 436-459. doi: 10.1111/j.1559-1816.2008.00312.x
- British Psychological Society. (2009). Psychological health and well-being: *A new ethos for mental health - A report of the working group on psychological health and well-being*. Leicester: British Psychological Society.
- Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, 103(5), 794-800. doi: 10.2105/AJPH.2012.301037

- Davidson, L., O'Connell, M. J., Tondora, J., Staeheli M., & Evans, A. C. (2005). Recovery in serious mental illness: paradigm shift or shibboleth? In. Davidson L, Harding C, Spaniol L, (Eds). *Recovery from severe mental illnesses: Research evidence and implications for practice center for psychiatric rehabilitation. Vol 1.* (pp. 5-26) Boston, Mass: Center for Psychiatric Rehabilitation, Boston University.
- Department of Health (2007). *Putting people first: A shared vision and commitment to the transformation of adult social care.* London: Department of Health . Retrieved on 4 April 2012, from:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document_s/digitalasset/dh_081119.pdf.
- Department of Health (2010). *Putting people first: Planning together – peer support and self-directed support.* London: Department of Health. Retrieved on 12 January 2014, from:
<http://www.groundswellpartnership.co.uk/DocumentDownload.axd?documentresourceid=18>
- Doherty, I., Craig, T., Attafua, G., Boocock, A., & Jamieson-Craig, R. (2004). The consumer-employee as a member of a mental health assertive outreach team. II. Impressions of consumer-employees and other team members. *Journal of Mental Health, 13*(1), 71-81. doi: doi:10.1080/09638230410001654576
- Doughty, C., Tse, S. (2011). Can consumer-led mental health services be equally effective? An integrative review of CLMH services in high-income countries. *Community Mental Health Journal, 47* (3), 252-266. doi: 10.1007/s10597-010-9321-5
- Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a

qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59-62. doi:
10.2975/32.1.2008.59.62

Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., & Manderscheid, R. W. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(1), 92-103. doi: 10.1007/s10488-005-0019-x

Hardiman, E. R. (2007). Referral to consumer-run programs by mental health providers: a national survey. *Community Mental Health Journal*, 43(3), 197-210. doi:
10.1007/s10597-006-9079-y

Hatzidimitriadou, E. (2002), Political ideology, helping mechanisms and empowerment of mental health self-help/mutual aid groups. *Journal of Community and Applied Social Psychology*, 12, 271–285. doi: 10.1002/casp.681

Fleuren, M., Wiefferink, K., & Paulussen, T. (2004). Determinants of innovation within health care organizations Literature review and Delphi study. *International journal for quality in health care*, 16(2), 107-123. doi: 10.1093/intqhc/mzh030

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory*, 17(3), 236-259.
doi:10.1080/16066350902770458

Kogstad, R. E., Ekeland, T. J., & Hummelvoll, J. K. (2011). In defence of a humanistic approach to mental health care: recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change. *Journal of*

Psychiatric and Mental Health Nursing, 18(6), 479-486. doi: 10.1111/j.1365-2850.2011.01695.x

- McLean, J., Biggs, H., & Whitehead, I. (2013). *Evaluation of the delivering of mental health peer support worker pilot scheme*. Retrieved on 24th November 2013, from: <http://scotland.gov.uk/Resource/Doc/291860/0089932.pdf>
- Meehan, T., Bergen, H., Coveney, C., & Thornton, R. (2002). Development and evaluation of a training program in peer support for former consumers. *International Journal of Mental Health Nursing*, 11(1), 34-39. doi: 10.1046/j.1440-0979.2002.00223.x
- Moran, G. S., Russinova, Z., Gidugu, V., & Gagne, C. (2013). Challenges experienced by paid peer providers in mental health recovery: a qualitative study. *Community Mental Health Journal*, 49(3), 281-291. doi: 10.1007/s10597-012-9541-y
- Moran, G. S., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. *Qualitative Health Research*, 22(3), 304-319. doi: 10.1177/1049732311420578
- Pistrang, N., Barker, C., & Humphreys, K. (2008). Mutual help groups for mental health problems: A review of effectiveness studies. *American Journal of Community Psychology*, 42(1-2), 110-121. doi:10.1007/s10464-008-9181-0
- Ratzlaff, S., McDiarmid, D., Marty, D., & Rapp, C. (2006). The Kansas consumer as provider program: Measuring the effects of a supported education initiative. *Psychiatric Rehabilitation Journal*, 29(3), 174. doi: 10.2975/29.2006.174.182
- Repper, J. (2013). *Peer Support Workers: A practical guide to implementation*. London: Implementing Recovery Through Organisational Change. Retrieved on 2 February 2014, from:

http://www.centreformentalhealth.org.uk/pdfs/ImROC_briefing7_Peer_Support_Workers_implementation.pdf

- Repper, J., Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal Of Mental Health, 20*(4), 392-411.
doi:10.3109/09638237.2011.583947
- Repper, J., Aldridge, B., & Gilfoyle, S. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health & Mental Health Network, NHS Confederation.
Retrieved on 13 January 2014, from:
http://www.recoverydevon.co.uk/download/ImROC_briefing_5-Peer_Support_Workers_Theory_and_Practice.pdf
- Repper, J., Perkins, R. (2006) *Social inclusion and recovery: A model for mental health practice*. London: Bailliere Tindall.
- Salzer, M. S., Darr, N., Calhoun, G., Boyer, W., Loss, R. E., Goessel, J., ... & Brusilovskiy, E. (2013). Benefits of working as a certified peer specialist: Results from a statewide survey. *Psychiatric Rehabilitation Journal, 36*(3), 219. doi: 10.1037/prj0000016
- Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal, 25*(3), 281-288.
doi: 10.1037/h0095014
- Simpson, E. L., & House, A. O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *BMJ, 325*(7375), 1265. doi: 10.1136/bmj.325.7375.1265
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Spaniol, L., Gagne, C., Koehler, M. (1997) Recovery from serious mental illness: what it is and how to assist people in their recovery. *Continuum*, 4, 3-15.

Zemore, S. E., & Kaskutas, L. A. (2004). Helping, spirituality and alcoholics anonymous in recovery. *Journal of Studies on Alcohol and Drugs*, 65(3), 383.

Appendix 1 Flow chart of literature search and search criteria

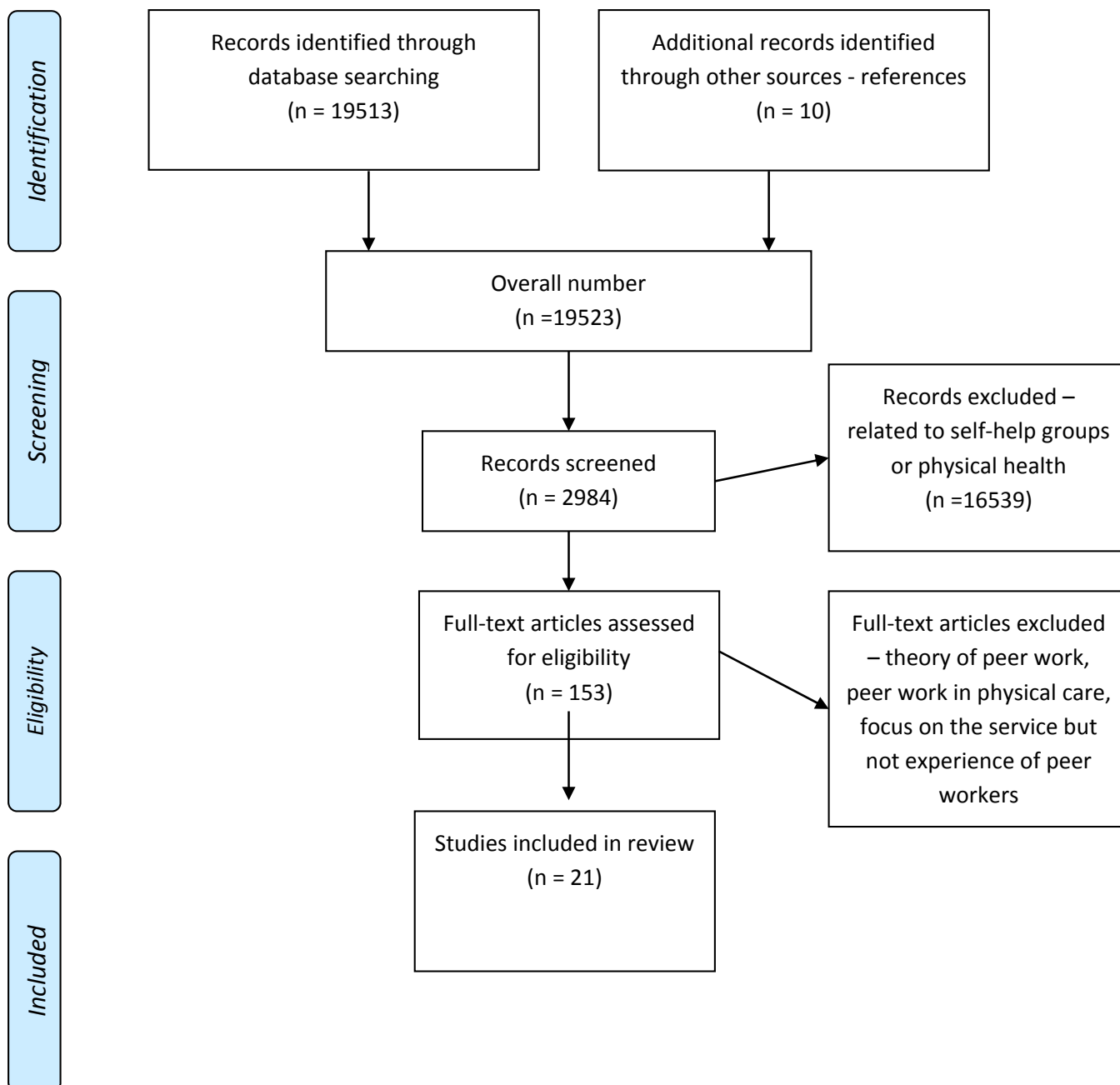
Inclusion criteria:

- Peer-reviewed research related to role of peer-workers in any supportive capacity (this includes volunteers or paid, face to face or telephone support, primary, secondary care or inpatient services).
- Whole or a part of research related to the experience of peer-workers, including benefits, challenges, experience, effects on view of themselves
- Excluded studies that focused solely on review of services including peer workers' views of the service
- Published in English

Key words: Consumer-provider, consumer staff, peer-worker, peer-support, peer-specialist, peers as staff, employment of consumers, experts-by-experience, support groups + all the above terms combined with term: mental health.

Databases searched: MedLine, PsylInfo, Jistor, Google Scholar

Flow Diagram



Appendix 2 Table summarising reviewed research

Study	Participants	Research design	Findings
Armstrong, Korba and Emard, 1995	Peer volunteers N=21(16 active and 7 former) Canada	Qualitative: interviews	<ul style="list-style-type: none"> • Importance of peer network • Support not based on sharing related to symptoms • Participants reported increased confidence and better access to community resources
Mowbray, Moxley and Collins, 1998	Former Peer Support specialists n=11 USA	Qualitative Thematic analysis of semi-structured interviews	<p>Varied benefits for peer workers related to having work, earning money and positive feedback from staff and workers.</p> <p>Challenges included problems with supervisions, some attitudes from other staff and difficulties related to setting boundaries when working with services users they knew personally</p>
Salzer and Shear, 2002	Peer Support Specialists in recovery from substance misuse and mental health problems, community-based programme n=14 Pennsylvania, USA	Qualitative Thematic analysis Semi-structured interviews focused on positive aspects of participants' experience of their position.	<p>Most frequently mentioned benefits were related to:</p> <ul style="list-style-type: none"> • Helping others and building competence to help • Feeling appreciated/increase in self-esteem • Professional growth <p>Other benefits included: working on different aspects of own recovery, specific work-related preferences such as travel, hours etc and mutual support</p>
Meehan, Bergen, Coveney, Thornton, 2002	Service users with past experience of hospitalisation that participated in 16-weeks peer work training n=10 Australia	Quantitative: battery of tests given at 4-weeks intervals (anxiety, stress level, locus of control and self-esteem) Qualitative: focus groups to discuss experience of training	<ul style="list-style-type: none"> • Improvement on all measures but not statistically significant. <p>Focus groups:</p> <ul style="list-style-type: none"> • Experience on the ward was appreciated but difficult as reminded some workers of their past experience • Peer workers recognised the value of their role for the patients • Lack of clear job description was at times problematic for peer workers when questioned by staff
Yuen and Fossey, 2003	Consumer-staff of the recreational programme, a part of psychiatric disability support service n=5 Australia	Qualitative Naturalistic Enquiry using semi-structured interviews	<p>Themes from interviews:</p> <ul style="list-style-type: none"> • Need for purposeful activity as motivator • Importance of work, including personal value and being paid • Meeting and establishing connection with people who went through similar experience

			<ul style="list-style-type: none"> • Rewarding experience of helping others • Feelings of belonging • Need to care for own wellbeing
Wells, 2003 In: Slade, 2009	Peer Support Specialists n=5 New Zealand	Qualitative design: Questions about challenges and ways of coping with work strain	<p>Six categories of strains were identified based on interviews:</p> <ul style="list-style-type: none"> • Super cool – limited range of emotions that could be shown i.e. trying to be cool at all times, hiding anger or feeling sad • Super normal – need for being conservative in behaviour and appearance • Super person – feeling need to be experts in all areas of mental health • Voyeurism – staff wanting to know the details of mental illness and admission but not the other parts of the story or what the lessons were • Remuneration – difficulties with pay due to lack of scales
Doherty et al., 2004	Peer Workers working in Assertive Outreach Team. n=2 London, UK	Qualitative Semi-structured interviews 6 and 18 months after employment. Part of a wider study including client outcomes and non-peer staff attitudes.	<ul style="list-style-type: none"> • Various difficulties related to work with clients and relationships with the team, e.g. feeling ‘too protected’, having to prove oneself due to past experience of illness • Seen as stepping stone to employment rather than doing work they wanted to do
Nelson, Ochocka, Janzen and Trainor, 2006 Ochocka, Nelson, Janzen and Trainor, 2006	New members of consumers/survivors initiatives (CSI) n=26 Canada	Quantitative: comparing active (n=14) and inactive members (n=12) Qualitative analysis: grounded theory based on semi-structured interviews at the baseline, 9 and 18 months since joining the CSI	<p>Significant differences for active group between baseline and 18-months follow-up on:</p> <ul style="list-style-type: none"> • social support measure; $t(60) = 2.55, p < .05$ • quality of life; $t(60) = 2.51, p < .05$ • decreased hospitalisation $t(56) = 2.81, p < .01$ <p>No difference on those measures for inactive group No difference on personal empowerment and symptom distress for either group For inactive group significant decrease:</p> <ul style="list-style-type: none"> • Instrumental role involvement ($F(2,206) = 5.54, p < .01$) • community integration $F(1.9, 196.7) = 5.08, p < .01$ <p>Summary of interviews</p> <ul style="list-style-type: none"> • Active member spoke more of stable mental health, improvements, social support, stable income and education within 2nd and 3rd interview

			<ul style="list-style-type: none"> • Inactive members spoke as much of their distress and hopelessness in each of the interviews
Ratzlaff, McDiarmid, Marty and Rapp, 2006	Graduates of Peer Worker programme (15-week including 8-week internship). Participants had diagnosis of serious mental illness. n=84 Kansas, USA	One group Pretest –posttest design on measures of: <ul style="list-style-type: none"> • Hope • Self-Esteem and • Recovery Additional retrospective pretest to check for response-shift bias	Statistically significant increase on measures of self-esteem and hope. Significant difference on pretest and retrospective pretest regarding own recovery suggesting that participants' understanding of what recovery means changed
Bracke, Christiaens and Verhaeghe, 2008	People with chronic mental health problems attending Day Therapy Centres (50 locations) n=590 Belgium	Quantitative: multilevel regression Dependant variables: self-esteem and self-efficacy Independent variable: balance of providing and receiving peer support.	Receiving and giving support was correlated 0.58 ($p < .001$) <ul style="list-style-type: none"> • Self-esteem was associated with total support ($r = .14$, $p < .001$), so the highest self esteem was linked with balanced high amount of giving and receiving support • Self-efficacy was correlated with total support ($r = .18$, $p < .001$) and with support inequity – providing more support than receiving ($r = .13$, $p < .001$) • In women self esteem was linked with receiving support and in men providing support had stronger effect on self efficacy
Chinman et al., 2008	Veteran Affairs (VA) Consumers Providers (CP) n=59 and VA supervisors n=34 USA	Qualitative Grounded theory Based on four focus groups	Effect on the team, patients and CP was discussed. Effects on CPs: <ul style="list-style-type: none"> • Boundary issues related to transition from 'patient' to 'staff' especially when working in the same places as they were before. As a result some CPs moved • Challenge in relationships with patients as they felt some 'resented' their success • Dealing with some 'patronising' attitudes or concerns of qualified staff • In time most felt accepted by the team and saw importance of their role
Moll, Holmes, Geronimo, Sherman, 2008	Interview with peer workers in six mental health urban projects n=6 Canada	Qualitative: Semi-structured interviews with peer workers and their managers, part of a larger study	Participants highlighted <ul style="list-style-type: none"> • Tensions in how the work is defined e.g boundaries and identity shift • Individual nature of work transition to be a peer worker, influenced by environment, specific role and the worker

Colson & Francis, 2009	Peer workers in community mental health agency n=4 (not fully clear) New York, USA	Qualitative: Ethnographic observation and discussions with staff	<ul style="list-style-type: none"> • Benefits: Status associated with employment, learning and self-help • Very wide range of using personal experience from seeing disclosure as non-beneficial, through selective disclosure to disclosure being a key in the role • Tension between being a peer worker and professionalism
Salzer, Katz, Kidwell, Federici and Ward-Colasante, 2009	Service users who attended a Peer Support training n=154 Pennsylvania, USA	A survey, follow up a year after the training.	82% were working, 22% increase in knowledge, overall peer specialists reported to be satisfied with their work and feeling accepted by co-workers.
Richard, Jongbloed and MacFarlane, 2009	Peer Specialists n=5 Canada	Qualitative: Phenomenological approach of semi structured interviews related to team integration	<ul style="list-style-type: none"> • Largely positive experience of interactions with non-peer staff • Slow process of integration and feeling part of the team
Moran, Russinova, Gidugu, Yim and Sprague, 2012	Peer Providers employed in a variety of mental health agencies. n=31 USA	Data were collected through face-to-face semi-structured interviews and analysed using a grounded theory approach. Separate analysis for data related to recovery , challenges and motivation.	<p>Analysis revealed a wide range of recovery benefits for the peer providers.</p> <ul style="list-style-type: none"> • The benefits span across five wellness domains: foundational, emotional, spiritual, social, and occupational. • The role of sharing one's personal story was highlighted as contributing to positively re-authoring one's self-narrative
Moran, Russinova, Gidugu and Gagne, 2013		Analysis of challenges	<p>Different challenges in conventional mental health settings and consumer-run agencies.</p> <p>Occupational domain challenges:</p> <ul style="list-style-type: none"> • lack of clear job descriptions, • lack of skills for using one's life story and lived experience, • lack of helping skills, • negative aspects of carrying a peer provider label. <p>Personal mental health challenges:</p> <ul style="list-style-type: none"> • overwork • symptom recurrence

Moran, Russinova, Yim, & Sprague, 2013	A theory driven approach used to analyse data related to work motivation using Self Determination Theory (SDT): external motivation and internally regulated motivations derived from basic needs (autonomy, competence, relatedness)	External motivations: <ul style="list-style-type: none"> • generic occupational goals • getting away from negative work experiences. Internal motivations corresponded with SDT basic needs: <ul style="list-style-type: none"> • autonomy needs - having freedom to disclose and work in accord with personal values; • competence needs - using personal experience as a resource to help others • relatedness needs - opportunity to connect and reciprocate with consumers 	
Tse, Tsoi, Wong, Kan and Kwok, 2013	Participants of training for Mental Health Peer Support Workers (PSW) Training consisted of 6 weeks coursework and 24 weeks on-the-job training. n=18 Hong Kong, China	Quantitative: Pre and post measures of hope, recovery and self-esteem. Training evaluation form Qualitative: Interviews after training	No significant results from pre-post measures. Post-training evaluation suggested positive experience for PWS and valuing of training and new role. Main themes from the interviews: <ul style="list-style-type: none"> • Positive gains: increased involvement in their communities, realisation of own skills and ‘benefits’ from illness • Factors that helped in new role: supportive relationships with peers, supportive supervisors and sense of satisfaction from helping others • Challenges of new role: difficulties with calling clients for the first time and paperwork (mostly in initial stages), dealing with emotionally distant or over-talkative service-users • Empathetic environment and empowering nature of work • Most PSW wanted to continue with their role
Salzer <i>et al.</i> , 2013	Certified Peer Specialists (CPS) n=154 Pennsylvania, USA	Quantitative: Chi ² based on difference between a number of CPS reporting decreased and increased use of services analysis of a state-wide survey Training evaluation using descriptive statistics	<ul style="list-style-type: none"> • reduced use of case management; Chi²(1)=8.02, p<.005 • reduced use of emergency and crisis services; Chi²(1)=22.22, p<.0001 • reduced hospitalisation; Chi²(1)=29.3, p<.0001 • Benefits from training and work: sense of hope 88%, opportunity to give back to others 99%, different aspects of confidence 74-95%

McLean, Biggs and Whitehead, 2013	Peer Workers in community and inpatient settings n=? Scotland	Qualitative: thematic analysis of interviews Pilot scheme evaluation: survey and significant events analysis	Challenges: <ul style="list-style-type: none">• Integrating with the team• non-recovery practice within teams,• reminder of past difficulties Overall positive experience, most helpful with challenges was supervision
-----------------------------------	---	---	---

Appendix 3 Journal's submission criteria

Journal of mental health

Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh> . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing. Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF. Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered. Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London: Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text.

Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied. Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in

parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt. Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/\$25.00 per copy. Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

Appendix 4 Consent form



Salomons Campus at Tunbridge Wells

Department of Applied Psychology

Faculty of Social and Applied Sciences

Version 1

Date: 2.11.2012

CONSENT FORM

Title of Project: Mental health service users' experiences of being involved in peer-brokerage service

Name of Researcher: Barbara Gieniusz

1. I confirm that I have read and understand the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I agree that anonymous quotes from my interview may be used in published reports of the study findings.
4. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix 5 University letter granting ethics approval

This has been removed from the electronic copy

Appendix 6 Interview Schedule

Interview questions (peer-brokers):

- What attracted you to attending the peer-brokers training? (prompts: tell me more, what else, how did you hear of it, what made you want to do it?)
- What was your experience of attending it? (Prompt: Does anything stand out for you when you think about this experience? What is it? How would you compare it to other experiences of training or education you have had before – any similarities? Differences?)
- What did this experience mean to you? (Prompt: What else is important for you in relation to this experience? How did it affect your life if at all?)
- Were there any aspects of the training that were perhaps difficult or challenging? (Prompts: How did you cope with these aspects? How did that affect you?)
- Were there any specific benefits from attending the training? (Prompts: Did this affect other areas of your life or not? In what way?)
- How do you feel about becoming a peer-broker?
- When you think about working as a peer broker, what does it mean to you? (Prompts: what is important to you about being a peer broker?)
- Are you planning to become a peer-broker or are you a peer broker now? What are /were your reasons for this choice of moving to this next stage? (*if not planning/not a peer broker* What led to your decision not to go to the next stage and become a peer broker?)
- Has anything changed in your life since you attended training (*if not already mentioned*)? If so, what sort of things?
 - (*if changes*) And what do you put those changes down to? – the training/ other things?
 - (*If the training*) What was it about the training, the trainers, or what happened in the training?
- How would you describe yourself as a person? (Prompt: In what ways is it different to how you would have described yourself before the start of the training? Or perhaps it would be the same?)

Appendix 7 Sample of an interview with annotations

This has been removed from the electronic copy

Appendix 8 Reflective diary – samples

Expectation prior to the first interview: feeling a bit nervous, unsure what to expect. Wondering how important peer brokerage is in life of people I will be talking to. People running the project are very personable, I am thinking how much their attitude is passed on to those who are trained and then become peer brokers. How do I stop myself from becoming a therapist rather than interviewer if people talk about very difficult experiences.

1st interview – initially felt a bit artificial, had impression that my interviewee was avoiding talking about her MH problems, wanted to present herself as a professional, highlighted her skills, experience and training, and never mentioned her diagnosis. Also said ‘i used to have’ mental health problems suggesting this is a part of her past identity.

Despite expectations –interactions did not resemble therapy, although listening and paraphrasing was the most helpful in encouraging the participant to talk.

Second meeting seemed very different (did she get used to me), now her past mental health experience became more present in her stories. Perhaps I became more confident to ask questions about personal issues. This meeting was easier and our rapport seemed better.

I cannot believe how much experience she has and the skills she needs to use in this role. Perhaps there should be more support, this is a part-time role that sounds fairly straight forward based on the description, but emotional stories of clients, presenting to the teams and struggling with professionals who do not know or belief in personalisation make it sound much harder than I suspected. Plus occasional wait for work and clients not having their budget approved, a lot of potential for disappointment, no wonder many people left the project as they probably struggled to manage those challenges.

Thought on comparison with professionals:

- The difference between professionals who experienced mental health problems in the past and peer workers
- in peer workers case it is known that they have experience similar to service users and they are encouraged to use it to help their patients
- professionals are encouraged to put their personal experience aside, some of them might hide it from others
- professionals might be in a more comfortable position as they experience less stigma
- Are professionals that are open about their mental health history experiencing their work differently than peer workers?

Interview 5.

Is a new identity forming when people get trained as peer brokers? Is peer workers identity something different than identity of a professional or a service user? Interesting that some peer workers see themselves as equal to service users while others seemed to think that they are equal to peer workers but not always to service users.

In this interview the mission to change mental health system was prominent. The ideas about changing the world, is this recovery through social activism? She mentioned that having a focus outside of herself helped as being a patient there is too much focus on own problem, it becomes overwhelming.

Despite questions being focused on recovery participants all mention work with clients and ideas about mental health system in their interviews. Are all peer workers as thoughtful about client work? Makes me envious that this work is not as bureaucratic as some of the work I need to do, does this help to focus on helping the other person, not having as many regulations and papers to fill?

I wondered initially if she felt I was judging her, she mentioned how professionals often expect very little of service users, that seems right based on my own expectations when starting this project. By the end of the interview I was seen as an ally. Felt compelled to stay and talk about ideas regarding use of diagnosis as labels and recovery, wanted to distance myself from the mental health system that she experienced.

The values mentioned in relation to work with clients sound similar to basic counselling skills –listening, unconditional positive regard, being authentic, empathy. Interesting that the way she talks this seems experience based. Maybe she experienced herself how healing those can be. Again makes me think about my profession and research of therapeutic techniques, while service users usually talk about being accepted, treated as a person and someone having faith that they can do better.

Appendix 9 Bracketing interview summary

2nd April 2014

Review focused on the experience of data collection and analysis.

Issues discussed:

1. Ideas that attracted me to investigate the topic –feeling challenged as a mental health professional by the idea of service users’ having their own initiative and suggesting that this works better than professionals-run service.
2. Evaluation of my own expectations e.g. doubts if peer brokerage would be of a good quality, wondering if peer brokers would be too suggestible and choosing activities that are not necessarily helpful as it is not based on research. My surprise of thoughtfulness and skill level of participants. This helped in assessing my own bias of not expecting much of people diagnosed with serious mental illness. Perhaps this bias steamed from work in inpatient setting where this diagnosis meant being very unwell or ‘stuck’ in the system for years. I reflected how my initial contact with inpatient services was all about recognising symptoms and understanding a diagnosis but then my current learning is about not letting those symptoms, and medical perspective to devalue them.
3. Seems that challenges of the peer brokerage role allow only people who are very resilient and with above average IQ to stay – based on prior work experience in ‘life before diagnosis’ and many skills they use when working with clients and in the system.
4. Reflections on how I was seen by participants, they seemed open and very friendly so I was not sure to what extend I represented mental health system to them, since none of them mentioned interactions with psychologist, perhaps this helped in being seen as someone more neutral. Despite that, during interviews I had moments of ‘professional guilt’ and feeling than people who seek help from mental health professionals are being let down, I even felt envy of not having the experience that would allow me to understand being a service user.
5. Realisation that peer work has its own identity and it is not just about helping peer workers feeling like they are equal to professionals (which seems to be an implicit perspective in some of the previous research), perhaps it is better for them to keep their own identity
6. Despite initial focus on peer brokers experience, their recovery and view of themselves, other issues became very prominent and emerged in final themes – wanting to change mental health system, consideration of what is best for their clients and struggles with pioneering new ideas. My thinking of the issue changed over the course of the interviews, I saw mental health system giving an opportunity to service users to enhance their recovery by helping others while now I think about more as service users improving the mental health system