University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

Exploring the Experiences of Mental Health Peer Support Workers: Interactions with Colleagues and Managing Wellbeing

by

Louise Taylor

Thesis for the degree of Doctorate in Clinical Psychology

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Abstract

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Peer support has become increasingly common within the mental health field, with literature demonstrating that this can be beneficial to both those receiving peer support, as well as to those providing it, often termed Peer Support Workers (PSWs).

The first chapter of this thesis is a systematic review synthesising the qualitative evidence exploring PSWs' experiences and perceptions of their non-peer colleagues. Thematic Synthesis was used to synthesise the findings of the nineteen included studies. Five themes were identified: 'Adverse Experiences', 'Feeling Valued, Welcomed and Supported', 'Providing a Unique Perspective', 'Influence of Systemic Factors' and 'Easier Over Time'. The review highlighted the mixed experiences that PSWs have with their colleagues and highlighted the need for further research in this area. Clinical implications for services employing PSWs were provided.

The second chapter of this thesis reports on an empirical study exploring how PSWs manage their wellbeing at work. Semi-structured interviews were conducted with twelve PSWs, with Thematic Analysis used to analyse the data. Four superordinate themes were identified, each containing a number of sub-ordinate themes: 'A Double Edged Sword', 'Structure, like any other profession', 'Culture' and 'Self-Care'. Clinical implications and suggestions for further research were discussed.

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Research Thesis: Declaration of Authorship

Print name: Louise Taylor

Title of thesis: Exploring the Experiences of Mental Health Peer Support Workers: Interactions with Colleagues and Managing Wellbeing

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: .... Date: 03/06/20

Acknowledgements

Chapter 1   What are Mental Health Peer Support Workers' Experiences and Perceptions of their Non-Peer Colleagues? A Qualitative Systematic Review.

1.1   Introduction

Within the field of mental health, peer support can be defined as people drawing on their own lived experience of mental health difficulties to support others with similar difficulties. Peer support has become increasingly common in various countries, including the UK and the USA (Repper & Carter, 2011), with research suggesting this can be beneficial for both those providing peer support, often termed Peer Support Workers, as well as those receiving it (Gillard & Holley, 2014). Nevertheless, the introduction of peer support into mental health services can be challenging, both for PSWs themselves and for the traditional mental health staff they work alongside (Colson & Francis, 2009; Mancini, 2018; Repper & Carter, 2011). This chapter reports on a systematic literature review which aimed to synthesise the existing qualitative evidence regarding mental health Peer Support Workers' experiences and perceptions of their non-PSW colleagues.

1.1.1   What is Peer Support?

Davidson et al. (1999) differentiated between three different types of peer support: mutually-occurring peer support, often termed 'informal peer support', peer support which takes place in 'consumer-run services', that is mental health services which are operated and run by current or previous mental health service users, and 'formal peer support' whereby peer support is provided within the context of traditional mental health services. Despite the varying types of peer support, the key defining feature is that people are required to draw on their own lived experience to support others with similar difficulties (Davidson, 2005; Repper & Carter 2011). Although various terms have been used within services and within the literature to describe people who provide peer support, for the purpose of this paper, these people will be referred to as 'Peer Support Workers' (PSWs).

In recent years, traditional mental health services have started to recognise the value of peer support (Repper & Carter, 2011). This has led to an increase in the number of PSWs being

employed within traditional mental health services across the UK, USA, Australia and New Zealand (Repper & Carter, 2011), with PSWs now working in many mental health services (Gillard et al, 2017).

Studies exploring the effectiveness of peer support have produced mixed results, arguably due to studies focusing on different outcome measures to evaluate peer support. Whilst some studies have shown that peer support can lead to reduced hospitalisation (Chinman et al., 2014; Lawn et al., 2008), others have found peer support has little effect on rates of hospital admissions (Lloyd-Evans et al., 2014; Pitt et al., 2013). However, some researchers have advocated for the need for recovery outcomes to be taken into account when evaluating the effectiveness of peer support, for example by focusing on the outcomes which are important to the individual service user (Watson, 2017). Studies which have focused on these types of outcomes have shown that receiving peer support has been associated with improvements in service-user empowerment (Resnick & Rosenheck, 2008), confidence (Chinman et al., 2001), hope and self-efficacy (Billsborough et al., 2017).

Moreover, research has highlighted that peer support can also be beneficial beyond the direct impact on service users. Benefits extend both to PSWs themselves, for example PSWs have reported feeling increased independence and empowerment (Walker & Bryant, 2013), as well as to organisations who employ them, for example by resulting in financial savings (Solomon, 2004).

1.1.2   Organisational Challenges of Introducing Peer Support

Despite the numerous benefits of peer support, a number of organisational challenges related to the employment of PSWs have been identified. This may in part be due to the uniqueness of the PSW role whereby PSWs are often perceived to be neither a patient nor a traditional member of staff (Mancini, 2018). Differences in approach and culture exist between PSWs and non-PSW staff. These differences have the potential to impact upon PSWs experiences and perceptions of their non-PSW colleagues.

The values of peer support do not always fit with the more traditional culture of mental health services (Watson, 2017). For example, whilst services may traditionally adopt a diagnostic-focused and medical approach to their work, peer support is grounded more in recovery-focused approaches to mental health, whereby a more strengths-based and holistic view of mental health is adopted (Davidson, 2005), focusing on growth and personal development (Deegan, 2003). Therefore, the introduction of PSWs can challenge the way in which services have traditionally viewed and interacted with service users, and thereby challenge mental health services' and teams' cultures (Mancini, 2018). Relatedly, the policies and procedures within traditional mental

health services can sometimes conflict with the recovery-focused values of peer support. For example, whilst an expectation of the PSW role is for PSWs to draw upon and share their own experiences with service users, staff self-disclosure is often advised against in mental health services (Colson & Francis, 2009).

A lack of clarity and understanding regarding the nature of the PSW role is another challenge which frequently exists amongst both PSWs themselves and non-PSW staff when introducing PSWs into mental health services. For peer support to be successful, stakeholders need to have a good understanding of the PSW role and what is expected from PSWs (Bach & Della Rocca, 2000). However, this often is not the case in practice, with confusion often existing about the job descriptions and role expectations of PSWs (Asad & Chreim, 2016; Gillard et al., 2015; Hurley et al., 2016; Kemp & Henderson, 2012; Mowbray et al., 1998). Moreover, traditional mental health staff do not always understand the PSW role, nor appreciate the value of peer support, and require additional support and training to address this (Repper & Carter, 2011; Coates, Livermore & Green, 2018).

1.1.3   Staff Views of Peer Support Workers

Non-PSW staff' views and perceptions of PSWs are often mixed, with some staff viewing PSWs in a positive light and recognising the distinct contribution they bring to the team, whilst others holding negative attitudes and beliefs about PSWs. Several studies have reported that non-PSW staff often have positive views of PSWs and see them as being beneficial to both patient care and to the staff team they work alongside (Cabral et al., 2014; Collins et al., 2016; Gillard et al., 2014; Gray et al., 2007; Holley et al., 2015; Kilpatrick et al., 2017;White et al., 2017). It appears that non-peer staff often value the lived experience of PSWs and feel it is this which means PSWs can offer a unique contribution to their work with patients. For example, managers in the Gillard et al. (2014) study reported that although PSWs and non-PSW staff often performed similar duties, PSW's lived experience of mental health difficulties allowed them to do these duties in a more collaborative way with service users. Similarly, non-peer staff and supervisors report that PSWs' lived experience creates a shared understanding with service users (Cabral et al., 2014; White et al., 2017), and allows them to model recovery, thus providing a sense of hope and inspiration (Cabral et al., 2014). Thus, it appears that non-PSW staff view the relationships that PSWs form with service users in a positive light and recognise the uniqueness of these relationships. Similarly, Collins et al. (2016) reported that non-peer staff view PSWs as more approachable than non-peer staff, whilst other non-PSW staff have described the relationships that PSWs build with service users as characterised by warmth, trust and good rapport (Gray et al., 2017). The relationships between PSWs and service users can also be used to facilitate client engagement with mental

health services, including helping to improve the relationships between clients and non-PSW staff (White et al., 2017).

Non-PSW staff have also reported that they benefit more directly from working alongside PSWs. In particular, non-PSW staff valued the unique expertise of PSWs, gained as a result of their lived experience (Kilpatrick et al., 2017), and felt PSWs helped to increase their knowledge of recovery practices (Cabral et al., 2014). PSWs helped to change the way non-PSW staff viewed mental health difficulties (Collins et al., 2016), including how risk issues were understood by staff and discussed with service users, helping the team to adopt a more positive approach to risk taking (Holley et al., 2015).

Despite recognising the value PSWs brought to service users and staff teams, non-PSW staff in Gray et al. (2017) reported that they sometimes struggled to communicate this to PSWs and explained that PSWs often found it difficult to recognise the value they added to the team. Despite the valuable contribution of PSWs to staff teams, studies have highlighted the importance of PSWs not being perceived as tokenistic. Kilpatrick et al. (2017), Gates et al. (2010) and Gillard et al., (2014) all discussed that non-PSW staff sometimes viewed the employment of PSWs as tokenistic, for example as a way of saving money, and highlighted that this had the potential to decrease the value that non-PSW staff attached to PSWs. This view of PSWs seemed to be particularly prominent when non-PSW staff lacked understanding of the PSW role (Gates et al., 2010; Gillard et al., 2014).

Introducing PSWs into services can be a challenge for existing mental health staff (Kilpatrick et al. (2017). Some staff fail to recognise the value of the PSW role (Mulvale et al., 2009) and perceive PSWs as a threat to the medical model and the traditional way in which mental health services are run (Bennetts et al., 2011; Kilpatrick et al., 2017). Other studies have reported negative and stigmatising attitudes amongst some non-peer staff towards PSWs (Gillard et al., 2014) and a "them and us" attitude (Collins et al., 2016). Some non-PSW staff have also expressed concerns about PSWs, highlighting that the relationships they form with clients may be inappropriate or lack boundaries (Holley et al., 2015). Non-PSW participants in White et al. (2017) and Collins et al. (2016) also recognised that their relationships with PSWs were often different to those they had with other staff, with boundaries being more blurred. This appeared to be particularly the case when PSWs had previously been treated by colleagues they now worked alongside, with participants therefore cautioning against PSWs working in services where they had previously been a client (Collins et al., 2016). Some non-PSW staff also expressed concerns about how the role may impact upon PSWs' wellbeing, suggesting some staff may view PSWs as vulnerable (Collins et al., 2016; Gray et al., 2017; Holley et al., 2015; Hurley et al., 2018), although in Hurley et

al.'s (2018) study, these views were reportedly based upon things PSWs had said about their wellbeing, as opposed to reflecting staffs assumptions about PSWs.

1.1.4   PSWs' Experiences with Non-PSW Staff

Research exploring PSWs experiences of their non-PSW colleagues is very much in its infancy, with few studies specifically aiming to explore this topic. Scoping searches revealed that only a small number of studies have specifically focused on PSWs' experiences of integrating into mental health teams (Asad & Chreim, 2016; Berry et al., 2011; Doherty et al., 2004), all of which discussed PSWs having negative experiences with their non-PSW colleagues. Whilst other studies have discussed PSWs' experiences of their colleagues, these studies have not specifically aimed to focus on this topic; rather, these studies have focused on other related questions, such as those aiming to explore the benefits and challenges of peer support. This poses a challenge to those wishing to access findings about this topic; thus, a systematic review of the literature would be useful to collate findings from existing research, something which the current review aims to do.

Similarly, whilst a small number of literature reviews have previously discussed PSWs' experiences with their colleagues, none have specifically focused on this. For example, in a meta-synthesis, Walker & Bryant (2013) aimed to identify the "active ingredients" of peer support. Within the review's findings, it was noted that PSWs had reported experiencing negative and rejecting attitudes from non-PSW staff, resulting in them sometimes being treated more like a service user than a member of staff and being excluded from some work-related activities. Similarly, in a review to explore barriers to the implementation of PSW roles, Vandewalle et al. (2016) found PSWs often reported experiencing discrimination and stigmatising attitudes from their colleagues, something which they felt was perpetuated by their colleagues' poor understanding of the PSW role. However, given that the review aimed to explore the *barriers* to implementing PSWs, it would not have been within the scope of the review to discuss any positive experiences PSWs may have with their colleagues.

1.1.5   Review Rationale and Aims

To summarise, research has demonstrated that there are mixed views about PSWs amongst non-PSW staff. Whilst some non-PSW staff value PSWs' contribution to services, a lack of understanding of the PSW role is common, and some staff hold negative attitudes towards PSWs and fail to recognise the value of peer support. These views are likely to have an impact on the way non-PSW staff interact with PSWs, and thus influence PSWs' experiences with the non-PSW colleagues they work alongside. The current review therefore aimed to explore PSWs' experiences

and perceptions of their non-PSW colleagues. To the best of the author's knowledge, no previous review has specifically aimed to focus on PSWs' experiences of their non-PSW colleagues. Although it is recognised that some reviews have discussed this topic, this was not the main focus of the review. Additionally, these reviews only included published papers, with grey literature excluded. Therefore, a comprehensive review focusing specifically on PSWs' experiences of their colleagues is needed. The current review therefore aims to synthesise the existing qualitative evidence to address the question: "What are mental health PSWs' experiences and perceptions of their non-PSW colleagues?"

1.2   Method

1.2.1   Inclusion and Exclusion Criteria

The PICOS (Population, Intervention, Comparison, Outcome, Study design) framework (Centre for Reviews and Dissemination, 2006) was used to structure the research question and to broadly guide the review's search terms and inclusion and exclusion criteria.

The review's inclusion and exclusion criteria are shown in Table 1. The review focused on PSWs working within mental health. Scoping searches revealed that in many studies conducted within the mental health field, additional contextual factors were also present, such as additional social, health or behavioural factors. Some studies were conducted in settings which included, but were not limited to, mental health support. For example, studies were conducted in settings focused on delivering other services, such as housing-related support, even though mental health support may have been a component of the work. Similarly, some studies specifically involved populations with additional contextual factors, such as dual-diagnoses, social factors, physical health problems and offending backgrounds. The presence of these additional contextual factors may have influenced the experiences and perceptions that PSWs had of their colleagues. Thus, given that the review was interested in PSWs working specifically within mental health, the research team decided to exclude studies which were conducted in settings which were not limited to mental health support, or where study populations included those with additional contextual factors. Whilst it is acknowledged that sometimes these factors coincidentally co-occur, papers were only excluded if these co-occurring factors were explicit, for example if participants were specifically recruited from these populations. In cases where this was unclear or only applied to some of the participants/research sites, a discussion was had between members of the research team and a consensus reached.

The review focused on the perspective of PSWs. Papers could include a combination of PSWs and non-PSWs as participants. Where this was the case, papers were included where it was possible to differentiate the views of PSWs from non-PSWs. Only the views of PSWs were included in the analysis.

The review sought to synthesise findings from qualitative studies. Scoping searches revealed that most of the research on peer support is qualitative. Qualitative studies facilitate exploration of participants' experiences and perceptions, and thus qualitative reviews can help to develop greater understandings and answer questions such as 'what is it like?' (Seers, 2015). Qualitative synthesis enables participants' experiences to be explored in-depth, due to the qualitative nature of included studies, but also allows for broader conclusions to be drawn due to synthesising findings from a number of studies and thus incorporating findings from a range of participants and a range of settings (Lachal et al., 2017). Therefore, qualitative synthesis lends itself well to the aims of the current review. Qualitative studies were included in the review, as well as mixed method studies where qualitative data was extractable. In these cases, only the qualitative aspect of the study's findings were analysed.

Only papers post the year 2000 were included in the review. This was decided given that the introduction of PSWs into mental health services was rare prior to the year 2000. Additionally, given that views on mental health have changed significantly in recent years, it was felt that any studies conducted prior to this would likely not be relevant to the experiences of PSWs today. Additionally, only papers written in the English language were included.

Table 1: *Review Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Participants are Peer Support Workers, defined as those recruited on the basis of their lived experience to provide peer support to others as part of their work or voluntary role.	Not related to the area of peer support. Participants do not include mental health peer support workers.
Studies which relate to peer support being provided to those with mental health problems.	Peer support is not primarily related to mental health (e.g. peer support for physical health, parenting, offending, education, employment etc.)
Peer support is provided within a primarily mental health setting e.g. mental health service, mental health ward.	Studies which specifically relate to support being provided to populations with explicit co-occurring social, health, behavioural or contextual factors, in addition to mental health problems (e.g. substance misuse, housing issues, student populations, forensic backgrounds).
Participants are adults (over the age of eighteen) and are providing peer support to other adults (over the age of eighteen).	Support is not provided within the context of a mental health service setting (e.g. support provided in schools, prisons).
	Some or all of study participants are children or adolescents under the age of 18 years.
	Study relates to peer support with children or adolescents under the age of 18 years e.g. parents views on support their children received.

Empirical research studies, defined as primary empirical research and secondary analysis of primary data sets.	Quantitative studies or mixed method studies where qualitative data is not extractable.
Qualitative studies or mixed method studies where qualitative data is extractable.	Papers which are not primary empirical research (e.g. systematic reviews, books).
Studies which discuss Peer Support Workers' experiences and perceptions of their relationships and interactions with their non-managerial, non-peer colleagues, from the Peer Support Workers perspectives.	Studies which do not discuss Peer Support Workers experiences or perceptions of their non-peer, non-managerial colleagues from the view of the peer support workers.

1.2.2   Registration of Protocol

The review protocol was registered on Prospero (Prospero reference CRD42019159902). This was done prior to formal screening of the search results against the review's inclusion and exclusion criteria.

1.2.3   Search Strategy

Four electronic databases were searched; these were PsycINFO (via EBSCO), CINAHL (via EBSCO), MEDLINE (via EBSCO) and Web of Science Core Collection. In addition, to avoid publication bias, grey literature was sought by searching PubMed and by searching for relevant theses via the British Library Collection. All searches were conducted on 4th November 2019. Title and abstracts were searched using the search terms shown in Appendix A, with the Boolean operator 'AND' used to combine each set of search terms. The exception to this was the British Library Collection search - due to its limited search options, only the term "peer support" was used.

The search terms were broadly guided by the PICOS framework (Centre for Reviews and Dissemination, 2006) and were devised through discussions amongst the research team and by consulting search terms used in an existing review of a related topic (Vandewalle et al., 2016). As the study sought to include qualitative studies, broad search terms were used as suggested by Cherry et al. (2017) and an academic librarian who was consulted.

1.2.4   Study Selection

See Figure 1 for a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Moher et al, 2009) demonstrating the study selection process. Final searches returned a total of 2003 papers. 'EndNote' was used to electronically remove duplicates, with hand screening being used to remove any additional duplicates which had been missed. A total of 912 papers remained once duplicates had been removed. Title and abstracts were screened according to the review's inclusion and exclusion criteria. This was mainly conducted by the chief researcher, with 10% of papers being screened by a second reviewer; any disagreements were discussed amongst the research team until a consensus was reached. A total of 768 papers were excluded at the title and abstract screening stage. Full texts were obtained for the remaining 144 papers which were then screened according to the review's inclusion and exclusion criteria. This was conducted by the chief researcher, with 10% being conducted by a second reviewer and any disagreements discussed amongst the research team until a consensus was reached. For some papers, insufficient detail was included to determine whether the paper met inclusion criteria. An example of this was where papers implied that peer support was provided to adults but did not specifically report this. In such cases, the two reviewers sought to reach a consensus decision. Where this was not possible, a third reviewer was consulted and a decision made based on the decision of the majority. A total of 125 papers were excluded at the full text screening stage, thus resulting in a total of 19 papers being included in the review.
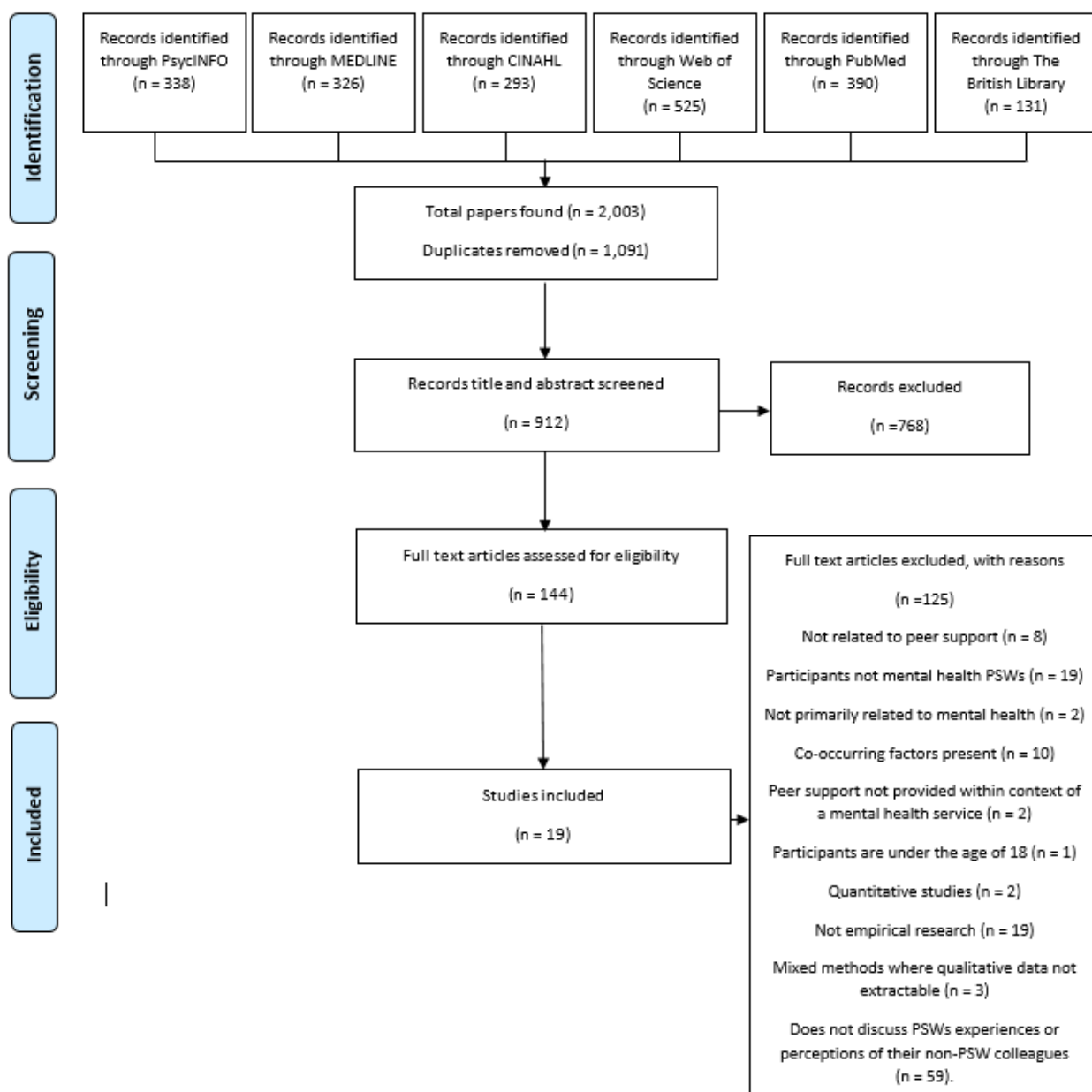
Figure 1: *PRISMA Flowchart of Study Selection*

1.2.5   Critical Appraisal of Qualitative Research

Quality assessment is an important part of qualitative systematic reviews (Hannes, 2011), however, there is no agreed consensus about how best to do this (Lachal et al., 2017; Thomas & Harden, 2008). The current review used the Critical Appraisal Skills Programme (2018) to assess the quality of included papers. This is a ten item checklist which addresses the key principles of qualitative research (Tong et al, 2012) and enables quality assessment to be conducted in a standardised way. Most questions consist of three choices of responses: 'yes', 'no' and 'can't tell'. It was discussed amongst the research team what should constitute a 'no' response versus a 'can't tell' response. It was agreed that 'can't tell' would be used if the issue was not mentioned in the paper and therefore it was unclear whether or not the issue had been addressed sufficiently. The 'no' response was selected when it was explicit from reading the paper that the issue had not been adequately addressed.

All quality checks of included papers were conducted by the chief researcher, with a second reviewer second rating the quality of 20% of papers. Any disagreements were discussed amongst the research team until a consensus was reached. Objective scores were not given because a formal scoring system does not exist for the CASP. Although all papers were quality checked, this was not with the intention of excluding any papers based on the quality.

1.2.6   Synthesis

Thematic synthesis (Thomas & Harden, 2008) was used to analyse and synthesise the findings of included studies. This is a method used for synthesising the findings of qualitative research, particularly when wanting to explore questions regarding peoples' experiences and perspectives (Thomas & Harden, 2008); this method was therefore well suited to address the aims of the current review. Thematic synthesis has three stages. First, the results section of included studies were coded line by line. This was done by hand and was conducted by the chief researcher, with a second reviewer retrospectively checking the coding of 20% of papers. Second, codes were grouped together to form descriptive themes. These were derived inductively from reading the results sections of the included papers. Third, descriptive themes were used to develop analytical themes, going beyond the content of the primary studies. Themes were identified initially by the chief researcher and were then discussed and refined through discussions between the chief researcher and the research supervisory team.

1.2.7   Reflexivity

Reflexivity is an important component of qualitative research and helps to ensure rigor and quality (Teh & Lek, 2018). Prior to analysis of the data, a bracketing interview was conducted with an independent Trainee Clinical Psychologist. This aimed to explore the main researcher's views of the topic area as well as any prior expectations or assumptions the researcher had about possible findings of the systematic review.

Throughout the bracketing interview, the researcher noted that they already had some experience working with PSWs. This was in both a research capacity, having previously carried out a service evaluation of a training programme for PSWs, as well as also briefly coming into contact with PSWs working in mental health services whilst the researcher had been on placement. From these experiences, the researcher had heard about both positive and negative experiences that PSWs had had with their non-PSW colleagues and wondered whether similar experiences may be reflected within the PSW literature and thus could potentially be one of the findings of the review. The researcher reflected that the bracketing interview helped them to become more aware of how their prior experiences with PSWs could potentially influence the research process and therefore highlighted the need for the researcher to take steps to ensure the findings of the review were based firmly upon the content of the included papers themselves, rather than being based upon their prior assumptions about the potential findings. Various steps were taken to help achieve this, such as methodically coding the results sections of included papers line by line, having a second person check the coding of 20% of included papers, and ensuring the final themes of the review were discussed and refined in conjunction with other members of the research team, as described in the methods section.

Another area explored within the bracketing interview was how the researcher's professional occupation may impact upon how they approached the review. More specifically, the researcher was a Trainee Clinical Psychologist employed by the NHS and had experience working in a variety of NHS mental health services. Given that the review aimed to explore PSW's experiences and perceptions of their non-PSW colleagues, it is important to note that the researcher has experience working alongside a range of non-PSW colleagues, including psychiatrists, nurses, occupational therapists and support workers; indeed, as a Trainee Clinical Psychologist themselves, the researcher, their fellow trainees and supervisors would also be classed as non-PSW colleagues. This was an important consideration, particularly given the potential for the review to highlight negative experiences that PSWs have with their non-PSW colleagues. The bracketing interview explored what it would be like for the researcher to read about these negative experiences. The researcher discussed having beliefs about mental health professionals

generally being caring and supportive and reflected that it would be somewhat uncomfortable to read about PSWs having negative experiences with their non-PSW colleagues, particularly if these experiences involved being treated badly or being stigmatised. The researcher acknowledged that this uncomfortableness could potentially lead them to inadvertently minimise these experiences or try to focus on PSWs' more positive experiences. This highlighted the importance of the researcher ensuring they remained open to all possible findings of the review, ensuring that the findings were closely linked to those of the included papers. The methods described above, such as involving a second coder and analysing themes as a team all helped to achieve this.Results

A total of nineteen papers were included in the review. See Table 2 for a descriptive summary of included studies. Eighteen papers were journal articles and one was an unpublished thesis. The number of participants involved in each study varied from two participants to 31. In total, 263 participants were included across all studies. Seventeen of the studies were qualitative studies, with two using a mixed method design. Fifteen studies used interviews, two studies used focus groups and one used a combination of interviews and focus groups. The method of analysis varied across studies, with grounded theory being the most common method used (n=6).

Table 2: *Descriptive Summary of Included Studies*

Authors	Title	Year	Country	Aims	Study design and analysis	No. of PSW participants
Aikawa & Yasui	Becoming a consumer-provider of mental health services: Dialogical identity development in prosumers in the United States of America and Japan	2017	USA and Japan	To investigate identity development in prosumers; to explore the possible effects of a training and certification system as a societal contextual factor	Interviews. Narrative analysis.	47
Asad & Chreim	Peer support provider's role experiences on interprofessional mental health care teams: A qualitative study	2016	Canada	How are peer support providers roles defined and integrated in inter-professional mental health care teams? How do these providers relate to other practitioners and clients?	Interviews. Analysis method not named	12
Berry, Hayward & Chandler	Another rather than other: experiences of peer support specialist workers and their managers working in mental health services	2011	UK	To further explore the integration of PSWs into existing mental health teams in the UK	Interviews. Thematic analysis	2
Byrne, Roper, Happell & Reid-Searl	The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles	2019	Australia	To present the experiences reported by participants of stigma/discrimination as the basic social factor faced in their employment as lived experience practitioners	Interviews. Grounded theory	13
Cleary, Raeburn,	'Walking the tightrope': The role of peer support workers in facilitating	2018	Australia	To explore the challenges faced by peer support workers when involving mental health consumers in	Interviews. Thematic analysis	6

Escott, West & Lopez	consumers' participation in decision-making			decision-making about their care and the strategies they employed to overcome these challenges so as to improve mental health consumers participation in decision-making and recovery		
Clossey, Gillen, Frankel & Hernandez	The experience of certified peer specialists in mental health	2016	USA	To explore the experiences of certified peer specialists and what they perceived to be the barriers and facilitators of effective certified peer specialist practice	Focus groups and interviews. Grounded theory	13
Doherty, Craig, Attafua, Boocock & Jamieson-Craig	The consumer-employee as a member of a Mental Health Assertive Outreach Team II: Impressions of consumer-employees and other team members	2004	UK	To provide a first hand account of the experience of being a consumer-employee within an assertive outreach team; Whether there were negative attitudes of staff in an inner London assertive outreach team towards the employment of people with severe mental illness within mental health services and, if found, what effect this would have on the team	Mixed method: Interviews for the qualitative aspect. Content analysis	2
Dyble, Tickle & Collinson	From end user to provider: making sense of becoming a peer support worker using interpretive phenomenological analysis	2014	UK	To explore how PSWs made sense of transitioning from their own experiences of mental health problems to supporting others with mental health problems	Interviews. Interpretative phenomenological analysis	10
Ehrlich, Slattery, Vilic, Chester & Crompton	What happens when peer support workers are introduced as members of community-based clinical mental health service delivery teams: a qualitative study	2020	Australia	How is peer support work constructed in an interprofessional clinical care team; How do interprofessional mental health clinical care teams respond to the inclusion of PSWs as team members?	Interviews. Thematic analysis	5

Gates & Akabas	Developing strategies to integrate peer providers into the staff of mental health agencies	2007	USA	What policies, procedures and structures can be provided to support the contribution of peers to the mental health service system	Focus groups. Analysis method not named.	15
Gillard, Edwards, Gibson & Holley	New ways of working in mental health services: A qualitative, comparative case study assessing and informing the emergence of new peer worker roles in England	2014	UK	To test the existing evidence base indicating facilitators and barriers to the adoption of peer worker roles in a range of mental health service settings in England, in statutory and voluntary sectors; To provide mental health service organisations with guidance on the development and introduction of peer workers in the delivery of mental health services	Interviews. Thematic and framework analysis.	22
Kido & Kayama	Consumer providers' experiences of recovery and concerns as members of a psychiatric multidisciplinary outreach team: A qualitative descriptive study from the Japan Outreach Model Project 2011-2014	2017	Japan	To clarify how consumer providers felt about their subjective experiences as members of a psychiatric multidisciplinary outreach team when providing psychiatric services to untreated individuals and individuals who had suspended treatment; To obtain suggestions about support policies for consumer providers and education about the consumer providers for other professionals working with them in psychiatric multidisciplinary outreach teams	Interviews. Qualitative descriptive method.	9
Mancini & Lawson	Facilitating positive emotional labour in peer-providers of mental health services	2009	USA	To explore the experience of recovery from serious psychiatric disabilities	Interviews. Grounded theory.	15

Moll, Holmes, Geronimo & Sherman	Work transitions for peer support providers in traditional mental health programs: Unique challenges and opportunities	2009	Canada	To examine the issues and challenges associated with integrating peer support services into traditional mental health services	Interviews. Analysis method not named.	6
Moran, Russinova, Gidugu, Yim & Sprague	Benefits and mechanisms of recovery among peer providers with psychiatric illnesses	2012	USA	To identify the benefits resulting from being a peer provider	Interviews. Grounded theory.	31
Moran, Russinova, Gidugu & Gagne	Challenges experienced by paid peer providers in mental health recovery: A qualitative study	2013	USA	To examine the challenges reported by individuals working in diverse workplaces, programs and peer roles, including consumer-run programs; To develop a broader conceptual framework that will illuminate challenges experienced by peer workers and serve as a guide to support peer providers' occupational paths	Interviews. Grounded theory.	31
Otte, Werning, Nosskey, Vollmann, Juckel & Gather	Beneficial effects of peer support in psychiatric hospitals. A critical reflection on the results of a qualitative interview and focus group study	2019	Germany	To explore the beneficial effects of integrating peer support work in detail	Interviews and focus groups. Content analysis.	8
Rocchio	Mental health service users as peer providers in Hawaii: Understanding recovery paths and perspectives	2018	USA	To examine the experiences and perspectives of Hawaii's mental health services users in becoming peer specialists and what their perspectives and experiences can possibly tell us about their recovery	Interviews. Grounded Theory.	8

| Simpson, Oster & Muir-Cochrane | Liminality in the occupational identity of mental health peer support workers: A qualitative study | 2018 | UK | To explore the formation of a "peer support worker" identity | Mixed methods: Focus groups for the qualitative aspect. Thematic analysis. | 8 |

1.2.8   Quality Assessment

All included studies were quality checked using the CASP tool, as described above (see Table 3). Overall, the quality of included papers appeared to be high. Out of the ten questions within the CASP, fifteen of the included papers had 'yes' responses to nine or more questions, meaning these areas of quality assessment appeared to have been sufficiently addressed in the papers. Three papers had 'yes' responses to eight out of the ten questions in the CASP, and only one paper had fewer than this, with it having six 'yes' responses to the questions in the CASP.

Across papers, three key points relating to the quality of studies were noted. First, many papers did not adequately discuss issues of reflexivity, an important consideration in qualitative research (Mays & Pope 2000; Tufford & Newman, 2010). This was the most frequently identified issue from completing the quality assessment. Second, whilst the research design was considered to be appropriate in the majority of the included studies, many did not fully justify their choice of research design or provide a rationale for the sample size used. Three of the included studies did not name the analysis method employed, but rather just provided a description of how the data was analysed. Third, whilst studies commented that the research had been approved by an ethics board, many did not elaborate on this further or provide any additional information about which ethical issues were considered and how these were addressed. However, for all of these issues, although the necessary information relating to these points was not included within a number of papers, it is difficult to know whether this was due to these issues not being fully considered within the research, or whether they had been considered but were not mentioned within the papers. Although not a factor considered by the CASP, it was also noted that a number of studies provided no demographic information regarding participants.

Table 3: *Results of CASP Quality Check*

First author	Clear statement of aims?	Appropriate methodology	Appropriate design to address aims	Appropriate recruitment strategy to address aims	Data collected in a way which addressed the research issue	Relationship between researcher and participants considered	Ethical issues considered	Data analysis sufficiently rigorous	Clear statement of findings	Is research valuable
Aikawa	YES	YES	YES	YES	YES	CAN'T TELL	CAN'T TELL	YES	YES	YES
Asad	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Berry	YES	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES
Byrne	YES	YES	YES	YES	CAN'T TELL	CAN'T TELL	YES	YES	YES	YES
Cleary	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Clossey	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Doherty	YES	YES	CAN'T TELL	CAN'T TELL	YES	YES	CAN'T TELL	CAN'T TELL	YES	YES
Dyble	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Ehrlich	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Gates	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES

Gillard	YES	CAN'T TELL	YES	YES	YES	YES	YES	YES	YES	YES
Kido	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Mancini	YES	YES	YES	YES	YES	CAN'T TELL	CAN'T TELL	YES	YES	YES
Moll	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Moran (2012)	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Moran (2013)	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Otte	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES
Rocchio	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Simpson	YES	YES	YES	YES	YES	CAN'T TELL	YES	YES	YES	YES

1.2.9   Themes

Analysis of the included papers identified five key themes: 'Adverse Experiences, 'Valued, Welcomed and Supported', 'Providing a Unique Perspective', 'Influence of Systemic Factors' and 'Easier Over Time' (See Figure 2). The first two themes, 'Adverse Experiences' and 'Valued, Welcomed and Supported', described the ways in which participants felt they were viewed and treated by their colleagues, whilst 'Providing a Unique Perspective' explored what PSWs felt they contributed to the experiences they had with their non-peer colleagues. The final themes of 'Influence of Systemic Factors' and 'Easier Over Time' explored factors which seemed to influence PSW's experiences and perceptions of their colleagues. Appendix B reports on the prevalence of these themes across the included papers.
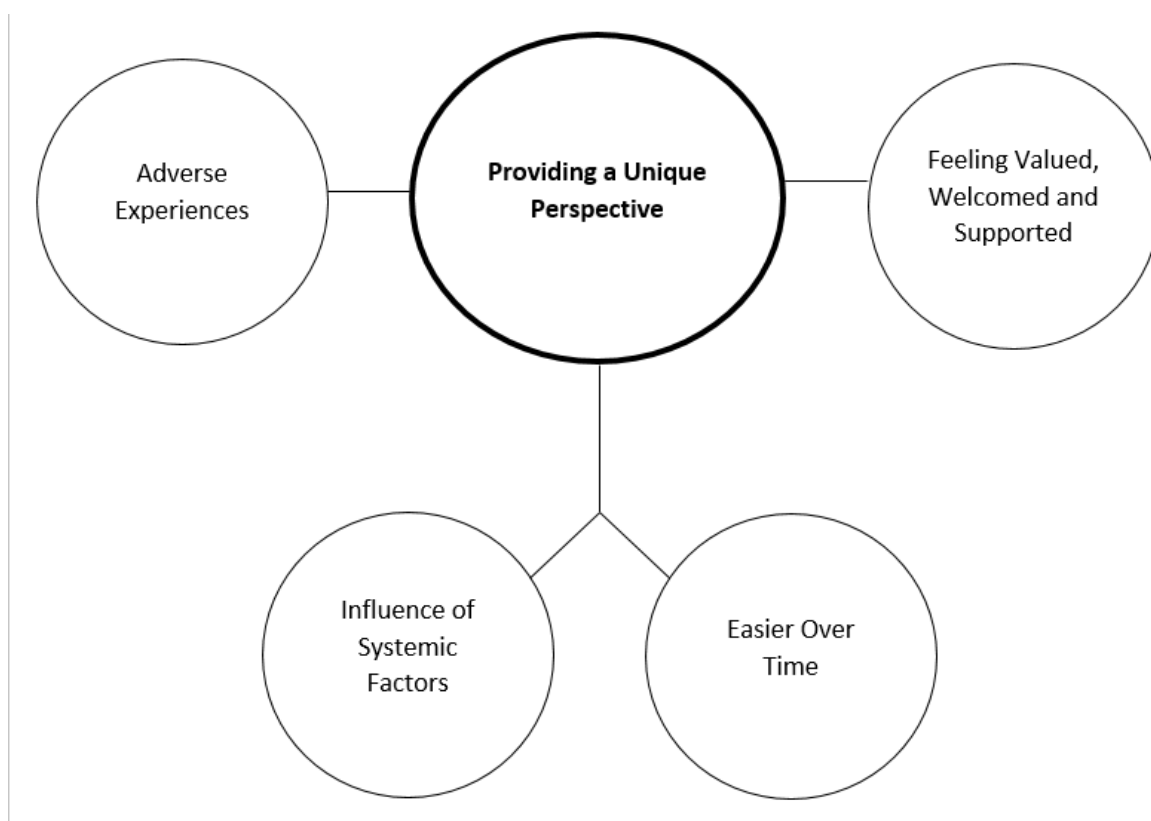
Figure 2: *Thematic Map*

1.2.9.1 Adverse Experiences

Fifteen papers referred to PSWs reporting adverse experiences with their colleagues. This included PSWs perceiving that they were treated differently to other staff and feeling disrespected by their colleagues, as well as experiencing stigma which they perceived was due to their lived experience of mental health difficulties: "reactions from some staff makes me feel that the stigma of identifying as having lived experience runs before me, before any sort of professional credibility" (Byrne et al., 2019). These experiences appeared to leave PSWs feeling undervalued and as though they had to prove themselves to their colleagues.

Most papers made reference to participants feeling that their colleagues treated them differently to other members of staff. A number of papers referred to PSWs reporting that they had little interaction with their colleagues, something which they implied was not the case for non-PSW staff (Asad & Chreim, 2016; Byrne et al., 2019; Clossey et al., 2016; Doherty et al., 2004; Mancini & Lawson, 2009; Simpson et al,, 2018). Examples of this included being excluded from patient care (Asad & Chreim, 2016; Ehrlich et al., 2020) and sometimes feeling ignored:

> "I felt like an outsider; nobody spoke to you, nobody in the staffroom spoke to you" (Simpson et al., 2018)

> "and then I asked 'Are there any questions?' [And] nobody looked at me, nobody answered me, they were all reading their mail, and it was just like I wasn't there…it was even more than that. It was like they didn't acknowledge that I was talking to them…they didn't even look at me like I was in the room…I never ever had that experience before it was really creepy" (Mancini & Lawson, 2009).

Even when PSWs did have interactions with their colleagues, PSWs sometimes reported either expressing doubts regarding whether or not their colleagues would value their opinions, or having had direct experiences whereby they felt their opinions were disregarded by colleagues (Clossey et al., 2016; Doherty et al., 2004; Gillard et al. 2014), something which led PSWs to feel disrespected:

> "I have been dismissed on a couple of occasions. As though what I had to say had no bearing or significance or that my input was irrelevant. Just cut off, short and curt answers by psychiatrists. A cold shoulder. A lot of mental health professionals are still getting used to CPS [peer support workers] being in service. We have been in service for how many years now? And we are still not looked upon with the respect that really should be given" (Clossey et al., 2016).

This seemed to reflect a wider picture of PSWs feeling under-valued by their colleagues, something highlighted in a number of papers (Asad & Chreim, 2016; Byrne et al., 2019; Clossey et al., 2016; Gillard et al. 2014; Mancini & Lawson, 2009; Moran et al., 2013). In particular, PSWs referred to feeling that their colleagues didn't recognise the value in the lived experience they brought to the role: "the psychiatrist had no interest in looking at the documents; I think because I have no degree" (Clossey et al., 2016).

Moreover, it was clear from numerous papers that many PSWs experienced some degree of stigmatisation from colleagues. Sometimes this was more subtle: "…when I first went into the team you could see people looking, thinking…" (Dyble et al., 2014), whilst at other times, PSWs reported experiencing more open discrimination and stigmatisation from their colleagues. This included colleagues asking them inappropriate and intrusive questions (Byrne et al., 2019), being asked to do menial jobs (Cleary et al., 2018; Ehrlich et al., 2020) and being spoken to in a disrespectful manner (Gillard et al., 2014):

> "…I said to him, 'Oh, I'm just about to go on the ward and ask anyone if they wanted to come down to this such-and-such group. Is there anything I should be aware of? Anything that I should know? If I can't take a patient down or whatever from a section or something.' And he said, 'No, I don't think, it's not as if you're responsible for the patients, is it?' and he just sort of snapped at me…I just walked off…" (Gillard et al., 2014).

In some cases, it seemed the lack of respect that PSWs experienced from their colleagues also extended towards service users. PSWs in many papers reported that, at least at times, they did not feel their colleagues were recovery-oriented and sometimes spoke about patients in a disrespectful manner (Cleary et al., 2018; Clossey et al., 2016; Gillard et al., 2014; Moran et al., 2013; Roccio, 2018):

> "you know, I would never want to be talked about by others on my team. They have no respect, you know, I get so angry when I listened to them. They don't know" (Rocchio, 2018)

> "I don't know why they do it, but they tend to make fun of clients outside of the appointment and that was hard to be around" (Moran et al., 2013).

Participants in some papers reported that their colleagues treated them as vulnerable (Berry et al., 2011; Byrne et al., 2019; Clossey et al., 2016; Doherty et al., 2004; Gates & Akabas, 2007), which sometimes led to participants feeling that their colleagues were overprotective, leaving PSWs feeling "wrapped in cotton wool. They are too careful…and you might just want to be like

everybody else" (Doherty et al., 2004). Similarly, a number of papers referred to PSWs reporting that their colleagues treated them as patients rather than colleagues (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Byrne et al., 2019; Dyble et al., 2014; Gates & Akabas, 2007; Mancini & Lawson, 2009), for example by interpreting everything in the context of their mental health difficulties, rather than within a work-related context:

> "Some of the psychiatrists and therapists try to therapize me. I stay in my role but other staff don't stay in their roles. They become overly concerned that I'm becoming symptomatic, [that they need to] give me meds" (Gates & Akabas, 2007).

This left some PSWs feeling that they were "always going to be in that sick role" (Dyble et al., 2014) and therefore were not going to be viewed as members of staff by their colleagues. As a result, Byrne et al. (2019) reported that PSWs sometimes felt that they needed to overcompensate in an attempt to gain recognition from their colleagues:

> "I do think I had to overcompensate. I'm aware of how I dress, of how I move, of how I engage, that there is always the potential I will be misread as being inappropriate, and that being due to my lived experience rather than just a personality thing" (Byrne et al., 2019).

Other papers also referred to PSWs feeling as though they needed to try to prove themselves to their colleagues (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Clossey et al., 2016; Ehrlich et al., 2020). Whilst in these papers PSWs felt the need to prove themselves as a result of how they were treated by their colleagues, Kido and Kayama (2017) highlighted that sometimes this was more due to the way in which PSWs positioned themselves in relation to their colleagues. Kido and Kayama (2017) reported that, even when PSWs' colleagues were supportive, PSWs saw themselves as being inferior to their colleagues and therefore felt that they had to "work hard and be highly evaluated by other staff because I have been employed" (Kido & Kayama, 2017). Regardless of the reason, Rocchio (2018) highlighted that there was a risk that PSWs could "push themselves too far" in trying to prove their worth to their colleagues and cautioned against PSWs doing this.

Whilst in many studies PSWs reported colleagues' negative attitudes as the source of stigma, some studies offered alternative explanations. These included that, although PSWs may feel treated disrespectfully by their colleagues, this may not have been their colleagues' intention (Ehrlich et al., 2020; Mancini & Lawson, 2009) but may be the result of a lack of understanding about the PSW role (Asad & Chreim, 2016). Indeed, many papers reported that PSWs perceived there to be a lack of understanding about their role amongst their colleagues (Asad & Chreim,

2016; Doherty et al., 2004; Erhlich et al., 2020; Gates & Akabas, 2007; Moran et al., 2013; Rocchio, 2018). This appeared to be something which PSWs viewed as only applying to them, and not to other members of staff: "There's no other position on the team or hospital…that you have to justify your role…A doctor comes in and nobody questions their role…Whereas a peer specialist, 'Oh we don't know what you do' " (Asad & Chreim, 2016). In particular, PSWs perceived there to be confusion amongst their colleagues about PSWs' roles and positions within the team (Ehrlich et al., 2020; Moran et al., 2013; Gates & Akabas, 2007), something which particularly occurred when there were similarities between the roles of PSWs and their colleagues. At times, PSWs said this led to their colleagues being unsure about how to work with them.

1.2.9.2   Feeling Valued, Welcomed and Supported

Despite the common occurrence of negative experiences reported by many papers, others referred to PSWs feeling valued, welcomed and supported by their colleagues. However, the extent of this varied across papers, with some papers, such as Moll et al. (2009) and Gillard et al. (2014) finding that this occurred commonly, whereas others reporting that this was more of an exception (Mancini & Lawson, 2009).

A number of papers described participants having positive experiences and perceptions of their colleagues and described the support PSWs gained from their colleagues. Moll et al. (2009) described how the majority of PSWs in the study felt welcomed and well-supported by their colleagues. There was a sense that PSWs perceived their colleagues as friendly and approachable and that they were willing to provide the help PSWs needed to enable them to thrive in the role and "really get back on your feet" (Moll et al., 2009). Similarly, Mancini and Lawson (2009) highlighted how beneficial PSWs perceived support from their colleagues to be in helping them to be successful in their roles and described how PSWs appreciated their colleagues being supportive and compassionate towards them and offering help when needed.

Whilst many studies discussed the importance of PSWs feeling supported by their colleagues, participants differed in their views regarding receiving emotional support from their colleagues. Participants in some studies had positive views of the emotional support they received from their colleagues and felt comfortable seeking this support from their co-workers and viewed it as beneficial to their wellbeing:

> "If I need help, I'm surrounded by a table full of experts who are all willing to help. I just
> have to ask…'I'm not doing well, I need some help'…Everyone on the team would drop
> what they're doing and say, 'Sure' " (Asad & Chreim, 2016)

> "Everybody's approachable. If I'm having a bad day I just grab any member of staff…and
> say, 'Have you got ten minutes? I'd like to have a chat'…" (Gillard et al., 2014).

However, some participants had different views, with those in Moll et al. (2009) suggesting that receiving emotional support from colleagues could be unhelpful and lead to PSWs being viewed as patients rather than members of staff. These participants therefore emphasised the importance of keeping relationships with their colleagues professional:

> "I learned after a while that, you know, it's important to draw the line and seek
> support…from my support team outside of work. Even though this working environment
> is very supportive and it's easy to want to…accept the help of everybody else and
> everything. It's just important to kind of draw that line…" (Moll et al., 2009).

Alongside feeling well-supported, feeling valued by their co-workers was also important for participants (Byrne et al., 2019; Clossey et al., 2016; Dyble et al., 2014; Ehrlich et al., 2020; Moran et al., 2012). Byrne et al. (2019) highlighted that feeling more accepted and valued by colleagues was more likely for PSWs working within not-for-profit or consumer-run organisations, compared to those working in government-run organisations. Moran et al. (2012) reported that PSWs in their study described feeling appreciated by their colleagues and said that their colleagues were interested in learning about, and saw the value in, PSWs' lived experience of mental health difficulties. Similarly, Ehrlich et al. (2020) reported that, with time, PSWs became accepted members of the team, with staff being increasingly able to recognise and value the strengths and skills PSWs brought to the work:

> "I think those [clinicians] who are on the ground with us [PSWs] and can see what we're
> doing, they're the ones seeing the benefits straight away, especially when we're on
> [acute care] ward and people on the ward have seen what we're able to do, how we've
> supported people [consumers]…They [acute care staff] are quite happy for it and it feels
> like to me that we have a gold card anywhere we go, from what I've experienced
> anyway." (Ehrlich et al., 2020).

1.2.9.3   Providing a Unique Perspective

In many papers, PSWs emphasised the unique perspective which they brought to their teams, based on the perception that their non-peer colleagues often approached things very differently to how a PSW would. Participants in a number of the papers spoke about how they used this unique perspective in their interactions with their colleagues, for example to challenge their colleagues' sometimes negative views and practice.

Participants in Berry et al. (2011) highlighted how they believed that their colleagues tended to adopt a more diagnostic-led and problem-focused approach to clients, whilst PSWs tended to focus more on clients' strengths and abilities. They highlighted how PSWs placed a greater importance on involving clients in decision-making processes, whereas they felt their colleagues were less inclined to do this. Other studies also highlighted the ways in which PSWs perceived their colleagues as being somewhat different to themselves, for example viewing them as having a more formalised approach to their work and being less approachable (Moll et al., 2009).

A number of studies discussed how participants felt the relationships they formed with clients was different to those that their colleagues formed (Berry et al., 2011; Doherty et al., 2004; Gillard et al., 2014; Moll et al., 2009; Otte et al., 2019). Otte et al. (2019) noted that PSWs felt that, compared to their colleagues, they had more time to spend interacting with clients, and this helped them to develop a different type of relationship with clients than the relationships their colleagues formed, and PSWs viewed this to be beneficial to client care:

> "Our team is great and very experienced; it is not like I want to say anything bad about them, not at all. But I – in contrast to them- have officially and formally the time to sit down for an hour and just talk. And to just let the patient talk and just listen" (Otte et al., 2019)

> "I feel like I have a different connection than the other mental health professionals"; "patients talk differently to a PSW than to a nurse for example…when I sit down with patients in a group, completely different topics emerge than would have if a nurse was present" (Otte et al., 2019).

Similarly, Gillard et al. (2014) reported that PSWs perceived their colleagues to be very busy with non-client facing tasks and therefore less available to clients, whereas PSWs felt they weren't classed as clinicians in the same way as their colleagues, meaning they had more time to spend building connections with clients.

Thus, it is clear from a number of studies that PSWs perceive there to be key differences between themselves and their colleagues. These differences were often viewed positively by PSWs, with some emphasising that "you're supposed to be independent of that really" (Simpson et al., 2018) and highlighting that the unique perspective of PSWs can help to strengthen their position amongst their colleagues (Asad & Chreim, 2016). Moran et al. (2012) highlighted how PSWs believed their colleagues also viewed these differences to be beneficial and valued the alternative perspectives which PSWs contributed to the team. Nevertheless, despite these differences, Berry et al. (2011) emphasised the importance of PSWs still being positioned as equal to their

colleagues, something which the previous theme of 'Adverse Experiences' shows does not always happen in practice.

Many studies discussed how PSWs drew upon their unique perspective in interactions with colleagues to have a positive influence on the work of their colleagues. This included challenging negative attitudes and stigma expressed by their colleagues, offering alternative views of clients and providing advice and suggestions of ways their colleagues could improve their practice and thus improve the quality of care offered to clients. Overall, this seemed to help PSWs to facilitate a positive shift in the team's overall culture, leading their colleagues to develop a more recovery-oriented approach to their work.

Berry et al. (2011) highlighted how PSWs often took on the role of "challenger" within their team by questioning things which they didn't feel comfortable with, such as their colleagues not adopting a recovery-focused approach, in order to improve client care. Other papers reported similar findings, with Cleary et al. (2018) and Otte et al. (2019) both highlighting how PSWs would often challenge their colleagues when they used disrespectful or stigmatising language:

> I often consult on a lot of their ideas around language, just as a basic example they'll send me documents and I will read over them and they just want the consumer recovery perspective on them. It's good because I can change a bit of the language and re word questions to be more suitable (Cleary et al., 2018)

> "I got the feedback that the tone of our meetings has changed since I have been present. I mean, of course, I ask myself if I were a patient here, would I be happy about the way people talk about me- so I try to address this issue from time to time. And I believe, just to have someone from the other side, the "patient side" sitting in these meetings, helps to raise attention regarding how people talk about patients" (Otte et al., 2019).

Gillard et al. (2014) described how PSWs would often help to challenge negative attitudes held by their colleagues about clients, and thus helped their colleagues to view clients in a more positive, recovery-oriented light. PSWs in Moran et al. (2012) highlighted how PSWs helped their colleagues to think less judgmentally about clients and adopt a more hopeful and less diagnostic-led approach to their work, as well as helped promote the idea of clients being more actively involved in their care. Additionally, Doherty et al. (2004) described how PSWs used their own lived experience of recovery to help challenge the sometimes negative views their colleagues held towards clients. Thus, it is clear that PSWs felt they helped to facilitate a positive change in their colleagues by offering an alternative and unique perspective (Kido & Kayama, 2017).

PSWs described how they used their unique perspective and lived experience to provide advice and guidance to their colleagues. Participants in Aikawa and Yasui (2017) described how their colleagues began to approach them for advice and valued the unique perspective they contributed. Similarly, PSWs in Asad and Chreim's (2016) paper explained how they used their lived experience to help inform and educate their colleagues:

"If in a meeting, it comes up that a client is not happy about taking medication…I can say I've experienced that and reflect it back to the team…You're advocating for the client and…educating the team" (Asad & Chreim, 2016)

Similarly, from Otte et al.'s (2019) paper, it was clear how PSWs could provide guidance to their colleagues about how best to support clients:

"We once had this patient who was very psychotic and the entire team was trying to find the best way to approach her. […] And they talked and talked to her forever. That's when I said: […] Just leave her alone for now. I know this from my own experience when I was in that state and so many people tried to talk to me, I just ran away, […], because I couldn't process any of the information these people were trying to convey, which made me feel under pressure. And as soon as we did leave her alone, she got better. It was the right thing to do" (Otte et al., 2019).

Additionally, PSWs also helped to improve the relationships which existed between their colleagues and clients, as demonstrated by Ehrlich et al. (2020):

"Part of my role is to vouch for them [clinicians]. So, I do that a few different ways, just by actually vouching for them. Saying 'yeah I've seen them [clinicians] do some good work and maybe encourage them [consumers] to give them [clinicians] a chance and that sort of thing" (Ehrlich et al., 2020).

It should be noted, however, that whilst some PSWs felt they had a "voice within my team" (Ehrlich et al., 2020), others sometimes found it difficult to challenge their colleagues (Gillard et al., 2014) or felt that their colleagues missed opportunities to draw on the unique perspective of PSWs:

"No other mental health professional; nurses, social workers, occupational therapists or psychologists have asked me about recovery. Ever. I think that's damning 'cause I don't know if you're getting the sense, I know a little bit about recovery" (Byrne et al., 2019).

Finally, participants in Berry et al. (2011) suggested they wanted more support from their non-peer colleagues to help them challenge non-recovery practices so that the "responsibility is more shared" (Berry et al., 2011).

1.2.9.4   Influence of Systemic Factors

Many papers described how various systemic factors, such as the organisational set up of services, had an influence on the type of experiences and interactions PSWs had with their colleagues. The hierarchical structure of services seemed to play a key role here, as well as the way in which the traditional medical model dominated the services' approach.

Several papers discussed how services adopting a medical model influenced the relations between PSWs and their colleagues (Asad & Chreim, 2016; Clossey et al., 2016; Dyble et al., 2014). Participants in Clossey et al. (2016) highlighted that they didn't feel they fitted into the dominant medical model and said this led to their colleagues being unsure about how to interact with them: "there is no place in the medical model discourse for CPS [certified peer specialists] and the result is poor understanding of how to interact with these workers" (Clossey et al., 2016). Difficulties in not understanding the medicalised language used by their colleagues also created a sense of difference between PSWs and their colleagues: "I didn't know how to argue in the meetings. There were all these very well educated people and…they would start with their rehabilitation lingo" (Asad & Chreim, 2016). Additionally, PSWs sometimes felt that their colleagues viewed them through the lens of the medical model and this appeared to elicit a sense of feeling stigmatised:

> "The medical model was there, it was like ok, "you're here Peter, you look ok, but what's wrong with you [laughs] […] I don't wanna be mad to have the job." (Dyble et al., 2014).

Whilst it was clear that the medical model was very prominent in services and often shaped the interactions between PSWs and their colleagues, PSWs in both Ehrlich et al. (2020) and Gillard et al. (2014) implied that trying to change the hierarchical, medicalised approach of services was difficult, particularly given that services had been this way for a long time. Ehrlich et al. (2020) argued working alongside PSWs was something which was "going against years of [clinical] training" for colleagues, and Gillard et al. (2014) highlighted how PSWs often found it difficult to challenge their colleagues' non-recovery focused attitudes:

> "I don't challenge much here…other members of staff about what they say because I feel, sometimes I don't feel able to do that…the changing of language. You can't expect someone that's been working in mental health for 20 years, you can't come along and say, 'Now you've got to use different language here'." (Gillard et al., 2014).

In addition to the wider set up of services, some papers also highlighted more current factors within the team which could influence how integrated PSWs felt with their colleagues. Berry et al. (2011) suggested that when PSWs were introduced into teams which were undergoing a period of change or instability, they were more likely to perceive that they were less welcomed by their colleagues and were treated differently to other staff. Additionally, some studies highlighted that when PSWs had greater opportunities to interact with other staff, they tended to experience more positive interactions with their colleagues (Asad & Chreim, 2016; Moll et al., 2009); for example, when they were introduced to their colleagues and attended team meetings (Simpson et al., 2018). Finally, some papers found that PSWs were more accepted by their colleagues if their colleagues had greater experience working with PSWs (Rocchio, 2018) and were more prepared for the introduction of PSWs into the team (Berry et al., 2011).

1.2.9.5   Easier Over Time

Participants in many studies suggested that their experiences with their colleagues improved with time. Aikawa and Yasui (2017), Asad and Chreim (2016) and Dyble et al. (2014) all described how whilst PSWs initially had experienced being disrespected and stigmatised by their colleagues, over time they began to feel increasingly accepted and valued, with Aikawa and Yasui (2017) highlighting how this led to their colleagues increasingly approaching them for advice:

> "At the beginning, my views, my opinions were not validated because my coworkers didn't see me as a staff person. I had to force people to listen and let them know that I could do a good job. So, that, was pretty challenging. Then, they saw that I was capable. I knew I was accepted once my coworkers started to come to me for help with members. They needed me" (Aikawa & Yasui, 2017)

Similarly, others described how, over time, they felt confident in their role amongst the colleagues within their team (Kido & Kayama, 2017) and their colleagues began to develop a better understanding of the PSW role (Gillard et al., 2014) meaning PSWs felt increasingly able to use their lived experience in ways which were beneficial to their colleagues (Ehrlich et al., 2020):

> "I got used to working with team members. This might mean that I started to be conscious of my standpoint as a member of a multidisciplinary team." (Kido & Kayama, 2017)

> "…So I think there was that sort of hostility, where they sort of looked at you and thought, 'Well, what are you doing?' But I think they understood it a bit better sort of a few months into it. I think it got better" (Gillard et al. 2014).

However, there was a discrepancy between the amount of time it took for PSWs to notice an improvement in their relationships with their colleagues, with some participants suggesting things improved within a few months (Gillard et al., 2014), whilst others suggesting it took considerably longer: "[it could take] years to properly build a rapport and trust [with colleagues]" (Cleary et al., 2018).

Equally, it sometimes also took time for *PSWs* to adjust to working alongside their colleagues:

> "To be honest it was- it was difficult at first because these were the type of people before that were more the enemy to me…Not the enemy but you know the- the people giving me help. The system, the system you know. And I was the person, you know, getting help from the system…it's that power thing. So now I was working with them I had to work with them and you know get along with them [laughing] and so it was a bit of a challenge for me because I had a bit of a chip on my shoulder from some of my experiences that I had." (Moll et al., 2009).

1.3   Discussion

This systematic review synthesised the existing qualitative evidence regarding mental health PSWs' experiences and perceptions of their non-PSW colleagues. This was an important topic to explore given that previous studies have highlighted that non-PSW staff can hold negative attitudes towards PSWs (Collins et al., 2016; Gillard et al., 2014) and that PSWs can experience stigma and discrimination from their non-PSW colleagues (Asad & Chreim, 2016; Berry et al. 2011; Doherty et al., 2004), something which can act as a barrier to PSWs' successful integration into services (Vandewalle et al., 2016). The current review therefore builds on this literature by exploring how PSWs themselves experience and view their non-PSW colleagues. Five key themes were identified: 'Adverse Experiences', 'Valued, Welcomed and Supported', 'Providing a Unique Perspective', 'Influence of Systemic Factors' and 'Easier Over Time'. Whilst the first three themes described the experiences and perceptions PSWs had of their colleagues, the final two themes discussed factors which PSWs felt could influence these. Given that the overall quality of included papers was high, the findings and clinical implications arising from this review should be considered strongly. However, several points relating to the quality of included studies were noted. In particular, the majority of papers did not adequately discuss the relationship between the researcher and participants. Although this lack of reflexivity may have biased the findings of individual studies, it is important to note that the themes identified from this review occurred in a number of the included papers, therefore suggesting these themes are reliable representations of PSWs' experiences.

The findings of the review suggest that PSWs experiences with their colleagues are mixed, with many feeling that their colleagues did not fully understand or see the value in PSWs, leading PSWs to feel stigmatised and discriminated against, whereas others felt valued and well supported by their colleagues, and felt accepted and welcomed into their teams. Furthermore, a number of papers reported PSWs experiencing a combination of these experiences.

PSWs in many of the included papers reported having at least some negative experiences with their colleagues and reported that they were treated differently to other members of staff. Examples of this included being ignored (Mancini & Lawson, 2009; Simpson et al., 2018), being asked inappropriate questions (Byrne et al., 2019) and spoken to disrespectfully (Gillard et al., 2014). Additionally, PSWs expressed concerns that they weren't valued by their colleagues (Asad & Chreim, 2016; Clossey et al., 2016; Byrne et al., 2019; Doherty et al., 2004; Gillard et al., 2014; Mancini & Lawson, 2009; Moran et al., 2013). These experiences of PSWs are consistent with the literature reporting that some non-PSW staff hold negative and stigmatising attitudes towards PSWs (Collins et al., 2016; Gillard et al., 2014). Thus, these attitudes, of which PSWs are very much aware, might influence how non-PSW staff interact with PSWs. Arguably, these negative views towards PSWs may reflect a wider culture where PSWs are not valued, as suggested by PSWs being offered fewer working hours and having lower rates of pay than non-PSWs (Walker & Bryant), as well as the perceived lack of career development and promotion opportunities available to PSWs (Vandewalle et al., 2016).

Literature has highlighted that non-PSW staff sometimes view PSWs as vulnerable and express concerns about the impact the role itself may have on PSWs' wellbeing (Collins et al., 2016; Gray et al., 2017; Holley et al., 2015; Hurley, et al., 2018). The findings of the current review are consistent with this, and PSWs in several of the included papers reported that their colleagues treated them as fragile (Berry et al., 2011; Byrne et al., 2019; Clossey et al., 2016; Doherty et al., 2004; Gates & Akabas, 2007), and sometimes as clients (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Byrne et al., 2019; Dyble et al., 2014; Gates & Akabas, 2007; Mancini & Lawson, 2009). Combined with the stigma that PSWs sometimes experienced, PSWs sometimes felt the need to 'prove themselves' to their colleagues (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Clossey et al., 2016; Ehrlich et al., 2020).

PSWs often reported feeling that their colleagues did not fully understand the role of a PSW (Asad & Chreim, 2016; Doherty et al., 2004; Ehrlich et al., 2020; Gates & Akabas, 2007; Moran et al., 2013; Rocchio, 2018). This is something which mental health staff have reported themselves in several studies (Asad & Chreim, 2016; Gillard et al., 2014; Hurley et al., 2016; Kemp & Henderson, 2012; Mowbray et al., 1998). Arguably, it is possible that this lack of understanding may have

contributed to the negative experiences PSWs had with their colleagues. Thus, it is important that steps are taken to address the lack of understanding about the PSW role, particularly given that this is one of the key factors required for peer support to be successful (Bach & Della Rocca, 2000) and that a lack of understanding can result in non-PSW staff perceiving the employment of PSWs as tokenistic (Gates & Akabas, 2007; Gillard et al., 2014).

'Adverse Experiences' was the theme which occurred most frequently across the included papers. Given this, and the overall high quality of papers which discussed this theme, services which employ PSWs should be aware that PSWs often perceive their non-PSW colleagues to hold negative and stigmatising attitudes towards them and have a lack of understanding of the PSW role. It is important that measures are taken to address this and recommendations of how this can be done are provided within the 'Clinical Implications' section below.

Despite the sometimes negative experiences PSWs had with their colleagues, PSWs also reported having positive experiences with their colleagues and described feeling welcomed, valued and supported. Some papers reported that PSWs felt well supported by their colleagues and felt that this support helped them to be successful in their roles (Mancini & Lawson, 2009; Moll et al., 2009). However, there were discrepancies in PSWs' views regarding receiving emotional support from colleagues, with some viewing this as helpful (Asad & Chreim, 2016; Gillard et al., 2014), whilst others felt this increased the risk of them being treated as patients rather than colleagues (Moll et al., 2009). Clinicians working alongside PSWs have also expressed the potential for boundaries to become blurred within relationships between themselves and PSWs (Collins et al., 2016; White et al., 2017). PSWs in many papers emphasised the importance of feeling valued by their colleagues (Byrne et al., 2019; Clossey et al., 2016; Dyble et al., 2014; Ehrlich et al., 2020; Moran et al., 2012), although it was clear they do not always feel valued in practice. It is also important to note that in some of the studies where PSWs reported having positive experiences with their colleagues, their experiences were not wholly positive. For example, although participants in Mancini and Lawson (2009) reported that some of their colleagues were supportive, many were not, as described in 'Adverse Experiences'. Similarly, Simpson et al. (2018) found that whilst some colleagues treated PSWs with respect, others did the opposite.

Findings of the current review highlighted that PSWs identified that they brought a unique perspective to staff teams, and often felt they approached things differently to their non-PSW colleagues; for example by promoting recovery-focused practice and facilitating more patient involvement and collaboration in their care. PSWs discussed how they often formed different relationships with service users than their non-PSW colleagues did (Berry et al., 2011; Doherty et al., 2004; Gillard et al., 2014; Moll et al., 2009; Otte et al., 2019), partly due to PSWs having more

time to spend with service users than their colleagues do (Gillard et al., 2014; Otte et al., 2019). Research has found that non-PSW staff share the view that PSWs form unique relationships with service users and describe these relationships as warm and trusting (Gray et al., 2017). In particular, non-PSW staff have emphasised the shared understanding PSWs have with service users (Cabral et al., 2014; White et al., 2017) and the way in which PSWs can act as positive role models to service users and thus provide hope (Cabral et al., 2014). Additionally, service users have also reported valuing the relationships they have with PSWs, reporting that PSWs often engage with them in a different way than other members of staff (Cabral et al., 2014).

Findings showed that PSWs can use their unique perspective more directly to benefit their colleagues, such as by advising, informing and educating them, for example about recovery-focused practises (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Cabral et al., 2014; Otte et al., 2019), and helping to change the way in which they viewed mental health difficulties (Collins et al., 2016). PSWs also felt they were able to improve the relationships between their colleagues and service users (Ehrlich et al., 2020), a view also shared by non-PSW staff (White et al., 2017). Despite this, some PSWs also felt that their colleagues sometimes missed opportunities to benefit further from the knowledge and lived experience of PSWs (Ehrlich et al., 2020).

The review highlighted a number of factors which influenced the experiences and perceptions PSWs had of their non-PSW colleagues. Systemic factors, which were generally associated with PSWs having more positive experiences and perceptions of their colleagues, included having more opportunities for PSWs to interact with their colleagues (Asad & Chreim, 2016; Moll et al., 2009; Simpson et al., 2018) as well as their colleagues being more prepared for the introduction of PSWs (Berry et al., 2011) and having more experience of working with PSWs (Rocchio, 2018). This is similar to Mulvale et al. (2019) who highlighted the role of managers in preparing non-PSW staff for the introduction of PSWs, for example by ensuring non-PSW staff have a good understanding of the purpose and benefits of peer support, have opportunities to mix with PSWs and that stigma is addressed. Conversely, high prominence of the medical model within services seemed to be linked with PSWs experiencing more stigma from their colleagues, perceiving that their colleagues lacked understanding of the PSW role and generally finding it harder to integrate with their colleagues (Asad & Chreim, 2016; Clossey et al., 2016; Doherty et al., 2004; Ehrlich et al., 2020; Gillard et al., 2014). Studies of non-PSW staff views of PSWs have reported that staff sometimes perceive PSWs as posing a threat to the medical model and the way in which services have traditionally operated (Bennetts et al., 2011; Kilpatrick et al., 2017).

Time appeared to be a key factor influencing the experiences PSWs had with their colleagues. More specifically, PSWs tended to report having more positive experiences with their colleagues

over time, feeling increasingly valued and accepted by their colleagues (Aikawa & Yasui, 2017; Asad & Chreim, 2016; Dyble et al., 2014). Moreover, PSWs reported that, with time, their colleagues began to understand their role better (Gillard et al., 2014), meaning PSWs were more able to use their knowledge and experience to benefit their colleagues (Aikawa & Yasui, 2017; Ehrlich et al., 2020; Kido & Kayama, 2017). This echoes findings of Mulvale et al. (2019) who emphasised that, whilst non-PSW staff may sometimes be sceptical and resistant of PSWs, over time, they often realise the value of peer support and thus become more accepting and supportive of PSWs.

1.3.1 Application to Wider Theory

The findings of the review can be considered within the context of wider psychological theories relating to social groups, such as Social Identity Theory. Social Identity Theory (Tajfel et al., 1979) proposes that individuals categorise themselves and others in terms of social groups to help them make sense of the world. The term 'in groups' is used to refer to groups in which individuals class themselves as belonging to, whilst those which individuals do not identify belonging to are termed 'out groups'.

The theory holds that people's perceptions of in and out groups shape the way that they view themselves. For example, Tajfel et al. (1979) suggested that belonging to an in group which is perceived by the individual as being of high status and value can have a positive impact upon the individual's self-concept and self-esteem. Furthermore, the theory states that individuals evaluate and make comparisons between the groups that they belong to and other groups, which subsequently influences how they perceive and interact with others, including members who are perceived as belonging to the same group as them, as well as members of out groups. When making these comparisons, compared to out groups, individuals tend to evaluate the groups which they belong to in a more positive light, a concept referred to as 'in group favouritism'. As a result of in group favouritism, the way individuals interact with other members of the in group is often different to how they interact with those belonging to other groups, with behaviour towards the former often being more positive. Indeed, Tajfel et al. (1979) argued that in order to ensure they are evaluated more highly than other groups, members of in groups may focus on identifying negative aspects of other groups, something which may contribute to discriminatory behaviour towards other social groups.

These concepts from Social Identity Theory could be used to make sense of some of the findings from the current review. The 'adverse experiences' theme highlighted that many PSWs perceived that their colleagues treated them differently to how they treated other members of staff. One

explanation for this could be that non-PSW colleagues categorised themselves and PSWs differently, perhaps seeing themselves and other non-peer members of staff as belonging to one group, the 'in group', whilst perceiving PSWs as belonging to an out group. Social Identity Theory would suggest that the in group, in this case non-PSW staff, would then compare themselves to other groups, such as the PSW group, and perceive this group as different to themselves. The theory would predict that this would then influence their behaviour towards PSWs. The review also showed that some PSWs experienced feeling less valued by their colleagues in comparison to other members of staff; this fits with the concept of in group favouritism and other research which has shown that members of in groups are likely to be valued more highly than members of other groups (Brewer, 1979). Social Identity Theory argues that one way in which in groups may do this is by minimising the positive aspects of out groups, something which could explain the review's finding that PSWs often felt devalued by their colleagues.

However, it is important to note that whilst the review highlighted that some PSWs experienced feeling devalued and discriminated against by their colleagues, others felt welcomed, valued and accepted by their colleagues. One possible explanation of this, based on Social Identity Theory, is that in these cases, non-PSW colleagues did not categorise PSWs differently to how they saw themselves and other members of staff, but rather categorised both non-peer staff and PSWs as belonging to the same in group.

The review also highlighted factors which appeared to influence PSWs' experiences and perceptions of their colleagues, a finding which Social Identity Theory can also be used to possibly explain. For example, it appeared that PSWs' experiences with their colleagues tended to be more negative and discriminatory if the service they were working in was strongly informed by the medical model. Given the discrepancy between the medical model of mental ill health and the more recovery-focused approach of peer support (Davidson, 2005; Deegan, 2003), non-PSWs working in services informed by the medical model might be expected to position PSWs as part of an out group and thus treat them negatively. Given that the review found some PSWs reported that they felt treated as patients rather than staff, one hypothesis could be that in these cases non-PSW staff categorised PSWs as belonging to the 'patient group' rather than the 'staff' in group. Finally, the theme 'Easier Over Time' reflected that the experiences PSWs had with their colleagues could become more positive over time, with PSWs sometimes feeling more valued and accepted as time went on. An explanation for this, based on Social Identity Theory, is that whilst staff might initially have positioned PSWs as members of an out group, this changed over time, possibly as a result of increased interaction and experience with each other. This could have led non-PSWs to re-categorise PSWs and consequently see PSWs as belonging to the same group as other staff members.

1.3.2   Strengths and Limitations

The current review synthesised existing qualitative evidence regarding PSWs' experiences and perceptions of their non-PSW colleagues, an important topic given the potential for this to have an impact on PSWs' experiences of their role more generally and their integration into mental health services. To the best of the author's knowledge, this is the first review to examine this topic specifically. Thus, it provides a valuable contribution to the peer support literature, as well as identifying factors for services who employ PSWs to facilitate positive relationships between PSWs and their colleagues. A broad range of qualitative studies were included, spanning a wide range of countries, allowing a variety of PSWs' experiences to be captured. Grey literature was included to avoid publication bias; however, only one of the included papers fell into this category. It would therefore have been useful for greater efforts to have been made to obtain grey literature, for example by searching conference proceedings or contacting subject matter experts.

Subjectivity is inevitable within any qualitative research. Steps were taken to reduce this, such as having a second person independently screen 10% of papers during both the title/abstract screening and the full text screening stage, having the coding of 20% of included papers checked retrospectively by a second person and by final themes being discussed and agreed upon by the wider research team. Subjectivity could have been further addressed by having the second person screen a larger percentage of papers, but this was not possible due to time limitations.

In addition, it was initially planned to identify further papers to include in the review by searching the reference lists of included papers and by using forward citation tracking. However, this was also impossible due to time limitations. At the screening stage of the review, a relatively high number of papers needed to be full text screened in order to determine whether or not they met the review's inclusion/exclusion criteria. Given this, it would not have been feasible to have screened the reference lists and to have used forward citation tracking for all of the nineteen papers included in the review within the time available, thus it is acknowledged that this is a limitation of the review.

1.3.3   Clinical Implications

The findings of this review are likely to be particularly of interest to services who employ PSWs, or those which are considering doing so in future. The findings of the review can help to highlight the mixed experiences PSWs have with their non-PSW colleagues, particularly the negative and stigmatising attitudes that PSWs sometimes perceive their non-PSW colleagues to hold towards them. In line with this, the review identified particular aspects which PSWs report increase or

decrease the likelihood of them having positive experiences with their non-PSW colleagues. These included the stability of the service at the time PSWs are introduced, the level of preparation and training non-PSW staff had regarding PSWs, the prominence of the medical model within services and the number of opportunities PSWs had to interact with their colleagues. The results of this review suggest that services who employ PSWs should be aware of these factors, for example, by introducing PSWs at a time when the team is relatively stable and not going through a period of change, maximising opportunities for PSWs and non-PSW staff to interact and by providing training to non-PSW staff regarding the PSW role, what it entails and its potential benefits. Emphasising the unique perspective which PSWs can bring to services, and the ways in which this can benefit both service users and staff, is likely to be particularly useful here, both to help increase staff understanding of the PSW role and to challenge potentially negative attitudes, including views that the employment of PSWs is tokenistic. It may be useful for staff working alongside PSWs to be offered reflective practice sessions to enable them to voice and reflect upon the ways in which they view PSWs, providing an opportunity for any stigmatising views to be gently challenged within a 'safe' environment. Given that the review highlighted that PSWs do sometimes feel stigmatised and treated differently to other staff, it is important that services are mindful of the impact this may have on PSWs' own wellbeing and ensure they have adequate supervision and support in place.

The review also highlighted that PSWs often felt that their experiences with their colleagues improved over time. It may therefore be useful for services to prepare for a 'transition period' when PSWs are initially employed, with the measures described above being particularly important during this period. Additionally, the finding that PSWs' experiences with their colleagues can improve with time may be something which managers of PSWs may wish to share with PSWs themselves to provide some reassurance that things will likely improve even if difficulties are experienced initially.

1.3.4   Directions for Future Research

The review highlighted that there is a lack of existing research which has specifically aimed to explore PSWs' experiences with their non-PSW colleagues. It is therefore suggested that future studies examine this and, given that the current review highlighted that these experiences can change over time, it may be useful for future studies to use a longitudinal design.

Quality checks of included papers highlighted a number of methodological issues within the existing literature. Future research should therefore be designed to account for these issues and ensure they are sufficiently addressed as part of the research process and reflected within the

study write up. This can be achieved by providing a full rationale regarding the research design used, as well as providing a justification regarding the sample size used in the study. Whilst the majority of studies included in this review stated that the research had been approved by an ethics board, many failed to provide any further information about ethical issues. As well as seeking necessary ethical approvals, it would be useful for future research to ensure that information is provided within the study write up regarding what ethical issues were considered and how these were addressed.

One of the most significant quality issues within this review was a lack of discussion regarding researcher reflexivity. It is unclear whether researchers had failed to consider this issue, or whether reflexivity was considered and addressed but not included in the papers. Future research should ensure reflexivity, including the relationship between researcher and participants, is adequately considered and also discussed within the study write up.

1.4   Conclusion

This systematic review aimed to synthesise the existing qualitative literature regarding mental health PSWs' experiences and perceptions of their non-PSW colleagues. Findings highlight that PSWs have mixed experiences with their non-PSW colleagues, with some reporting feeling excluded, disrespected and stigmatised by their colleagues, whilst others reported feeling valued and well supported. Others still, reported a combination of these experiences. The unique perspective which PSWs can bring to mental health services was highlighted, both in terms of their unique contribution to service users, as well as the role they can play in educating, challenging and improving the practice of their non-PSW colleagues. Various factors which can have an impact upon PSWs' experiences with their colleagues were discussed, such as the prominence of the medical model within services, team instability and the length of time PSWs have been in the service. A need for further qualitative studies to explore PSWs' experiences of their non-PSW colleagues was identified, with a number of methodological suggestions to improve the quality of studies.

Chapter 2 How do Mental Health Peer Support Workers Manage their Wellbeing at Work?

2.1 Introduction

In recent years the prevalence of peer support in mental health has increased in various countries across the world, including in the UK, as discussed in Chapter 1, with the importance of including peer support in mental health services now being emphasised in UK policy (Department of Health, 2012; Mental Health Taskforce 2016).

This chapter reports on an empirical study exploring how PSWs manage their own wellbeing at work. First, the existing literature regarding the benefits and challenges of working as a PSW will be explored, including how the role can impact upon PSWs' wellbeing and how they manage this. The current study will then be introduced and the aims, methods and study findings discussed.

2.1.1 Benefits to PSWs

As well as being beneficial to those receiving peer support, as discussed in Chapter 1, the PSW role also has a positive impact on PSWs themselves. This includes PSWs experiencing some of the benefits related to working more generally, as well as positive changes related to working as a PSW more specifically. These benefits have the potential to positively impact upon PSWs' sense of wellbeing.

PSWs often begin peer support roles after being unemployed for some time (Moran et al., 2012) and appear to benefit from being in work. Commencing employment has been associated with PSWs having a better routine (Mowbray et al., 1998), increased social networks (Mowbray et al, 1998; Salzer & Shear, 2002), reaping financial rewards and feeling they are contributing to society (McLean et al., 2009). In addition, working as a PSW has been associated with increased quality of life (Bracke et al., 2008; Mowbray et al, 1998; Salzer & Shear, 2002), self-esteem (Ratzlaff et al., 2006) and empowerment (Walker & Bryant, 2013).

Whilst some of these benefits seem related to being in employment more generally, there are arguably some unique benefits which appear to be specifically related to working as a PSW, particularly those related to improvements in PSWs' wellbeing. PSWs have reported particularly valuing being in a role where they can help others (Moran et al., 2012) and have reported experiencing improvements in their own recovery (Bailie & Tickle, 2015; Ratzlaff et al., 2006).

Moran et al. (2012) found PSWs reported having a greater understanding and acceptance of their own mental health difficulties and felt better able to manage these. Similarly, Debyser et al. (2019) found that PSWs reported increased resilience and said they felt that the role helped them to make meaning of their own difficult experiences.

2.1.2 Challenges Experienced by PSWs

Despite the benefits discussed above, working as a PSW can also be challenging at times and thus has the potential to negatively impact upon PSWs' wellbeing. Holley et al. (2015) found that PSWs are mindful of the need to maintain their own wellbeing, a concern which non-PSW staff also express about PSWs they work alongside (Holley et al., 2015; Gray et al., 2017).

PSWs often report feeling stressed (Bassett et al., 2010; Mowbray et al. 1998), anxious (Tse et al., 2013) and frustrated (Debyser et al. 2019; Mancini, 2018; Mowbray et al., 1998). This is unsurprising given that PSWs often experience high workloads (Kemp & Henderson, 2012; Moran et al., 2013), unclear job roles and are sometimes expected to do things inappropriate to their roles (Mancini, 2018). Being required to draw upon their own experience of mental health difficulties as part of their work can also be challenging for PSWs, with PSWs reporting that this can be distressing and can trigger difficult memories (Asad & Chreim, 2016; Faulkner & Kalathil, 2012; Holley et al., 2015).

Working as a PSW can pose interpersonal challenges, both with service users and staff. Whilst having their own experiences of mental health difficulties can mean PSWs are able to develop a better understanding of service users' difficulties than traditional mental health staff (Coatsworth-Puspokey et al., 2006), it can also lead to difficulties with establishing and maintaining professional boundaries. Thus, the relationships PSWs form with service users can appear more like friendships rather than the formal relationships which traditional mental health staff form with service users (Mowbray et al., 1998). As discussed in Chapter 1, PSWs can also experience difficulties integrating into teams, with PSWs reporting sometimes feeling less valued and treated differently to other staff (Asad & Chreim, 2016; Gates & Akabas, 2007; Mancini, 2018), unsupported by their colleagues and viewed more as patients than as staff (Debyser et al. (2019).

2.1.3 Organisational Support

Research has emphasised the importance of organisational support in helping PSWs to deal with the challenges of the role and the potential impact of these on their wellbeing (Bassett et al., 2010; Faulkner & Kalathil, 2012; Walsh et al., 2018). Gillard et al. (2014) found that receiving organisational support, such as training and supervision, was associated with benefits for PSWs,

including helping them to develop the skills needed for working as a PSW, as well as helping them to manage the emotional impact of the role. Knowing PSWs were well supported was also important for service users and helped to reassure them that "it was acceptable to draw on them [PSWs] for support" (Gillard et al., 2014, p. 53). PSWs have reported that not having organisational support can negatively impact on their wellbeing, leading to stress, burnout and emotional exhaustion (Mancini & Lawson, 2009).

Despite various methods, such as supervision, training and reasonable adjustments, being used by organisations to support PSWs, discussed below, little consensus exists around how to best support PSWs, and organisations often face challenges in implementing adequate support for PSWs (Faulkner & Bassett, 2012; Holley et al., 2015; Mancini & Lawson, 2009).

2.1.3.1 Supervision

Supervision appears to be an important source of organisational support for PSWs, however, PSWs experiences of the usefulness of this with managing their wellbeing varies. The importance of addressing PSWs' wellbeing in supervision has been emphasised (Gillard et al., 2014; McLean et al., 2009; Simpson et al., 2014); however, this does not always happen in practice. Studies have shown that some PSWs felt they received inadequate supervision (Cabral et al., 2014; Gates et al., 2010; Kemp & Henderson, 2012), perhaps due to supervision predominantly focusing on work-related issues, with not enough consideration being given to PSW's wellbeing (Mowbray, 1998; Vandewalle et al., 2016). This can result in PSWs finding it difficult to switch off from work (Mowbray et al., 1998).

Additionally, PSWs appear to have varying relationships with their supervisors. Some PSWs have reported not feeling able to speak openly with their supervisors (Ahluwalia, 2018; Debyser et al., 2019) and have highlighted that supervisors do not always fully understand the PSW role (Kemp & Henderson, 2012), particularly as supervisors are often not PSWs themselves (Mancini, 2018). Yet, other PSWs have reported having more positive relationships with their supervisors. Participants in Simpson et al.'s (2014) study described their supervisors as warm and approachable and experienced supervision as a 'safe space' to discuss both work and more personal and emotional issues. However, it should be noted that in this study a specific person had been appointed to provide supervision to participants as part of a randomised control trial exploring the effectiveness of peer support and therefore the supervision received may not be reflective of the type of supervision that PSWs typically receive.

2.1.3.2   Training

Specific training to help PSWs to better understand the PSW role and to develop the knowledge and skills required for the role can also be beneficial for PSWs, including helping them to manage their wellbeing. Training has been linked to a number of benefits for PSWs, yet the training PSWs receive varies widely. Training for PSWs has been associated with the development of new skills, greater self-esteem, increased empowerment, improved job satisfaction and better employment prospects (Hutchinson et al., 2006; Salzer et al., 2009; Simpson et al., 2014). PSWs have also reported that training helped them to better manage their own mental health and gave them a more optimistic view of recovery (Gerry et al., 2011). Training can also help to reassure non-PSW staff about the capabilities of PSWs (Coates et al., 2018), an important consideration given the difficulties PSWs can sometimes experience with their colleagues.

Despite the benefits of training, not all PSWs feel they receive adequate training (Asad & Chreim, 2006; Gates et al., 2010) and some report that their training does not address particular issues sufficiently, such as boundaries (Gillard et al., 2013), the skills needed to help others (Moran et al., 2013) or the impact of the role on themselves (Rebeiro-Gruhl et al., 2016; Simpson, 2014).

2.1.3.3   Reasonable Adjustments

Reasonable adjustments may be another method which PSWs can use to manage their wellbeing. The Equality Act (2010) highlights the need for UK employers to make reasonable adjustments to ensure that those with a disability, including those with significant mental health difficulties, are not disadvantaged at work. Despite this, studies show variations in the extent to which these are used in practice. Whilst a literature review by Vandewalle et al. (2016) found that many PSWs made use of reasonable adjustments, such as flexible working hours, Gates et al. (2010) found that reasonable adjustments are not always put in place. Moreover, some have cautioned about the use of such measures as they may further differentiate PSWs from other staff (Berry et al., 2011; Gillard et al., 2013).

2.1.3.4   Access to Other PSWs

Having access to support from other PSWs can be helpful for PSWs in managing their wellbeing and it has been recommended that organisations who employ PSWs make efforts to facilitate this, for example by employing multiple PSWs within a service or by arranging peer supervision (Davidson et al., 2012; Mancini, 2018; Moran et al., 2013). PSWs report that having contact with other PSWs helps them to feel more connected (Moran et al., 2012) and can reduce feelings of isolation (Mancini, 2018), and can be particularly useful during times when PSWs are struggling with their wellbeing (Ahmed et al., 2015).

2.1.4   Self-Care/Informal Strategies

In addition to organisational support, PSWs need to take an active role in managing their wellbeing at work (Walsh et al., 2018). Taking steps to manage their workload and the demands placed on them is one method PSWs use to achieve this (Kemp & Henderson, 2012; Silver, 2004; Yuen & Fossey, 2003). Additionally, self-care is an important way of helping PSWs to maintain their wellbeing (Ahmed et al, 2015; Gillard et al, 2014; Yuen & Fossey, 2003); however, this is often a challenge for PSWs (Rebeiro-Gruhl et al., 2015).

Despite the literature emphasising the importance of self-care, relatively little is known about what methods PSWs use to achieve this. Although PSWs have reported that relapse prevention strategies (Yuen & Fossey, 2003), positive coping skills and seeking external support with their mental health (Ahmed et al., 2015) are useful features of self-care, the author is only aware of one study which has specifically aimed to explore the coping strategies used by PSWs (Silver, 2004). This study found that PSWs in the United States of America used a range of both formal and informal coping strategies, such as pacing themselves, being assertive, taking a break, accessing therapy and/or medication where appropriate and drawing on support from others. Additionally, PSWs believed that adopting certain attitudes and cognitions helped them to manage their wellbeing in their role; factors such as a willingness to learn, being motivated and having a positive outlook were all important coping strategies for PSWs, as were engaging in problem solving, being solution-focused and thinking about when and what they wished to disclose.

2.1.5   Study Rationale

Working as a PSW has the potential to impact upon a person's wellbeing, yet little is known about how PSWs manage this. Whilst studies have highlighted the importance of PSWs receiving support from the organisations in which they work, there is no clear consensus regarding what specifically is helpful or unhelpful about such support. More research is therefore needed to explore how organisations can best support PSWs with managing their wellbeing, including how organisational support, such as training and supervision, can be best provided to enable it to be useful to PSWs with managing their wellbeing. These are issues which the current study aimed to explore.

Moreover, relatively little is known about how PSWs themselves manage their own wellbeing at work, particularly the less formal strategies PSWs may use. This is an important topic to explore given that studies have emphasised the importance of PSWs taking an active role in managing their wellbeing (Walsh et al., 2018). Although some studies have discussed this, this has often not

been the intended aim of the study. Only Silver (2004) has specifically aimed to explore this topic. Their study was conducted a number of years ago and only involved PSWs working in the United States of America, where health care systems are significantly different from the UK. Thus, research is needed to improve our understanding of what informal methods PSWs use to manage their wellbeing, particularly those working in mental health services in the UK.

2.1.6   Research Aims

The current study aimed to explore the organisational support offered to PSWs, and PSWs' perceptions of what made this support more or less useful, as well as the informal strategies PSWs used to manage their wellbeing.

Therefore, the primary research questions were:

1. What formal strategies, including support from their organisation, do PSWs use to maintain their wellbeing at work?

2. What do PSWs perceive as being helpful or unhelpful about the organisational support they are offered?

3. What informal strategies do PSWs use to manage their wellbeing at work?

A secondary research question was:

1. What suggestions do PSWs have regarding how the organisational support they are offered could be improved?

2.2   Methods

A qualitative approach was chosen for the current study. Qualitative approaches are useful for studying the area of peer support (Repper & Carter, 2011) as they facilitate the exploration of people's experiences and perspectives (Hammarberg et al., 2016), enabling researchers to develop an in-depth understanding of the topic being studied (Marshall & Rossman, 2011; Miles et al., 2014). A qualitative approach was therefore well suited to the current study, given that the study aimed to explore PSWs' *experiences* of managing their wellbeing and their *perspectives* about what makes organisational support helpful and unhelpful.

2.2.1   Ethical Approval

Ethical approval was granted by the University of Southampton's Ethics committee (Appendix C) and the Health Research Authority (HRA) (Appendix D).

2.2.2   Involvement of a Peer Consultant

Researchers have advocated for the involvement of PSWs in the research process to increase the validity and meaningfulness of the research (Vandewalle et al., 2016). The current study therefore recruited a 'Peer Consultant', that is, someone with personal experience of being involved in the provision of peer support, who was asked to provide their advice and opinions throughout the research process. Unfortunately, contact was lost with the initial Peer Consultant, therefore a second Peer Consultant was recruited. Details of the involvement of the Peer Consultants are outlined below.

2.2.2.1   Study Design

The Peer Consultant was involved from the early planning stages of the research until study completion. Once the researcher had decided to focus on exploring the topic of PSWs' wellbeing, the Peer Consultant was approached to provide their thoughts and opinions on the study topic. The Peer Consultant reported that while the wellbeing of PSWs was an important topic, it was often overlooked. They therefore felt that it was a useful and meaningful research focus. The Peer Consultant drew on their expertise to shape and refine the research question; they reported that services were often unsure about how best to support PSWs' wellbeing and therefore suggested exploring PSWs' experiences of organisational support in relation to their wellbeing would be a useful area to consider. In addition, they highlighted that PSWs had often developed their own ways of managing their wellbeing at work, independent of organisational support, and therefore advised that the research should also focus on PSWs' informal strategies to manage their wellbeing at work.

The Peer Consultant advised the research team on research design. It was agreed that a qualitative approach was appropriate and the Peer Consultant highlighted that this would help to give PSWs a voice and allow them to talk in depth about their experiences. The Peer Consultant advised that participants may find it harder to speak honestly about their experiences in a focus group than individual interviews, particularly if their experiences of organisational support had been neutral or negative. Furthermore, they suggested that focus groups could be difficult to arrange because only a small number of people work as PSWs, and that those employed in voluntary PSW roles often had other paid roles, making it difficult to find a time which suited

everyone. It was therefore agreed that individual interviews were the most appropriate choice of research method. The Peer Consultant suggested offering the option of both face to face and telephone interviews, because some participants may find it easier to speak over the telephone, whether due to practical issues or anxiety, or both. The researcher considered also giving participants a questionnaire to provide an objective measure of their wellbeing. The Peer Consultant advised against this, highlighting that it might be seen by PSWs as mirroring the diagnostic systems used within services, something which does not fit with the more recovery-oriented approach of peer support.

The Peer Consultant was also involved in developing the interview topic guide. The Peer Consultant and the researcher met to brainstorm ideas of areas to explore in the interviews. The researcher then produced a draft list of questions and discussed these with the Peer Consultant. The Peer Consultant thought that a good way to start the interviews would be to ask participants about the benefits and challenges of the PSW role, and then explore issues related more directly to wellbeing. The Peer Consultant was also centrally involved in choosing the wording of questions to promote acceptability to participants.

The Peer Consultant offered valuable input regarding the recruitment process. They reported that organisational support for PSWs often varied depending on the type of service in which PSWs work and therefore suggested trying to recruit from both NHS and voluntary sector organisations. They also advised that they were aware of some PSWs who had chosen to stop working as a PSW due to the lack of support from their organisation. Given this, the Peer Consultant emphasised the importance of trying to recruit participants who had previously worked as a PSW but who were no longer doing so. The Peer Consultant highlighted that, although the focus of the research was PSWs' wellbeing *at work*, due to the lived experience aspect fo the PSW role, it might be difficult to separate wellbeing at work from PSWs' wellbeing more generally and, therefore, suggested that the researcher be mindful of this during the interviews.

2.2.2.2 Data Analysis and Dissemination

The Peer Consultant met with the researcher and wider research team to identify and refine themes from the data. The Peer Consultant offered unique insights into the data analysis process and helped the researcher and team to consider alternative ways in which the data could be interpreted, as well as providing insight regarding how best to name and structure themes.

The Peer Consultant emphasised the importance of ensuring the study findings were disseminated to ensure that the research was of value to both PSWs and services who employ them. They suggested ways in which the researcher could disseminate the study findings to

services and highlighted that creating a short summary of the results, with practical suggestions as to how services could best support PSWs' wellbeing, could be helpful to ensure the findings were quickly accessible to those reading it. They also suggested that the researcher should offer to speak with services in person to present the study's findings.

2.2.3 Participants

2.2.3.1 Recruitment

A combination of purposive and snowball sampling was used to recruit participants. Three organisations which employed PSWs were approached and asked to share details of the study with PSWs in their organisations. This included one NHS Mental Health Trust and two voluntary organisations, all within England, which provided support to adults with mental health difficulties. A gatekeeper within each organisation emailed a copy of the Participant Invitation Letter (Appendix E) to PSWs within the organisation. PSWs could then email the researcher to find out more information or express an interest in participating.

Details of the study were also spread via word of mouth from one PSW to another, as well as through links the research team and Peer Consultants had with PSWs. This was with the aim of attracting a greater number of participants, particularly those who had previously worked as a PSW but who were no longer doing so at the time the study took place. The first Peer Consultant highlighted the importance of targeting this population given the potential for them to have had different experiences to those who have continued to work as PSWs.

2.2.3.2   Inclusion and Exclusion Criteria

Inclusion and exclusion criteria for participants are shown in Table 4.

Table 4: *Participant Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Either currently, or have been previously, providing peer support to adults with mental health difficulties, in either a paid or voluntary capacity	Has provided peer support for less than one month
Class themselves as having lived experience with mental health difficulties	Has not provided peer support within the last five years
Over the age of 18 years	Has not provided peer support within the UK
Willing and able to give informed consent for participation in the study	Evident that they are experiencing a mental health crisis

2.2.3.3   Sample Size

There is much debate regarding sample size in qualitative research. Generally, it is considered acceptable for studies which aim to explore participants' experiences to involve a relatively small sample size as this allows a detailed exploration of participants' views and experiences (Crouch & McKenzie, 2006). Indeed, gathering a greater amount of useful data from each participant can mean a lesser sample size is needed (Morse, 2011).

Twelve participants were involved in the present study and it was felt that data saturation, the point at which no new themes could be identified from the data (Glaser, 1965), was achieved within ten interviews. This is in line with studies which suggest saturation can be achieved within twelve interviews (Guest et al., 2006). Additionally, given the relatively high level of homogeneity within the sample, arguably fewer participants would be needed to achieve adequate information power (Malterud et al, 2016).

2.2.3.4   Participants' Demographic Information

Eleven females and one male participated, ranging from 30 to 48 years old (M=39). Eleven participants self-identified as being 'White British' and one as 'White European'. All participants were current PSWs, four within NHS organisations and eight within voluntary organisations. Seven participants worked in a paid PSW role and five participants in a voluntary capacity. The length of time in their role varied from eight months to six years (M=20 months). The number of hours participants worked as a PSW each week ranged from one hour to thirty seven and a half hours (M=16 hours).

Individual demographic details have not been provided to protect participants' identities.

2.2.4   Procedure

Once participants had expressed an interest in taking part in the study, they were sent a copy of the Participant Information Sheet (Appendix F). Participants then had the opportunity to ask any questions relating to the study. Those who wished to take part were then emailed a Participant Consent Form (Appendix G) and a Participant Demographics Form (Appendix H) and were asked to complete and return these either via post or encrypted email. A suitable date and time for the interview was then arranged.

Interviews followed a semi-structured topic guide (Appendix J). The topic guide consisted of ten questions, with further follow up prompts. The topic guide remained a working document throughout and was therefore briefly refined as the interviews progressed to reflect information provided by previous participants.

Eleven interviews were conducted via phone and one was conducted in person. All interviews were conducted by the lead researcher, a Trainee Clinical Psychologist, who had no prior relationship with the participants. Duration of interviews ranged from forty seven minutes to eighty minutes (M=62 minutes). All interviews were recorded to enable transcription. The first interview was conducted as a pilot interview; no changes were made to the topic guide as a result and therefore data from this interview was included within the main analysis. After the interviews, participants were emailed a study Debrief Sheet (Appendix I) and were given the option to ask questions about the study. Participants were given a £10 Amazon voucher for taking part.

2.2.5   Data Analysis and Epistemology

Interviews were transcribed by a combination of the chief researcher, a research assistant and a third party transcription company.

Data was analysed using thematic analysis. Thematic analysis is an appropriate method for when the researcher wishes to identify and summarise themes across a data set, and thus enables shared meanings and experiences to be identified in relation to a specific question (Braun & Clarke, 2012). Thematic analysis was therefore well suited to the aims of the current review. Moreover, the flexible and accessible nature of thematic analysis lends itself well to participatory research projects (Braun & Clarke, 2012), and thus enabled a Peer Consultant to be involved with data analysis in the current study. An inductive, bottom-up approach to analysis was employed to ensure themes identified were grounded in the data (Patton, 1990). The chief researcher, research supervisory team and the Peer Consultant were involved with the data analysis process, which followed the six stages of thematic analysis identified by Braun & Clarke (2006), see table 5.

It was decided to approach the research from a critical realist epistemological stance, an approach which falls between positivist and constructionist approaches. Critical realism suggests that although an objective reality exists, research can only access the subjective versions of reality, that is, the way in which participants give meaning to their experiences (Howitt, 2010), and thus all subjective versions of reality are considered fallible (Bhaskar, 1979). Critical realism allows researchers to explore experiences from an individual's point of view, whilst also considering the role that wider social contexts may play in influencing how individuals interpret their experiences, thus making it suitable for researching topics related to mental health (Pilgrim, 2013).

Table 5: *Stages of Data Analysis*

Stage	Description
Stage 1: Becoming familiar with the data	Transcripts were read and re-read by the chief researcher.
Stage 2: Generating initial codes	The chief researcher used the 'comment' function in Microsoft Word to go through the transcripts systematically and generate initial codes based on the semantic content of the data (see Appendix K). A second member of the research team second coded twenty percent of transcripts.
Stage 3: Searching for themes	The chief researcher grouped similar codes together to form provisional themes and sub-themes and identified quotations from the data to support each provisional theme and sub-theme.
Stages 4 and 5: Reviewing the themes; Defining and naming themes	The chief researcher, research supervisory team and peer consultant met to review the provisional themes identified in stage 3. Themes were refined several times and final themes were identified based on a consensus decision. Themes were then named and defined.
Stage 6: Producing the report	The chief researcher and supervisory team discussed the themes to ensure themes were related to the research questions and to ensure the quotations selected were the best representation of each theme. The final report was produced.

2.2.6   Validity/Quality

Various measures were taken to increase the quality of the research. This included searching for negative cases and including quotations from the interviews to support themes (Smith & Osborn, 2003) to improve the validity of the study's findings.

2.2.6.1   Reflexivity

Researcher subjectivity will inevitably have an impact upon data collection and subsequent interpretation in qualitative research (Mays & Pope, 2000), thus, it is important for researchers to acknowledge their own influences on the research process (Tufford & Newman, 2012). Various steps were taken to address this, as described below.

2.2.6.1.1   Bracketing Interview

A bracketing interview was conducted prior to any interviews taking place to help increase awareness of the researcher's preconceptions and biases (Rolls & Relf, 2006). This explored the researcher's own motivations for choosing the research topic and considered how the researcher's own beliefs, values and assumptions may influence the research process.

The bracketing interview was conducted between the chief researcher and another Trainee Clinical Psychologist who was both independent of the research project and unfamiliar with the area of peer support. This Trainee was from the researcher's training cohort and someone whom the researcher already had a good relationship. This rapport helped the researcher to be able to use the bracketing interview as a safe space to explore their own expectations and assumptions about the research project.

As part of the bracketing interview, the researcher reflected on why they had chosen to research the topic of peer support. More broadly, the researcher had always been interested in service user involvement and had a clear passion for supporting service users to become more involved in mental health services and the way in which care was provided to people. The researcher first became interested in peer support specifically during a previous clinical placement whereby they conducted a service evaluation exploring PSWs' experiences of attending a training programme to help prepare them for their role. Participants had reported finding the training helpful, expressed some anxieties about starting their role and reported worrying that they may be offered inadequate support once in post. They had also reported some concerns about how non-PSW staff may view them, possibly seeing them as inferior to non-PSWs. The researcher reflected that it was likely this experience- of hearing PSWs reflections of preparing to begin their roles- which led them to want to research PSWs' wellbeing. From speaking about this in the bracketing

interview, the researcher acknowledged that they were expecting some participants in the current study to speak about similar issues to those mentioned by the PSWs the researcher had had contact with previously. The researcher was able to reflect on this and became more aware of how having these assumptions could potentially have an impact on what parts of the interviews they pay more or less attention to and also how they interpret the data. This helped the researcher to recognise the importance of being mindful of their own expectations and assumptions and the need to try to put these to one side to ensure they remained curious and heard what it was participants were really saying. This was something that the researcher felt strongly about, particularly given that the PSWs they had previously worked with had reported feeling that their opinions were neither fully heard nor valued by services. Consequently, the researcher felt a great responsibility to "do the participants justice" and ensure the research findings really captured participants' experiences and helped give them a voice. The involvement of the Peer Consultant, as well as having regular research supervision throughout the interview and the analysis stages, would be particularly helpful with this.

Another topic explored in the bracketing interview was how the researcher, as a Trainee Clinical Psychologist, might influence how they approached the research, particularly given that the Trainee Clinical Psychologist role involves both a clinical and research elements. The researcher reflected that although a large part of their work involves working with people therapeutically, their role within this research project was that of a researcher rather than a therapist. Nevertheless, they recognised that many of the skills they draw upon as a therapist, such as active listening, remaining curious and reflecting information back to the person they are speaking with, could be useful when conducting the interviews. However, the researcher also highlighted that whilst the purpose of therapy was often to help people manage their difficulties, this was not the purpose of the interviews, so the researcher needed to ensure they did not take on the role of a therapist within the interviews. In particular, the researcher expressed some concerns during the bracketing interview about how they should respond should participants report struggling with their wellbeing, particularly if they reported any risk to themselves. Whilst the researcher said they would feel comfortable managing risk if it was disclosed in a therapy session, they were aware that their duty of care as a researcher would likely look somewhat different. This prompted the researcher to discuss this issue within supervision and a plan was made about how the researcher should respond should this scenario occur.

Particular consideration was given to the fact that the researcher was employed within the NHS; this was important given that it was hoped the research would include participants working in both NHS and voluntary sector services. During the bracketing interview, the researcher wondered about how participants knowing that the researcher was employed within the NHS may

influence how they viewed the researcher, or how willing they might be to share their experiences, particularly for PSWs working in NHS services who may not have had positive experiences. Given this, it was acknowledged that there may be a potential for the researcher unintentionally to interact differently with participants working within NHS services compared to those in non-NHS services. The researcher therefore decided not to ask participants about what kind of service they worked in, and not to look at the information contained in the participant demographics form prior to interviewing participants.

2.2.6.1.2   Reflexive Journal

The researcher kept a reflexive journal throughout the interviews and data coding process to further aid reflexivity. This involved the researcher making notes about their thoughts, feelings and observations both before and after each interview (see Appendix M for excerpts). Through this process, the researcher noticed that they were making a particular effort to ensure they reflected and summarised to participants the information they had heard during the interviews. This helped to ensure they were accurately understanding what participants had said, an important consideration given the topics discussed during the bracketing interview.

The researcher noted that, as the number of interviews progressed, they were mindful of what previous participants had said. This highlighted areas that the researcher could explore with participants further, so was helpful at times. The researcher also had to remain open and curious to what each participant was saying to ensure the researcher's interpretation of this was not being misinterpreted based upon what previous participants had said. Supervision was used to explore this and the researcher made an effort to actively listen for exceptions and information which was different to what previous participants had mentioned.

2.2.6.2   Triangulation

Triangulation is another method used to increase the quality and validity of qualitative research (Patton, 1990). Investigator triangulation was used to gather multiple perspectives on the data and subsequent interpretations, something which helps to both confirm the validity of conclusions drawn, as well as to offer alternative perspectives (Denzin, 1978). This was achieved by a second researcher reading and coding twenty percent of the interview transcripts, with any discrepancies being discussed and resolved. This not only helped to ensure that codes accurately reflected what participants had said, but also helped to identify ways in which the researcher could improve the delivery of remaining interviews. For example, by highlighting areas the researcher may have missed or suggesting ways in which the researcher could facilitate further exploration and reflection of participants' experiences during the interviews.

Triangulation was also employed during the process of identifying themes from the data. The researcher identified provisional themes within the dataset and discussed these themes in detail with the two other members of the research team and the Peer Consultant. During this process, the researcher explained why they had identified each provisional theme and provided supporting quotations from the interviews, as well as any exceptions which did not fit with the themes. The provisional themes and sub-themes were revised multiple times throughout this discussion with all discrepancies discussed until an agreement was reached. The Peer Consultant played an essential role in this process and provided a significant contribution to the identification and revision of themes, offering valuable insights and alternative perspectives based upon their experience of peer support.

2.2.6.3   Member Checking

Member checking helps to ensure themes and conclusions drawn from the data accurately reflect participants' experiences (Lincoln & Guba, 1985). All participants were invited to take part in a member check, with nine participants subsequently participating in this. This involved talking participants through the themes which had been identified in the data analysis stage and asking them to provide feedback on these. Throughout this process, the researcher explained to participants that they were keen to ensure the data accurately represented participants' experiences and emphasised that they welcomed participants' open and honest feedback about the themes. Participants were thereby encouraged to disagree with, or suggest changes to, the themes. Overall, participants said that the themes accurately reflected their experiences and no significant changes were suggested.

2.3   Results

The research aimed to explore both the formal and informal strategies used by PSWs to manage their wellbeing at work. Analysis of the data identified four superordinate themes: 'A Double Edged Sword', 'Structure', 'Culture' and 'Self-Care' (See Figure 3). Each of these themes contained sub-ordinate themes as shown in Table 6, with the frequency of these themes demonstrated in Appendix L.
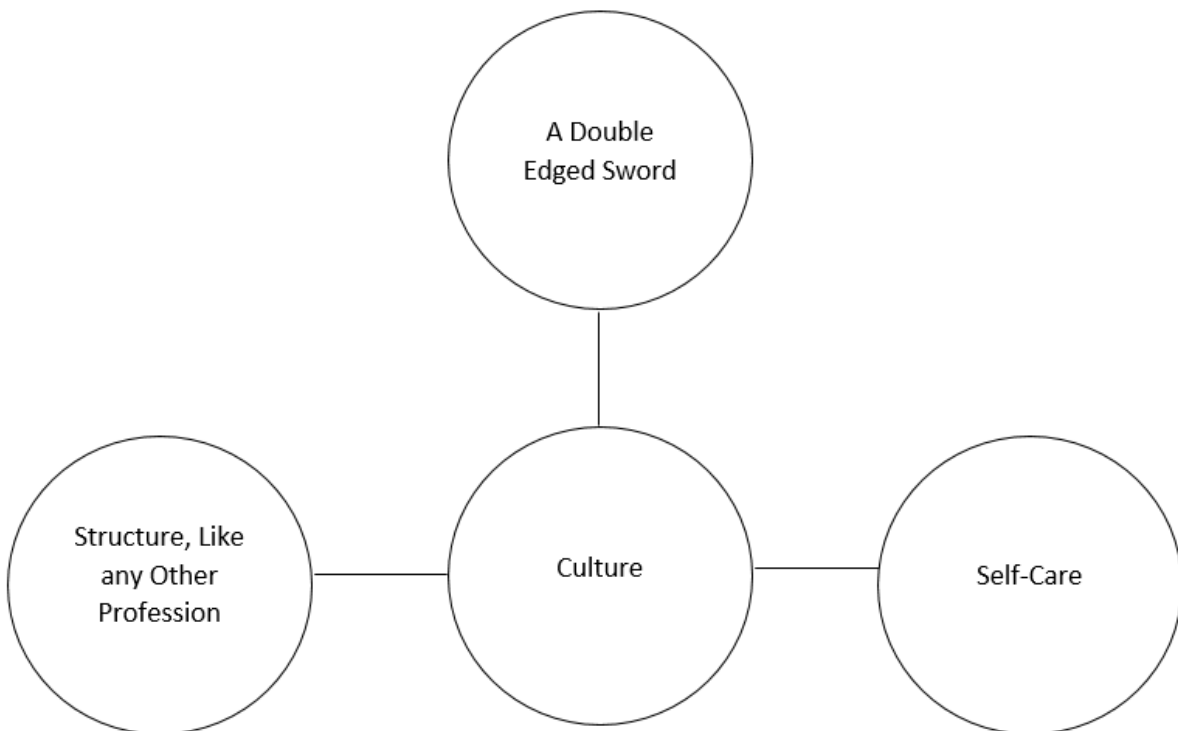
Figure 3: *Thematic Map*

Table 6: *List of Themes*

Superordinate Theme	Sub-Ordinate Themes
A Double Edged Sword	Drawing on your own Experiences
	Not doing enough vs Doing too much
Structure, like any other profession	Clinical Supervision
	Training
	Career Development
	We're not there yet
Culture	Collegiality and Caring
	Genuinely prioritising wellbeing
Self-Care	Taking Care of the Basics
	Checking in with Yourself
	Knowing your Limits

2.3.1   A Double Edged Sword

Throughout the interviews, participants implied that working as a PSW could be 'a double edged sword', and referred to both the immensely positive and challenging aspects of the role. This applied particularly to the way participants were expected to draw on their own experiences as part of their work. Participants also referred to experiencing a dilemma regarding how much to support people, describing on the one hand feeling that they were not doing enough to help people, whilst on the other acknowledging the potential to do too much and risk their own wellbeing.

This theme therefore explored the impact of working as a PSW on participants' own wellbeing, and thus provided some context to the other superordinate themes which described *how* PSWs managed their wellbeing.

2.3.1.1   Drawing on your Own Experiences

PSWs are required to draw on their own lived experience of mental health difficulties throughout their work. Participants discussed both the advantages and disadvantages of doing this, highlighting how being a PSW can be a 'double edged sword'.

Participants reflected on their own experiences as part of their role and described how this helped them to see the value in, and give meaning to, their experiences: "Being a peer worker validates and gives value to the really difficult times that I've been through, it makes the suffering worthwhile" (Participant 11). They described how using their experiences to help others meant that "something good comes out of something that you've experienced that wasn't so nice" (Participant 4) and helped them to reflect on the progress they'd made with their own mental health difficulties: "it makes me feel really proud of how far I've come and how much I've achieved…I never thought that I'd be at a point where I'm actually peer supporting somebody else" (Participant 3).

Participants explained how they were able to use their own experience of mental health to form unique connections with clients and said this helped to "break a lot of boundaries that a lot of professionals, you know, aren't able to do" (Participant 9). Participants said these relationships helped to reduce stigma, normalise mental health difficulties and facilitate more open conversations: "When you make eye contact with someone who you know is thinking 'oh my gosh, I've thought that too' or 'I felt that too' or 'I didn't think we were allowed to say that aloud" (Participant 5). However, participants also highlighted that having this unique connection made it "tricky not to overstep the boundaries" (Participant 12).

Sharing and reflecting on their own experiences could also be difficult for participants. Participants described how sharing their experiences could be "mentally draining" (participant 5) and this appeared to take its toll on participants over time: "I will have given so much of my lived experience and shared so much of myself sometimes I just get really tired of talking about myself…that sort of peer fatigue, that sort of constant giving of yourself again" (Participant 11). Participants also highlighted that talking about their own experiences could sometimes trigger difficult emotions. This appeared to be particularly difficult when this occurred unexpectedly "One of the difficulties however can be that sometimes I can trigger myself, if I talk about something sometimes out of the blue it will hit an emotional chord with me and I'll think 'oh that really hurts' " (Participant 11).

2.3.1.2   Not Doing Enough Vs Doing Too Much

Participants referred to feeling conflicted about how much to support people. This, again, appeared to be a 'double edged sword', with participants on the one hand feeling as though they weren't doing enough to help, whilst at times feeling that they'd invested too much of themselves.

Despite finding the role rewarding, it appeared participants felt great responsibility towards people they were supporting. Participants described feelings of failure and self-doubt and there was a tendency for participants to take it personally when clients made little progress: "You can have someone who you're supporting and you might think, 'Oh, I'm not seeing any progress,' and you might get frustrated, or feeling like you're failing or you're doing something wrong" (Participant 2); "You do walk away and think, " 'Oh my goodness, what have I done? Have I helped this person? I don't think I have, I don't know what I can do' " (Participant 4).

Additionally, participants perceived the wider system as limiting the support they could offer people. This led to feelings of sadness, frustration and anxiety:

> "I think one of the difficult things that I find is the impact of the state austerity cuts and things and the impact that's having on people, but I guess that's just being human really...It just makes me feel very sad really in terms of some of the desperation for people" (Participant 6)

> "So, it does increase my anxiety when I've got to worry about the possible repercussions of that, of that person not getting the support that he/she needs, and also the frustration that I can't do any morel" (Participant 12).

However, despite participants feeling that they were not doing enough to help people, the reverse also appeared to be true at times; participants implied that at times they felt they gave too much of themselves and risked pushing themselves too far:

> "It could impact on your emotional wellbeing, as in, you pick up on yourself some of the problems that people come with and you might, you know, find yourself awake at night thinking about how to solve that person's problem or what to say or what to do, and yeah, you might get emotionally involved a bit too much" (Participant 2).

Participants highlighted the potential for this to negatively impact on their wellbeing, possibly leading to burnout: "I think there's always a risk of putting too much of yourself into it and then that being detrimental to your own health" (Participant 6).

2.3.2   Structure, like any other profession

This superordinate theme explored participants' experiences of their organisation's formal, organisational support structures.

Participants spoke about the importance of having structured support, such as clinical supervision and training, to help them maintain their wellbeing. This appeared to provide a sense of safety

and containment: "I've got some direction and I've got support, they check in with me" (Participant 1). However, participants' experiences regarding the access, quality and usefulness of such support varied.

2.3.2.1   Clinical Supervision

All participants emphasised the importance of having *regular* clinical supervision in helping to maintain their wellbeing: "The helpful thing is when it's regular. It's not always been regular but when I've had it every four weeks no matter what that has been really helpful" (Participant 4). As well as having regular, planned supervision, participants also appreciated their supervisor being available outside of these times:

> "I have a monthly slot officially for supervision but you know if there was something, particularly if it's pushing buttons and is going to affect the way I work…then I need to be talking to somebody to work out how to manage that…saying we're going to have weekly or monthly supervision I don't think that necessarily covers that, I think it's important to have that supervision when you need to" (Participant 10).

However, access to supervision varied significantly, with some participants having fortnightly or monthly supervision, whilst others had it sporadically, and one participant having none at all.

Participants spoke about the ways in which they found supervision useful in managing their wellbeing. Participants seemed to appreciate the reflective nature of supervision, as well as "getting some direction" (Participant 1):

> "My supervisor tends to try and take the pressure off… When I've got a lot on, and I'm beginning to panic, I'll ring them and I'll go, 'Right. I'm panicking'. And they say, 'Right. Okay. Let's do it'. And we literally, the pair of us, sit down and we write a list of all of the things that I need to do, and we prioritise them, and then I have a much clearer head. I don't feel like I'm juggling twelve million china plates" (Participant 12).

Participants also highlighted the importance of their wellbeing being prioritised in supervision and appeared to particularly value their supervisor directly asking them about issues relating to wellbeing:

> "First thing on the agenda is wellbeing, it's always wellbeing. Whenever I speak to them [supervisor], wellbeing is first because it's got to be. So, I talk about my wellbeing, I talk about any difficulties I've been having, I talk about any real positive highlights and any support that I need" (Participant 1).

"My supervisor always says to me, '[name], how are you doing? How is your wellbeing? Are you under control? Are you okay? Is there anything that's worrying you?' And if there is, then I will talk about it" (Participant 3).

However, it was clear that for some participants, supervision was very much focused on work-related tasks, leaving little room for wellbeing to be discussed. In some cases, wellbeing not being discussed in supervision appeared to be related to service changes:

"There's also an element of checking in on people's personal lives. 'Is everything going okay?', just taking a genuine interest in people...people used to do that and then a productivity agenda came in and it felt like there wasn't the time to have those conversations anymore" (Participant 6).

As well as the content of supervision being important, the style of supervision also appeared to be key, with participants discussing factors which made supervision more or less useful. Participants highlighted the importance of the supervisory relationship and appreciated supervisors who were friendly and approachable: "someone that you know that you can approach...without the fear of judgement" (Participant 3). This enabled participants to have honest and open conversations with their supervisors which helped them to feel supported, something which was key for managing their wellbeing: "Oh, she's the loveliest person, I feel really...I can be really open with her and she's warm, yeah, you literally feel like you find support" (Participant 2). Additionally, some participants discussed how their supervisor taking a strengths-based approach helped to increase their confidence and self-esteem: "They [supervisor] were brilliant at validating the things you'd done and pointing out your strengths and things like that, so you would come away from supervision feeling like, 'Yeah, I'm doing a good job; I'm doing the right thing'" (Participant 4).

Additionally, participants emphasised the importance of having a balance between autonomy and support. Participants valued supervisors who allowed them an appropriate level of independence and autonomy, whilst continuing to ensure they felt supported:

"She [supervisor] comes at the beginning of every course [a group run by PSWs for clients]... I love her being there, it's another hand, but she doesn't do anything because it's definitely mine and the co-facilitators role to run the group so she's there mainly in the background...in fact I don't notice, not in a harsh way, if she's there or not there. It's really nice to see her but if she's not there I don't feel unsupported and every week regardless she'll follow up with thanks, it was a great session and then if she's not been there, how was it and is there anything you want to talk about" (Participant 5)

"So she [supervisor] will say to me 'don't come to me with problems, come to me with solutions'…so it really encourages that self-management but I still feel supported because if I was to go to her and say I just don't know what to do about this she would help me" (Participant 11).

When this balance was not achieved, this appeared to have a negative impact on participants' wellbeing. Some participants spoke about feeling micro-managed by their supervisors: "She would breathe down my neck, and I just felt completely and utterly pressured, and I would make mistakes all over the place and I couldn't relax, you know, it was just, I hated it" (Participant 11). Whereas others described being given too much responsibility and feeling very unsupported:

"I ended up being quite anxious and quite low in mood so I know I was phoning my boss at the time regularly because of this issue. 'What are we going to do, what are we going to do, it's making me ill, what we gonna do'…he must think I'm doing a brilliant job to trust in me but it would be nice to have that supervision…there's never really been any direction even when I first started I had to work it all out myself" (Participant 1).

Thus, overall, participants highlighted the potential for supervision to be a useful form of organisational support, but highlighted that how useful this was for managing their wellbeing depended on both the content of supervision and the style of their supervisor.

2.3.2.2   Training

All participants discussed how training to develop the key skills needed for the role had the potential to help them better manage their wellbeing: "it [training] encourages us to look at things like our triggers and how we would manage them" (Participant 4). However, the amount of training participants received varied significantly, ranging from none at all to five days. Consequently, some participants reported feeling well prepared and supported in their role, whilst others felt their training was inadequate.

Those who felt they received adequate training reported that it had helped them to feel more confident and prepared for their role, things which they said were key for their wellbeing. This was especially true when training was practical in nature and covered topics which were directly relevant to their role. Participants particularly valued receiving training focused on how to manage their wellbeing in the role: "we went through a lot, including wellbeing and how to manage your wellbeing and boundaries" (Participant 2).

However, a number of participants felt they didn't receive adequate training, either because they weren't offered enough training or because the training they had was not appropriate to their job. This resulted in feelings of frustration:

"So training, what's appropriate and what's not, so you know, I had to go to one recently on how to move patients off beds and I'm never going to do that, that's not my job, I don't do physical jobs and that kind of stuff because that's not my part of my role… we're still having an argument about it" (Participant 10).

Regardless of the reason, it was clear that not receiving adequate training had a detrimental impact on participants' wellbeing:

"I was exposed to some people who were really unwell and some of the stories that those people told were really quite graphic, I think they refer to it as sort of second hand trauma…I didn't have anywhere to go with any of that information, I didn't know how to deal with it, I had no training… nobody had taught me what I was supposed to do with all that pain and suffering that I had taken in that day" (Participant 11).

Among those who did find training helpful, there was an acknowledgement that it could not cover everything. Participants reported that although training helped with managing their wellbeing, it was not sufficient by itself and thus participants emphasised the importance of having opportunities for continuous learning and ongoing support in place, in addition to the training:

"I think our training prepares us for certain things, like we do a wellbeing at work plan and we identify triggers and ways to manage that. But I think until you actually are sitting with someone and they start sharing an experience that maybe triggers you or upsets you just because it's something really distressing that's happened to that person that you've built up a relationship with, I don't think anything can really prepare you for that" (Participant 4)

"You might find yourself in situations that maybe you have…that weren't covered [in training] or you weren't expecting, so then it's just your supervisor [you can turn to]…and if they don't know, they're going to go somewhere and find out" (Participant 2).

2.3.2.3   Career Development

Participants emphasised the importance of continuous learning and valued the new knowledge and skills they gained from their roles. Some participants had experienced additional professional development opportunities, such as interviewing new staff and providing training or mentoring;

they reported that these had a positive impact on their wellbeing and helped them to recognise the strengths and value they brought to their role:

> "We did a workshop training other health care professionals which does feel quite strange…but that feels liberating and empowering to think we shared our lived experience and are actually making a difference…also some of my colleagues sit on panels when interviewing staff because they see that it's very important to have someone with lived experience sit on the panel" (Participant 7).

Some participants said these opportunities helped inspire their future career development, providing a sense of hope and aspiration and giving them "something to attain to in the future" (Participant 11): "It gives you the other opportunities to do different work and other training opportunities and things…I'm hoping that in future I'll be able to get a degree" (Participant 4).

However, although, the learning and opportunities which accompanied participants' roles appeared to positively contribute to their wellbeing, less than half of participants reported having access to these.

2.3.2.4   We're not there yet

This subordinate theme focuses on participants' perceptions of weaknesses in the organisational support they were offered and ways in which this could be improved.

Some participants described barriers which prevented them from accessing support put in place by their organisation; these tended to be of a practical nature, such as geographical issues or supervision being arranged for inconvenient times:

> "Our service is quite spread out...We don't have like an office where you can just walk – you can't just walk over and see your manager and then walk over to see your supervisor…they're all over across the county so things are going to have to wait sometimes" (Participant 8)

> "The trouble has been it's been restricted in the timing…it's just not being very practical. I mean they are trying to overcome that but so far, we are a bit behind on what we should be" (Participant 7).

In addition, two participants spoke of formal support which had not been put in place, or had been, but had then been consistently cancelled:

> "To be honest, that was one thing that I was told would happen, would be that we would have a monthly debrief, or whatever you like to call it, and that hasn't happened;

and I've been doing this now for nine months…they've been cancelled by the service"
(Participant 12).

All but one participant identified at least some improvements that could be made to the way they were supported. Participants talked about wanting to have had more support and guidance, particularly when they started the role. Additionally, participants advocated for having more support with their wellbeing in general and said they would value discussions about wellbeing being prioritised more:

> "It's one of those things that I think we really do need [more support]. If we're going to be peer supporting under a service then they should be supporting us to do the job… In those early, very fraught early days, where you're trying to find your way… you need the advice, and you need the support, and it would have been really helpful to have used the support" (Participant 12).

> "I think it [discussing wellbeing in supervision] could be more of a routine, yeah, that would be good…How are you feeling? That kind of thing…And being able to say if I'm struggling, you know? You know, that should be an okay thing" (Participant 8).

> "Maybe just like the wellbeing supervision, like a wellbeing review every so often but that, yeah, not like formal or anything, just … just a chat really maybe… It could be a meeting or a group meeting really… but strictly about wellbeing" (Participant 8).

Some participants suggested that these more open conversations about wellbeing could be better facilitated if their supervisors had a greater awareness of PSWs: "I think they [supervisor] could have more knowledge about peer support work, that would be good…not so much the work but about what it's about, you know, the process I've gone through" (Participant 8).

Arguably, this would help supervisors to have an increased appreciation and recognition of PSWs, something PSWs advocated for:

> "PSWs would like to be recognised more formally...things like certificates or recognising a particular person has done this or celebrating a year a peer support for this person…Might sound silly to some to get a certificate but it really isn't. It's not having the piece of paper, it's having the recognition. A real kind of we're proud of what you do, you make a big difference and these are the reasons why" (Participant 5).

Additionally, many participants said having greater contact with other PSWs, including senior PSWs, would have helped them to feel better supported and connected, things they identified as being important for their wellbeing: "Something I think could be useful is more of a network [of

PSWs], I don't know just to share that experience of what it's like and some of the difficulties and what other people have found useful" (Participant 10).

Some participants also spoke about wanting more frequent training and development opportunities to help them feel supported, and there was a suggestion that this could be one way of facilitating greater connections with other PSWs:

> "One of the things we're trying to do generally is working on more training for PSWs…so maybe have a number of refreshers during the year or an away day once a year so all the PSWs can get together and share experiences. That will really enhance the support network" (Participant 5).

2.3.3   Culture

All participants highlighted that organisational culture was key, particularly with managing the impact of some of the challenges of the role on their wellbeing. Whilst the previous theme explored the more structured forms of support that participants valued in managing their wellbeing, participants highlighted that they needed to be accompanied by a caring and supportive culture in order to be effective: "I think having that [culture] is probably the key to people taking advantage of all the tools available to them" (Participant 6).

2.3.3.1   Collegiality and Caring

Participants emphasised the importance of having a caring and supportive culture: "Here everybody is about collaboration, working together and helping each other out as much as possible" (Participant 6) and described how this helped them to feel able to seek support from their colleagues. They also emphasised the importance of feeling valued and supported by their non-PSW colleagues: "We're really grateful to be working somewhere that values and appreciates us and has given us an opportunity to thrive again" (Participant 6). However, the extent to which this happened varied significantly.

Some participants reported having positive relationships with their colleagues: "Everyone that I've ever worked with here has been really supportive, really friendly and caring of each other" (Participant 1). Participants who felt appreciated and well supported by their colleagues reported that this had a positive influence on their wellbeing and led them to feel "a respected part of the team" (Participant 10). Additionally, participants explained that receiving advice and guidance from their colleagues increased their confidence and helped them feel more reassured:

"I think it's just talking through with, sometimes it's just saying it's getting a bit of validation... just saying 'I think I'm going to manage it doing blah blah blah, what do you think?' And they go 'yeah, you've got it and it's okay'...That's when it's particularly useful...even if it's just to go 'yeah, you're doing fine' " (Participant 10).

"We're very proactively checking in with each other as well, which I think is probably important...Even sometimes when, for example, there's a couple of clients that we all work with that can be quite difficult to work with, and actually just saying, 'I've had a similar experience,' can be quite useful in terms of you thinking, 'Oh good, that's not just me'" (Participant 6).

Some participants also said that support from their colleagues was helpful with managing their wellbeing when they were finding things more difficult outside of work and reported particularly valuing the comfort and understanding that their colleagues provided:

"I had a little cry and he [a non-PSW colleague] just sat and listened and then, you know, gave me a reassuring, sort of, tap on the back and said, 'You're very valuable to us and you're valuable to me as a team member,' and that was fine, the next day I was back to normal" (Participant 9).

However, not all participants experienced a supportive organisational culture and some reported experiencing stigma and disrespect from their colleagues, which they said left them feeling devalued and unsupported:

"There's definitely a 'them and us'...there's a tension there... I've overheard things when people don't know I'm there. You know, I've heard things like 'what do [peer support workers] actually do?'...throwaway dismissive comments about why are we paying for people that just sit around doing sod all type thing" (Participant 9).

"I mean a lot of people say, 'Oh, we're recovery-focussed', but they'll see a peer worker and they won't be like that, they'll be like, 'Oh, they're going to go off sick', or, 'They're going to need their hand holding …I mean I've even had people saying, 'Do you get paid to do this?' It's kind of almost like people think it might be a bit of sympathy job, you know? 'Oh, you can't really work properly so you're going to be a peer worker because you're not very well', sort of thing"'" (Participant 4).

Participants also highlighted the importance of support from other PSWs. Participants who had regular contact with other PSWs explained that these relationships helped them to feel more confident and reassured and helped to buffer the impact the role's challenges had on their

wellbeing. Being able to share knowledge and ideas with other PSWs, and being able to talk openly about the challenges of the role were things participants particularly valued:

> "It [reflective practice] is just a real opportunity for peer [support] workers to get together and have a bit of a moan about things that are frustrating…It gives you a bit of solidarity as peer [support] workers as well that we all get together…it helps you park some things as well if they've been niggling you…it's safe and you can talk about what's been going on…it's not documented, it's not fed back to your managers, it's just that time and that space and you walk away and that's that." (Participant 4).

Whilst many of these benefits were similar to those gained from the support of their non-PSW colleagues, participants emphasised that there was something unique about the relationships they formed with other PSWs. This appeared to be related to the unique understanding which existed between PSWs: "There is kind of a natural kind of bond…we're all in it together…it makes all the difference really because you don't have to explain things or try and justify yourself" (Participant 7); "You don't have to say anything and that's the wonderful thing. Someone can just see the look on your face" (Participant 1).

However, the extent to which participants had contact with other PSWs varied. Some had regular contact and described this as being very valuable "we're very close-knit, we're like a little extended family" (Participant 3), whilst others had few, or even no, opportunities to interact with other PSWs: "we [PSWs] don't really see that much of each other, ironically, because we're always out and about in the community or passing each other in the corridor" (Participant 9).

2.3.3.2   Genuinely Prioritising Wellbeing

Participants highlighted the importance of an organisational culture which promoted and prioritised wellbeing: "If we can't look after ourselves, if we can't look after each other, what does that say? We're a mental health service. C'mon we've got to lead the way" (Participant 1). There was a sense that managing wellbeing should be important for all staff, not just PSWs: "It's for everyone. I think just because you're a peer [support] worker doesn't necessarily mean you have to be thinking about your wellbeing in a way that's different" (Participant 4); "everybody's on a mental health continuum, people with mental illness and people who don't have mental illness, everybody has some kind of mental health that needs to be looked after, and that's really driven home and really supported here" (Participant 11).

An organisational culture which prioritised wellbeing seemed to facilitate open conversations about mental health and wellbeing: "As an organisation, we seem to be quite far ahead in terms of really embracing wellbeing…letting people be very open about their health when it

deteriorates as well…I think something about transparency and honesty is really important as well" (Participant 6). Participants explained how this facilitated better access to, and enabled participants to feel more able to make use of, support to manage their wellbeing. This included drawing on support from their colleagues, as discussed previously, and having access to initiatives designed to improve wellbeing, such as mindfulness sessions and team lunches. Additionally, participants explained that having a culture which prioritised wellbeing helped them to feel comfortable making use of reasonable adjustments, for example by having the flexibility to alter their working pattern when they were finding things more difficult:

> "Sometimes when I just think 'I just can't face it today, I just cannot face it today' I will usually say 'Can I swap my days?' or, 'Can I work from home?' or, 'Can I take time off in lieu, or even an annual leave day'" (Participant 9).

> "Sometimes for my shit days I say 'I'm having a shit day and I need to go [home from work], I need to take some leave' you know…so there's that flexibility. Or if I was to say 'I found it really hard in the morning, can I come in at 10 and leave at 6?' there's flexible working hours there. Within reason, if they can do it, they'll do it" (Participant 1).

However, whilst participants highlighted the importance of a culture which prioritised wellbeing, participants emphasised that this needed to be genuine in order for it to be helpful:

> "It's something that I see a lot of organisations talking about [supporting staff wellbeing] but not actually doing, whereas they're very much walking the talk here…it's not just people saying the right things to make sure that HR don't, you know, a grievance doesn't come through, people are very genuine about what they're saying and how they're trying to help and work with each other…you can have as many policies as you want…but actually the culture and what really happens in the business I think speaks much louder than that really" (Participant 6).

2.3.4   Self-Care

Participants ascribed importance to self-care and taking an active role in managing their wellbeing. Participants emphasised the need to being proactive and that 'prevention was better than cure' when it came to managing their own wellbeing, with many reporting that their perspective on self-care had become more positive over time:

> "Now I have those [self-care tasks] much higher up my list of things to do and I'm much more comfortable stopping work and thinking 'actually, taking a rest is good for me and it will mean I'll come back better and stronger'" (Participant 6).

2.3.4.1 **Taking Care of the Basics**

Participants explained that paying attention to lifestyle factors, such as sleep, exercise and diet were key components of self-care and were essential in helping to maintain their wellbeing:

> "I have to have eight hours sleep every night or, school nights as I call it, to maintain my wellbeing because work is busy, so busy. So you've got a mental health issue but the businesses still have to be done so I make sure that I'm eating healthily and that I'm sleeping enough" (Participant 1).

As well as doing things outside work to look after themselves, such as doing things they enjoyed, spending time with friends and family and making time to relax, participants also highlighted the importance of doing things *at* work to manage their wellbeing. This included managing their time well and ensuring they took breaks: "I have a lunch break scheduled in my diary for every day" (Participant 4).

Participants spoke about how using the skills that they taught to others as part of their role, such as meditation, breathing exercises and making lists, also helped them to look after themselves. This seemed to promote a sense of genuineness in their practice as a PSW, something which appeared to be important to participants: "If we're encouraging people to do things to improve their wellbeing, I'd feel like a bit of a fraud if I wasn't doing it myself" (Participant 6).

2.3.4.2 **Checking in with Yourself**

Participants acknowledged that their wellbeing often changed over time and therefore stressed the importance of 'checking in with themselves' regularly to monitor this. Being aware of their own wellbeing needs seemed to be a particularly important part of this and helped participants to notice the early warning signs that things were becoming more difficult: "Recognising when you're getting towards that boundary of 'I'm not feeling that great myself' or 'I need some extra support' and tapping into that early" (Participant 5). Many participants did this informally, but some described using more formal ways of monitoring their wellbeing, such as using 'Wellness Recovery Action Plans' (WRAPs). Participants reported that these helped them become more aware of their triggers and how best to respond to these, something which they said helped to keep them well: "It [WRAP] makes you really have a sit down and go through things, think about them logically and actually write up a plan so that both you and your manager would know what to do and also know what the signs are if your health is starting to deteriorate" (Participant 6).

Participants stressed the importance of taking action if they noticed their wellbeing was starting to change: "I'm really self-aware and I know what I need and I reach out to friends and I reach out

to professionals if I need to. I went to the doctors I've started taking antidepressants" (Participant 1).

2.3.4.3   Knowing your Limits

Participants discussed how "know(ing) your limits" (Participant 3) was an important part of being able to manage their wellbeing. Participants spoke about the importance of taking measures to help them stay within their limits and ensure they did not go beyond what felt manageable. This included finding ways to keep their work and home life separate, working out what they felt comfortable sharing, and taking a step back and "learn[ing] to say no" (Participant 2) to avoid difficult emotions being triggered:

> "It's learning what I feel safe sharing, my story is not everybody's, just because I'm a peer [support] worker my whole recovery isn't everybody's property... working out where your limits are, where your boundaries are for you to keep yourself safe...there's times where I have to take responsibility for going 'no, we're not talking about that'". (Participant 10).

Participants spoke about the importance of being realistic regarding how much support they could offer people to ensure they didn't feel overwhelmed or become burnt out. Learning to accept that there were some things they couldn't change seemed important here:

> "It's easy to take it personally and get discouraged...but you have to remind yourself that, you know, the other person is a human and they have their own difficulties and challenges and you can't control that...all you can do is do your best and be there for them" (Participant 2).

2.4   Discussion

2.4.1   Key Findings

This study aimed to explore the formal and informal strategies PSWs use to manage their wellbeing at work, including to explore what PSWs find more or less useful about any organisational support they receive and to identify ways this support could be improved.

Four overarching themes were identified: 'A double edge sword' (Drawing on your own experiences; Not doing enough vs doing too much); 'Structure, like any other profession' (Clinical supervision; Training; Career development; We're not there yet); 'Culture' (Collegiality and caring;

Genuinely prioritising wellbeing) and 'Self-Care' (Taking Care of the Basics; Checking in with yourself; Knowing your limits).

The results highlighted that working as a PSW can be both beneficial and challenging to PSWs' wellbeing, particularly regarding the way in which participants are expected to draw on their own experiences in the role, a finding consistent with previous literature (Holley et al., 2015; Mancini, 2009). Participants also described feeling torn about how much to support people. Participants described feeling they were not doing enough to support others at times, whilst also noticing their tendency to over-invest in their role, which they highlighted put them at risk of burnout, something which affects between 21% and 67% of the mental health workforce (Morse et al., 2012).

The study highlighted the important role that formal, organisational support structures, such as supervision and training, could play in helping PSWs to manage their wellbeing; this is consistent with previous research (Bassett et al., 2010; Faulkner & Kalathil, 2012; Walsh et al., 2018).

Clinical supervision appeared to play a key role in helping PSWs to manage their wellbeing, particularly when this was regular and included discussions about their wellbeing. This is a key finding given that previous research has highlighted the tendency for supervision of PSWs to focus on work-related matters as opposed to issues related to wellbeing (Mowbray et al., 1998; Vandewalle et al., 2006), despite wider models of clinical supervision emphasising the need for supervision to serve a restorative function, in addition to normative and formative aspects of supervision (Proctor, 1988). Supervisor style also appeared to be important, with participants appreciating supervisors who were warm and trustworthy and provided PSWs with an appropriate balance between autonomy and support. This is similar to previous studies which have shown PSWs value supervisors who are warm and approachable (Simpson et al., 2014), as well as being available and flexible (Silver, 2004); this echoes findings from the wider mental health literature which highlights the importance of the supervisory relationship (Sloan, 1999; Beinart & Clossey, 2017). Interestingly, Silver (2004) reported that some PSWs appreciated having supervisors who provided more guidance and support, whilst other PSWs valued being given more freedom and responsibility, however, participants in the current study emphasised that it is important to have a *balance* between these two dimensions.

Training was another important form of formal support which had the potential to help PSWs better manage their wellbeing. This is in line with previous studies which have highlighted the importance of training for PSWs (Hutchinson et al., 2006; Salzer et al., 2009; Simpson et al., 2014), with Tse et al. (2013) highlighting the improvements in hope, knowledge and confidence reported by PSWs following training. Participants in the current study described how having good quality

training helped them to feel more prepared and confident in their role, however the extent to which they received this varied. Training was particularly valued when it had a practical approach to it and seemed relevant to the role of a PSW. However, there was a recognition that training by itself was insufficient and that ongoing development and support was needed. This is consistent with previous research which has emphasised the importance of continued learning, development and support for PSWs, in addition to training (Mancini, 2018; Repper, 2013; Simpson et al., 2014). Career development was also seen as important to participants, both to help open up new opportunities, as well as to aid further career development. This fits with findings of Silver (2004) whereby PSWs in the USA reported that adopting an attitude to embrace personal growth was helpful with managing their wellbeing.

Whilst organisational support had the potential to be useful in helping PSWs to manage their wellbeing, participants' experiences of the frequency and perceived quality of such support varied. It was clear that just having organisational support in place was insufficient in itself, but rather it was the quality of this support which influenced how useful it was in helping participants to manage their wellbeing. This fits with the findings of existing literature, for example, Ahluwalia (2018) highlighted that the *amount* of training PSWs received did not necessarily correlate with how useful PSWs reported finding it. In addition, the current study highlighted the importance of organisational culture in influencing how able PSWs felt to make use of organisational support. Having an organisational culture which was supportive and genuinely prioritised wellbeing helped PSWs to have open conversations about their wellbeing and thus facilitated them to make use of formal organisational support, such as reasonable adjustments. Participants in the current study reported only beneficial effects of using reasonable adjustments, yet others have highlighted the potential for these to negatively increase the perceived differences between PSWs and other staff (Berry et al., 2011; Gillard et al., 2013), and thus concluded that reasonable adjustments should not be relied on too heavily by PSWs (Holley et al., 2015).

Having a caring and supportive culture also helped facilitate supportive relationships with their PSW and non-PSW colleagues. Participants highlighted that these relationships were important in managing their wellbeing, due to both the practical, work-related advice participants gained from these relationships, as well as the emotional support. However, it was clear that this relational support was not always available, partly because of the negative attitudes that participants felt some of their non-PSW colleagues held towards PSWs. As discussed in Chapter 1, numerous studies have reported PSWs feeling stigmatised by their non-PSW colleagues (Byrne et al., 2019; Clossey et al., 2016), including PSWs feeling disrespected by their colleagues and that they were treated differently to other members of staff due to their lived experience (Dyble et al., 2014; Mancini & Lawson, 2009; Moran et al., 2013). Given that many of these studies were conducted a

number of years ago, the findings of the current study suggest some staff continue to hold negative attitudes towards PSWs and thus the issue of some PSWs experiencing stigma from some of their colleagues remains, however, a number of participants also reported having positive relationships with their colleagues.

Not all participants had access to other PSWs and thus this was another barrier to some participants accessing relational support. This is key given the unique relationships which often form between PSWs and the findings from previous literature which have shown having access to other PSWs helps PSWs to feel more socially connected and less isolated (Moran et al., 2012; Mancini, 2018). This highlights the importance of organisations facilitating PSWs integration into teams, something which Vandewalle et al. (2016) highlighted can often be a challenge.

The study also identified a number of ways in which organisational support for PSWs could be improved to enable it to be more useful in helping PSWs to manage their wellbeing. This included providing more access to support and training, increasing the amount of contact PSWs had with other PSWs and providing increased recognition of the value of PSWs. Some of these issues have been discussed in the existing literature, for example, a number of studies have argued for PSWs to have greater access to other PSWs for support (Davidson et al., 2012; Mancini, 2018; Moran et al., 2013) and other studies have highlighted the need to improve training offered to PSWs (Mowbray et al., 1998). Given these studies were conducted a number of years ago, the findings of the current study suggests that at least in some services, many of the same issues with organisational support for PSWs remain.

Participants also emphasised the importance of them taking an active role in managing their wellbeing, as advocated by Walsh et al. (2018). The importance of drawing on more informal strategies to maintain their wellbeing, such as engaging in good self-care, was highlighted. Additionally, participants emphasised the importance of 'knowing their limits', for example by choosing carefully how much they shared with others, learning to say 'no' and finding ways to switch off from work. This supports previous research which has highlighted the importance of PSWs putting boundaries in place (Debyser et al., 2019; Silver, 2004). Many of the informal strategies that participants used to maintain their wellbeing were similar to those found by Silver (2004), for example acceptance of their own limits, being selective about how they drew on their own lived experiences, maintaining a good work life balance and engaging in self-care tasks. However, participants in Silver's (2004) study also highlighted the importance of using the support of their friends and family and highlighted this as one of the key strategies they used to manage their wellbeing; this was not something which was particularly emphasised by participants in the current study.

2.4.2   Application to Wider Theory

To date, there is no specific theory of PSW wellbeing. However, the findings from the current study can be seen in the context of wider psychological theories, for example Maslow's Hierarchy of Needs (Maslow, 1943). This is a theory of human motivation which proposes a five-stage model to describe various needs humans are motivated to meet; these are Physiological Needs, Safety, Belonging, Self-Esteem and Self-Actualisation. The model is hierarchical, meaning lower level needs need to be met in order for humans to focus on achieving higher level needs. Therefore, before individuals are able to achieve self-actualisation, that is focusing on personal growth and achieving one's full potential, they must first have other more basic needs met.The stages outlined in Maslow's Hierarchy of Needs are important to consider when thinking about wellbeing. Indeed, Gormon (2010) highlights that an individual's wellbeing is related to the needs proposed in Maslow's model; meeting a greater number of these needs may be associated with greater social and emotional wellbeing (Gormon, 2010). Furthermore, researchers have also considered how the model can be adapted and applied in occupational settings, for example in the employment of healthcare workers (Benson & Dundis, 2003). Given this, Maslow's Hierarchy of Needs appears a useful framework in which to consider the findings of the current study, particularly regarding how the strategies participants reported using to manage their wellbeing may be mapped onto the different needs identified in Maslow's model, as described below.

2.4.2.1   Physiological Safety

This stage of the model relates to the need to ensure individuals' basic needs are addressed. Participants in the current study emphasised the importance of engaging in self-care, for example by paying attention to basic lifestyle factors, such as sleep and diet, and ensuring good time management, such as scheduling lunch breaks. Participants suggested if these measures were not taken then this had a negative impact on their wellbeing, which Maslow's model would suggest meant they were unable to move onto meeting higher level needs.

2.4.2.2   Safety

This concept refers to both physical and psychological safety. The current study highlighted that working as a PSW could be challenging at times but suggested that adequate organisational support could help PSWs to manage the challenges of the role, including the emotional impact of the work, could increase a person's sense of psychological safety. Having regular supervision with a caring and supportive supervisor seemed particularly important, as did having training which included topics such as managing emotional wellbeing. Indeed, Benson & Dundis (2003) and Maslow (2000) highlighted that training can facilitate individuals feeling safer and more secure at

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work. In addition, some of the informal strategies PSWs employed, such as only talking about experiences they felt comfortable sharing, would likely also have been useful in promoting psychological safety.

2.4.2.3   Belonging

Maslow's model accounts for the importance of social relationships and people feeling a sense of belonging. Indeed, the 'Collegiality and Caring' theme in the current study emphasised the importance of PSWs having a supportive team around them and supportive relationships with their colleagues. Participants who had these experiences reported that this had a positive impact on their wellbeing and helped them to feel valued and supported, whereas other PSWs experienced stigma and disrespect from their colleagues. In particular, the findings of the current study highlighted the importance of PSWs having contact with other PSWs, with participants suggesting there was something unique about these relationships which helped them to feel more confident within their role and arguably may have contributed to a feeling of belonging.

2.4.2.4   Self-Esteem

This stage of the model refers to individuals' need to feel valued, respected and self-confident. Participants reflected that some of the benefits of working as a PSW included feeling proud at how far they had come in their own recovery, as well as doing something worthwhile to help others, both things which may influence an individual's self-esteem. It appeared that supervision had the potential to help increase PSWs' self-confidence at work, particularly when supervisors adopted a strengths-based approach and encouraged participants to work with an appropriate level of autonomy. Participants in the current study reported that training could serve a similar role; this echoes findings of Benson & Dundis (2003) who found that training was associated with reports of increased self-confidence at work.

It was clear that feeling valued by their organisation was important to participants, with some highlighting the need for increased recognition of PSWs achievements and contributions to services, something which could arguably help to increase PSWs' self-esteem.

2.4.2.5   Self-Actualisation

This refers to self-development and an individual achieving their full potential. Findings of the current study suggest that this was important to PSWs, with participants expressing a desire to learn new skills and increase their knowledge, something which training could potentially provide. Additionally, participants spoke about the importance of having access to wider opportunities to help further develop their career.

2.4.3   Strengths

The current study has provided new insights regarding strategies PSWs use to manage their wellbeing, including PSWs' experiences of organisational support and suggestions about how this could be improved. Additionally, the study identified informal strategies used by PSWs to manage their wellbeing, a topic which has previously received little attention. The study therefore provides useful information about how organisations can best support PSWs with managing their wellbeing, as well as suggesting things PSWs can do themselves to play an active role in managing their wellbeing.

A further strength of this study was the efforts made to improve the validity of the findings. The use of triangulation in both the research design and analysis helped to address researcher subjectivity. Additionally, member checks helped to ensure the themes identified were accurate perceptions of participants' experiences. Conducting a bracketing interview and keeping a reflexive journal throughout enabled the researcher to be reflexive, an important factor in qualitative research (Mays & Pope, 2000).

The involvement of Peer Consultants throughout the research process was of significant value and helped to ensure the study was meaningful, as well as providing valuable consultation at various stages of the research.

2.4.4   Limitations

Given the relatively small sample size, the findings need to be interpreted with caution, particularly given the similar demographic profile of participants. Nevertheless, data saturation was achieved. In addition, whilst efforts were made to recruit people who had previously worked as a PSW but who were no longer doing so, this was not achieved in practice. This is important given the potential for this population to have had a different, possibly more negative, experience of managing their own wellbeing in the role.

The majority of interviews were conducted over the phone. Whilst this was due to both participants' preferences and practicalities, this resulted in the loss of non-verbal cues. It is also possible that some participants may have found it harder to form a rapport over the telephone.

Finally, although the researcher had no prior relationship with any of the participants and was not affiliated with the specific services they worked for, it is acknowledged that as the researcher was employed as a Trainee Clinical Psychologist in the NHS, this may have had an impact on how open participants felt able to be, although this was not something which was apparent in the

interviews. Future research may wish to consider involving a Peer Consultant in data collection to reduce this risk.

2.4.5 Clinical Implications

The findings are likely to be of interest to services who employ PSWs or those considering doing so in future. It is hoped that the findings can help inform and improve the organisational support provided to PSWs, particularly with regards to clinical supervision and training, as well as promoting the importance of the wider organisational culture in helping PSWs make use of this support. Additionally, it is hoped that the findings will help organisations become more mindful of the need to integrate PSWs into teams, given the importance of relational support for PSWs which the study highlighted.

It is also hoped that the findings will be beneficial to those working in PSW roles themselves as a way of providing suggestions of things which may be helpful in managing their wellbeing. This may be particularly useful to people who are new to the role, or to those who are having difficulties managing their wellbeing.

2.4.6 Recommendations for Future Research

In the current study, participants' experiences of organisational support varied significantly. Anecdotally, some differences were noticed between experiences of those working in the NHS compared with third sector services, something which Gillard et al. (2014) also alluded to. Further research may wish to examine this, for example by exploring and then comparing the experiences of PSWs working in specific service contexts.

Additionally, further research may wish to adopt a mixed-methods approach to exploring wellbeing in PSWs, particularly alongside introducing specific interventions to improve wellbeing, such as wellbeing-focused supervision or training programmes for PSWs.

Future research should ensure a Peer Consultant is involved in all aspects of the research process, as also emphasised by Vandewalle et al. (2016).

2.5   Conclusion

This study highlighted both the benefits and challenges of working as a PSW, and the potential for these to have an impact on PSWs' wellbeing. The findings emphasised the need for PSWs to manage their wellbeing, drawing on both more formal mechanisms provided by their organisation, such as supervision and training, as well as informal strategies, such as self-care.

Findings showed that the level of organisational support participants received varied significantly, something which subsequently impacted on participants' sense of wellbeing. Critically, the study highlighted the need for a supportive and caring organisational culture to enable PSWs to make the best use of the available support offered to them.

Appendices

Appendix A   Search Terms

The following search terms were used to search the title and abstract of returned papers. The Boolean operator 'AND' was used to combine each set of search terms, as shown. The example below shows the syntax entered into PsycINFO.

Domain	Search Terms
Population	"peer support*" OR "peer provider*" OR "peer expert*" OR "peer specialist*" OR "peer worker*" OR "peer educator*" OR "peer mentor*" OR PSW OR "lived experience work*" OR "consumer survivor*" OR "consumer employee*" OR "consumer provider*" OR "expert by experience*" OR "consumer worker*" OR "service user worker*" OR "prosumer*"
	AND
	"mental health*" OR "mental distress*" OR "mental illness*" OR "mental disorder*" OR "psychiatric distress*" OR "psychiatric illness*" OR "psychiatric disorder*" OR "psychiatric problem*" OR schizo* OR depress* OR psychosis OR "personality disorder" OR anxi* OR "eating disorder*" OR bipolar* OR OCD OR "obsessive compulsive" OR PTSD OR posttraumatic OR "post traumatic" OR bulimia* OR anorexia* OR panic OR mania* OR manic OR "mood disorder*" OR phobi*
	AND
Intervention	Staff* OR team* OR interperson* OR colleague* OR "non-peer" OR nonpeer OR professional* OR "multi-disciplin*" OR organisat* OR organizat* OR integrat*
	AND
Comparison	N/A

Outcome	Relation* OR attitude* OR integrat* OR "organisat* culture*" OR "organizat* culture*" OR experience* OR perception* OR impact* OR benefit* OR challeng* OR conflict* OR difficult* OR barrier* OR disadvantage* OR advantage* OR improv* OR effect* OR implement* OR problem* OR obstacle* OR enrol* OR recruit* OR limit* OR employ* AND
Study Design	Interview* OR qualitative* OR "semi-structured" OR semistructured OR "semi structured" OR unstructured OR structured OR "open-ended" OR "case stud*" OR "focus group*" OR narrative* OR phenomenolog* OR "grounded theory" OR thematic* OR IPA OR discourse* OR theme* OR ethnograph* OR "group discussion*"

Outcome

Relation* OR attitude* OR integrat* OR "organisat* culture*" OR

"organizat* culture*" OR experience* OR perception* OR impact* OR

benefit* OR challeng* OR conflict* OR difficult* OR barrier* OR

disadvantage* OR advantage* OR improv* OR effect* OR implement* OR

problem* OR obstacle* OR enrol* OR recruit* OR limit* OR employ*

Appendix B   Frequency of Themes Across Papers

Themes → Included Papers (First Author) ↓	Adverse Experiences	Valued, Welcomed and Supported	Providing a Unique Perspective	Influence of Systemic Factors	Easier Over Times
Aikawa	✓		✓		✓
Asad	✓	✓	✓	✓	✓
Berry	✓		✓	✓	
Byrne	✓	✓	✓	✓	
Cleary	✓	✓	✓	✓	✓
Clossey	✓	✓		✓	✓
Doherty	✓		✓		
Dyble	✓	✓		✓	✓
Ehrlich	✓	✓	✓	✓	✓
Gates	✓		✓		
Gillard	✓	✓	✓	✓	✓
Kido		✓	✓		✓
Mancini	✓	✓			
Moll		✓	✓	✓	✓
Moran (2012)		✓	✓		
Moran (2013)	✓				
Otte	✓		✓		
Rocchio	✓			✓	
Simpson	✓	✓	✓	✓	

Appendix C University Ethical Approval

UNIVERSITY OF Southampton

RGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 47540
Submission Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work
Submitter Name: Louise Taylor

The Research Integrity and Governance team have reviewed and approved your submission.

You may only begin your research once you have received all external approvals (e.g. NRES/HRA/MHRA/HMPPS/MoDREC etc or Health and Safety approval e.g. for a Genetic or Biological Materials Risk Assessment).

The following comments have been made:

-
-

Once external approvals are received you should upload your final document set and approval letters to ERGO using the *Upload External Approvals* button.

Appendix D   HRA Ethical Approval

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research Authority

Miss Louise Taylor
Trainee Clinical Psychologist
Somerset & Taunton NHS Foundation Trust
University of Southampton
University Lane
Southampton
SO17 1BJ

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

16 September 2019

Dear Miss Taylor

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	A qualitative study exploring how peer support workers maintain their own wellbeing at work
IRAS project ID:	261583
Protocol number:	47540
REC reference:	19/HRA/4844
Sponsor	University of Southampton

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval
has been given for the above referenced study, on the basis described in the application form,
protocol, supporting documentation and any clarifications received. You should not expect to
receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in
line with the instructions provided in the "Information to support study set up" section towards
the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and
Scotland?**
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland
and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of
these devolved administrations, the final document set and the study wide governance report
(including this letter) have been sent to the coordinating centre of each participating nation.
The relevant national coordinating function/s will contact you as appropriate.

Appendix E   Participant Invitation Letter

HOW DO PEER SUPPORT WORKERS MAINTAIN THEIR WELLBEING?   UNIVERSITY OF Southampton

Do you provide peer support to others with mental health difficulties?

If so, we'd love to hear from you!

We want to find out how people who provide peer support maintain their own wellbeing whilst working/volunteering in their role. This would involve asking you some questions about your experiences of managing your own wellbeing, including your experiences of any support you are offered from your employing/voluntary organisation.

The findings will help to improve our understanding of peer support and hopefully help to improve the support which is offered to peer supporters in the future. It will also help to identify ways peer supporters maintain their wellbeing; this information is likely to be useful to other peer supporters working in similar roles, especially those who are new to the role or who are having difficulties managing their own wellbeing.

Your participation will be confidential and you'll be given a £10 Amazon voucher to thank you for taking part.

For more information, or to express an interest in taking part, please contact Louise Taylor at L.Taylor@soton.ac.uk

Appendix F   Participant Information Sheet

Participant Information Sheet

Study Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work

Researcher: Louise Taylor

ERGO number: 47540   **IRAS Number:** 261583

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide whether to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

My name is Louise Taylor and I am a Trainee Clinical Psychologist at the University of Southampton. As part of my doctorate degree, I am conducting some research exploring how people who provide peer support, sometimes called Peer Support Workers, manage their own wellbeing whilst working/volunteering within their role. The research will focus on exploring Peer Support Workers perceptions of the support they receive from their employing/voluntary organisation, as well as exploring the more informal strategies they may use to help maintain their wellbeing at work. It is hoped that the research will help identify the ways in which people who provide peer support manage their wellbeing at work, as well as help to improve the way organisations support Peer Support Workers in carrying out their role. The research is sponsored by the University of Southampton.

Why have I been asked to participate?

You have been asked to take part in the research because you are either currently, or have been previously, providing peer support to other adults with mental health difficulties.

What will happen to me if I take part?

You will be invited to be interviewed about the ways in which you manage your wellbeing whilst providing peer support. The interview will be with a Trainee Clinical Psychologist and is expected to last approximately one hour; it can take place either face to face or via the telephone, depending on your preference and any practicalities. The interview will be informal and there are no right or wrong answers!

All interviews will be recorded using a Dictaphone to allow for the interview to be transcribed later; the only people who will be able to listen to the recording will be the researcher, the person who transcribes the interview and the research supervisory team at the University of Southampton. All interview recordings and transcribed data will be stored securely on a password protected computer and in accordance with the Data Protection Act and the University of Southampton's policies. All personally identifiable information will be changed or removed during transcription and your identity will be kept confidential. Quotes from the interview may be used in the research write up and any subsequent reports or publications to highlight key points, however, these will be pseudonymised to help protect your identity; your name or personal details will not be included.

You will also be asked whether you are happy to participate in an optional follow up phone call once the interview has been transcribed. This will be to check that the interviewer has correctly understood the main points you expressed in the interview. This follow up call will be completely optional and will last approximately fifteen minutes. Brief notes may be made during the call to aid the researchers memory but no personally identifiable details will be included.

It is expected that between eight and twelve participants will be needed for the study, which is expected to be completed by May 2020.

Are there any benefits in my taking part?
The interview will give you an opportunity to reflect on how you manage your own wellbeing whilst providing peer support to others, as well as to reflect on the support you receive from your employing or voluntary organisation. Additionally, participating in the research will allow you to contribute to the knowledge base regarding how Peer Support Workers manage their own wellbeing, and their views on what workplace support is helpful and unhelpful. It is hoped that this information will help to inform services about how they can best support Peer Support Workers in the future. The research will also explore informal strategies Peer Support Workers use to manage their wellbeing; this information is likely to be useful to other Peer Support Workers who are in similar roles.

If you choose to participate in the research, you will be given a £10 Amazon voucher to thank you for taking part in the study.

Are there any risks involved?
The interview will encourage you to reflect on how you manage your own wellbeing whilst providing peer support, and there is a risk that you might find this upsetting. However, given that you are likely used to talking about, and reflecting on, your own experiences as part of your role, it is not expected that the risk of becoming upset would be any greater than that experienced within your role. You can take a break from the interview or choose to stop at any time. Additionally, there will be time at the end of the interview to ask any questions or to talk about any concerns or distress which may have arisen for you during the interview. You can also contact your GP or the following services for support should you wish:

- **The Samaritans**
  Telephone: 116 123 (freephone)
  Address: 11 College Place, London Road, Southampton, SO15 2FE
- **MIND**
  Infoline: 0300 123 3393

It is also possible that the interviews may highlight that some people have little or no support in place from their employing or voluntary organisation. If this is the case, you may wish to contact the following service for advice:

- **ACAS (Advisory, Conciliation and Arbitration Service)**- for free, confidential advice on employment related issues: 0300 123 1100

What data will be collected?
Prior to being interviewed, you will be asked to complete a consent form and a short demographics form which will ask for your age, gender and ethnicity. This form will also ask some brief questions about your peer support role. All questions will be optional, and you can choose not to answer them if you wish. Details of how these forms will be stored are described below:

For face to face interviews: You will be asked to complete the consent form and demographic form in person before being interviewed. These forms will then be stored securely in a locked filing cabinet in a locked office at the University of Southampton. Only the researcher and the research supervisory team will have access to this information.

For telephone interviews: You will be asked to return the consent form and demographic form either via post or encrypted email. Forms returned via post will be stored securely in a locked filing cabinet in a locked

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office at the University of Southampton. Only the researcher and the research supervisory team will have access to this information. Forms returned via encrypted email will be stored electronically as a password protected document on a password protected computer. Only the researcher, supervisory team and authorised personnel from the University of Southampton will have access to this information.

All interviews will be recorded on a Dictaphone. After the interview, the recording will be transferred to a password protected computer at the earliest opportunity and the original recording deleted from the Dictaphone. Interviews will then be transcribed; this will be done either by the researcher, a Research Assistant working at the University of Southampton or a confidential third party transcription company approved by the University of Southampton. During transcription, all personally identifiable information will be changed or removed to protect your identity. Once transcription has taken place, the interview recording will be deleted.

In addition, if you have chosen to participate in the optional follow up phone call, you will be asked at the end of the interview to provide an email address or contact telephone number so that we can contact you to arrange the follow up call nearer the time. These contact details will be stored electronically in a password protected document on a password protected computer. Only the researcher and supervisory team will have access to this and it will only be used to contact you regarding the follow up telephone call. Your contact details will be deleted once you have participated in the follow up call.

To protect your identity, you will be assigned a participant identification number. All study data, including your interview recording and transcript, will be referenced using this number, instead of your name. This is to protect your identity. A secure, password protected document will be created which links your name to your participant identification number; this will be stored on a password protected computer and only the researcher and research supervisory team will have access to this document. As explained above, all other study data will be referred to by your participant identification number only to protect your identity.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team, research supervisors and authorised personnel will have access to data about you. As described above, this may include a research assistant working for the University of Southampton or a third party transcription company, approved by the University of Southampton, having access to the interview recordings for transcription purposes only. Additionally, responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

As described above, all personal identifiable information will be changed or removed in the study write up and any subsequent reports or publications; your name will not be included. To ensure you cannot be identified in the study's write up or subsequent publications/reports, your exact age, ethnicity and your employing/voluntary organisation will not be included specifically in relation to you; instead, an overall summary of the ages, ethnicities and employing organisations across all participants will be included. Similarly, whilst an overall summary of the length of time people have worked as a peer support worker and the number of hours per week they work will be included across participants, this information will not be provided about you specifically. Care will be taken to ensure that any quotes included in the study write up and subsequent publications/reports do not contain any information which could potentially allow you to be identified.

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Do I have to take part? What do I do if I want to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part.

Should you wish to participate in the study, please contact the researcher, Louise Taylor, via email:
L.Taylor@soton.ac.uk

What happens if I change my mind?
You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. You can withdraw from the research by emailing L.Taylor@soton.ac.uk. No further data will be collected but we will keep the information already obtained about you for the purposes of achieving the objectives of the study only. Pseudonymised quotes from your interview may still be used in future reports or publications, however any personally identifiable information will be changed or removed to protect your identity; your name will not be included. The same will apply should you lose capacity to consent during the study period.

What will happen to the results of the research?
The results of the research will be written up as part of my Doctorate in Clinical Psychology and will be available via the University of Southampton's repository. The research findings may also be published in relevant academic journals and/or presented to services who employ Peer Support Workers to help increase their understanding of the area. Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Once the research is completed, you can obtain a copy of the research findings by requesting this from the researcher by emailing L.Taylor@soton.ac.uk

Where can I get more information or express an interest in taking part?
For further information, or to express your interest in taking part in the study, please contact the researcher, Louise Taylor, via email on L.Taylor@soton.ac.uk

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researcher who will do their best to answer your questions. You can do this via email L.Taylor@soton.ac.uk
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

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Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at
http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for a minimum of ten years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage
(https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

As explained above, you will be assigned a participant identification number to protect your identity. All study data, including your interview recording and transcript, will be referenced using this number, instead of your name. A secure, password protected document will be created which links your name to your participant identification number; this will be stored on a password protected computer and only the researcher and research supervisory team will have access to this document. As explained above, all other study data will be referred to by your participant identification number only to help protect your identity.

Where can I get more information or express an interest in taking part?
For further information, or to express your interest in taking part in the study, please contact the researcher, Louise Taylor, via email on L.Taylor@soton.ac.uk

Thank you.
Thank you for taking the time to read this information sheet and for considering taking part in the research.

Appendix G   Consent Form

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Consent Form

Study Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work

Researcher name: Louise Taylor
ERGO number: 47540   **IRAS Number:** 261583
Participant Identification Number:

This form will be stored securely in the study file at the University of Southampton. You will also be given a copy for your records.

Please initial the box(es) if you agree with the statement(s):

I have read and understood the participant information sheet (Version 2, 01/07/19) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw for any reason without my participation rights being affected. I understand that if I withdraw, no further data will be collected, but that any information already collected will remain in the study. I understand that this will also apply should I lose capacity to consent during the study.	
I understand that special category information (gender identity and ethnicity) will be collected about me to achieve the objectives of the study. I understand that I can choose not to disclose this information.	
I understand that my personal information collected about me such as my name or where I live will not be shared beyond the study team.	
I understand that my interview will be audio recorded, transcribed and then destroyed as set out in the participant information sheet.	
I understand that direct quotes from the interview may be used in the research write up and any future reports/publications, but that any personally identifiable information will be changed or removed to protect my identity	
I understand that my data will be stored in accordance with the Data Protection Act and the University of Southampton's policies	

HOW DO PEER SUPPORT WORKERS MAINTAIN THEIR WELLBEING?

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Optional - please only initial this box if you wish to agree to it:

I am happy to be contacted by the researcher regarding taking part in a brief follow up telephone call. I understand that I will be asked for my contact details at the end of my interview and agree to the researcher retaining these to contact me to arrange the follow up call.	

Name of participant (print name)...

Signature of participant...

Date...

Name of researcher (print name)...

Signature of researcher ....

Date...

Appendix H   Demographics Form

HOW DO PEER SUPPORT WORKERS MAINTAIN THEIR
WELLBEING?

UNIVERSITY OF
Southampton

Demographics Form

Study Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work

Researcher: Louise Taylor

ERGO number: 47540   **IRAS Number:** 261583

Thank you for agreeing to participate in the above study. The questions below are used to find out more information about you and your role providing peer support. All questions are optional- you can choose not to answer some or all of the questions if you wish.

Age................................

Gender: Male/Female/Other- Please specify.......................

Ethnicity................................

Please indicate whether you are currently providing peer support or have been previously:

 Currently / Previously (please circle)

Do you provide peer support in a paid or voluntary capacity? Paid / Voluntary (please circle)

Do you provide peer support for an NHS or voluntary organisation? NHS / Voluntary Organisation (Please circle)

On average, how many hours per week do you work in your role providing peer

support?...............................

How long have you worked/volunteered in this role?...................................

Thank you for taking the time to complete this form.

Appendix I Debrief Sheet

HOW DO PEER SUPPORT WORKERS MAINTAIN THEIR WELLBEING?   UNIVERSITY OF Southampton

Debriefing Statement

Study Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work

Debriefing Statement (Written) (Version 1.1 ,13/06/19)
ERGO Number: 47540   **IRAS Number:** 261583

The aim of this research was to explore the ways in which people who provide peer support manage their own wellbeing at work. It is hoped that this will help to identify the strategies peer support workers use to maintain their wellbeing at work (both in terms of formal, organisational support, as well as the informal strategies they may use). It is also hoped the research findings will help inform services about how to best support peer support workers in their roles. Your data will help to improve our understanding of this area. Once again, results of this study will not include your name or any other identifying characteristics. The research did not use deception.

When you agreed to take part in the study, you would have been asked whether you would be happy to be contacted regarding taking part in an optional follow up telephone call. If you agreed to this, you will be contacted by the researcher in due course to arrange this. The phone call will last approximately fifteen minutes and taking part is entirely optional.

You may have a copy of this summary if you wish. Additionally, should you wish to receive a copy of the research findings once the study and write up is complete, please email the lead researcher, Louise Taylor, at L.Taylor@soton.ac.uk.

If you have any further questions, please contact Louise Taylor at L.Taylor@soton.ac.uk.
Thank you for your participation in this research.

Should you feel any distress having taken part in the research, you can contact your GP or the following services for support:

- **The Samaritans**
  Telephone: 116 123 (freephone)
  Address: 11 College Place, London Road, Southampton, SO15 2FE
- **MIND**
  Infoline: 0300 123 3393

Additionally, should you wish to access confidential advice on employment-related issues, you can contact **ACAS (Advisory, Conciliation and Arbitration Service)** on 0300 123 1100.

Signature _____   Date _____

Name _____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Version 1.1 (13/06/19)   Ergo Number: 47540, IRAS Number: 261583

Appendix J Topic Guide

HOW DO PEER SUPPORT WORKERS MAINTAIN THEIR WELLBEING?   UNIVERSITY OF Southampton

Interview Topic Guide

Study Title: A qualitative study exploring how peer support workers maintain their own wellbeing at work

Interview Topic Guide (Version 1, 10/04/19)

ERGO Number: 47540   IRAS Number: 261583

1) Firstly, can you tell me what you feel is the best part of being a Peer Support Worker?
2) What are the challenges of working as a Peer Support Worker?
   a. Prompt: service related challenges, individual challenges, difficulties with colleagues, work load, other challenges
3) How do you feel working as a Peer Support Worker influences your wellbeing?
   a. Prompt: positive and negative ways
4) Can you tell me about how you monitor your own wellbeing at work?
   a. Prompt: Individually, at a service level, anything/anyone else which helps you do this
5) How do you manage your own wellbeing whilst working in the role?
   a. Prompt: coping strategies, what's helpful/unhelpful about these, what would you do if you were noticing things were starting to become more difficult, prompt using answers given to questions 3 and 4
6) Can you tell me about the types of support you receive from your organisation or service?
   a. Prompt: training, mentoring, supervision, occupational health/reasonable adjustments, support from colleagues, networking with other peer support workers
   b. What have your experiences been of these types of support?
      i. Prompt regarding each type of support mentioned- what has been helpful/unhelpful, what specifically makes these things helpful/unhelpful
7) Can you think of any ways in which the support you receive from your organisation could be improved?
   a. Prompt: Any support you'd like which isn't provided? Any changes you'd like to see
8) Are there things outside of work which help you maintain your wellbeing at work
   a. Prompt: support on social media, social support, work/life balance, hobbies
9) Out of everything we've spoken about so far, what would you say are the key things in supporting your wellbeing at work?
10) Is there anything else you'd like to say?

Appendix K   Example of Coded Transcript

[0:00:00]

Interviewer: So, firstly, can you tell me what you think is the best part of being a peer support worker?

Respondent: Okay. (Inaudible 0:01:11) because my battery is a bit low.

Interviewer: Oh, okay.

Respondent: That's it. I'm plugged in now; that's better. So, the best thing about being a peer worker… oh my God, there are so many things. I think you get a lot out of supporting other people and you kind of see a bit of yourself in them as well, and using your own experiences to do something good. I know a lot peer workers say, "Something good comes out of something that you've experienced that wasn't so nice", and to give something back to mental health services as well; if you've received some really nice support it's nice then to go back and be part of that team that provides support to other people.

> **Commented [TL1]:** Helping others
> **Commented [TL2]:** Using your own experiences in a positive way
> **Commented [TL3]:** Making something positive out of a difficult experience
> **Commented [TL4]:** Giving back to services

Interviewer: Absolutely, yeah.

Respondent: One of the other things about it is that it can lead you to other work opportunities as well, so if perhaps you haven't been able to work because of your mental health and then you're holding down a job and you're doing all these wonderful things then it gives you the other opportunities to do different work and other training opportunities and things. So, I personally know peer workers who have gone on and they're now mental health Nurses.

> **Commented [TL5]:** Leads to other opportunities, career development, shows you that you can do it

Interviewer: I wonder if there's something about it almost giving you the confidence to see actually, "I can do this"?

Respondent: Yeah, I think so; and being supported by the right kind of support in going into work I guess.

> **Commented [TL6]:** Having the right support is important

Interviewer: Yeah. And when you say, "The right kind of support", what do you think that might look like?

Respondent: I mean it's written on the tin isn't it when you're a peer worker and you've had that bit of experience? So, there are good and bad sides to that I think but one of the good sides is people know that you've had those challenges so they're more aware, they're able to support you – like your Supervisor and things. It's okay to talk about… You know if you went into a job where no one knew about your mental health then I think there's so much stigma you'd be thinking, "Oh, I'd better not say anything. If I'm off sick I'd better pretend I've got the flu", or, "It's not okay to be off because of my mental health", and things like that. So, I think it enables you to be really open and honest about your well-being as well and I think that encourages other members of staff as well who aren't in a role where it's obvious that you've had those challenges but, yeah.

> **Commented [TL7]:** People more likely to provide good support because they know you have your own experiences ie your supervisor, can be more open about difficulties
> **Commented [TL8]:** Able to be open about your experiences/wellbeing, able to self-disclose, less stigma, transparency
> **Commented [TL9]:** Encourages other staff to be more open about own wellbeing too, culture of openness?

Interviewer: Yeah, absolutely; and what about the flip-side of this? What are maybe some of the more difficult things or some of the challenges of working as a peer worker?

Respondent: I think the challenges of being a peer worker are that some… I mean a lot of people say, "Oh, we're recovery-focussed", but they'll see a peer worker and they won't be like that, they'll be like, "Oh, they're going to go off sick", or, "They're going to need their hand holding". I think old school sort of thought; other people who have been working in our sector a very long time can be a bit like that. It's kind of, "Why are you employing people…?" It doesn't make sense to them I don't think. So, I think there is that kind of thing. I mean I've even had people I've supported saying, "Do you get paid to do this?" It's kind of almost like people think it might be a bit of a sympathy job, you know? "Oh, you can't really work properly so you're going to be a peer worker because you're not very well", sort of thing. So, there's that kind of side to it as well I think.

> **Commented [TL10]:** ?Tokenistic
> **Commented [TL11]:** Negative staff attitudes, worries about you going off sick, ?worries about whether you can do the job
> **Commented [TL12]:** People not recognizing the value of the role, tokenistic

0:04:50]

Interviewer: Yeah. And how do you manage some of those attitudes from staff?

Respondent: I think I've mostly been really lucky. The team I work on has about... we've got about XXX [number] peer workers on our team, so I've not experienced that kind of being the only peer worker in the team where the one school of thought is kind of like, "Oh, what can they possibly do for our team?" sort of thing. So, we're quite a strong group of peer workers I think so if anyone comes across as that we're kind of like, "Well, there are more of us than there are of you", and we're more able to stand up to it I guess. And a lot of what we do is about just role modelling for people; we wouldn't challenge anyone directly and be direct about anything, we'll just show them that this is what recovery looks like, this is how we work, and this is the language we use, and hopefully other staff, Nurses, Occupational Therapists or whatever, Social Workers, they get used to seeing us and hearing us and looking at what we do.

> **Commented [TL13]:** Helpful having other PSWs around

> **Commented [TL14]:** Other PSWs- stand together, safety in numbers

> **Commented [TL15]:** Having a positive impact on other staff, role modelling

Interviewer: Yeah. And I think that's a really important point because you could get up and you can tell people something but I think actually if people are able to just see how you work and, as you said, the kind of language you use and the way you speak to people, hopefully that really has an impact

Respondent: Yeah.

Interviewer: Okay. And you mentioned there that there are quite of lot of peer workers in your team; are you able to tell me a little bit about maybe what you think are the benefits of that, I guess of having other peer workers around you?

Respondent: Yeah. I mean I think for a lot of us coming into the team it's been our first peer support job so then a sense that there's somebody else there and they know what they're doing. When I first started it felt easier to ask another peer worker, "Oh, what do I do about this?" than it necessarily did about asking my Supervisor. So, there's that and we have reflective practice together, we kind of support each other, encourage each other. A lot of what we do is lone working as well so it's really helpful that we do have those connections that we feel are coming up – this peer worker – if I'm not sure about this. So, I can ask them if we can meet and have a chat about this. So, I think yeah there's definitely a lot of advantages to having so many peer workers on our team because I think we're quite unique actually in that from what I've read about other services and things.

> **Commented [TL16]:** Learning from other PSWs, drawing on their experience in the role

> **Commented [TL17]:** Ask other PSWs for advice- felt easier than asking sueprvisor

> **Commented [TL18]:** Reflective practice

> **Commented [TL19]:** Using each other for support, building connections

Interviewer: And it sounds as though there's a mixture there between having some of the formal, if you like, strategies in place in terms of the reflective practice you mentioned but also just being able to go to other peer workers for maybe a less formal chat or to bounce ideas off them or to run things past then, is that right?

Respondent: Yeah, absolutely. I mean there are quite a few formal things in place in our service. We have an induction training for new peers which didn't exist when I started but it does now which is designed to introduce you more to the workplace and the challenges that might throw up. So, it's things about coping with when you might go off sick and what is supervision and, "How do I do this?" There's that side of it. And we also have a peer forum four times a year where all the peer workers from across services meet up and it's a huge day and it's wonderful; lunch time is very long and we kind of catch up with each other, but there also sessions like CPD sessions as well; we have guests who come and speak to us. Yeah, so that's what we get as well in terms of support. And there's also a senior peer worker in post who is available if you've got any issues that you can't resolve in your team or if you just need someone to talk to if you've got any concerns about work and things like that; we've got that person as well. So, there are really lots of opportunities for us to get support if we need it.

> **Commented [TL20]:** Possibly training isn't enough by itself?

> **Commented [TL21]:** Support has improved. More induction stuff- introduction to workplace, focus on challenges

> **Commented [TL22]:** Induction- to supervision, how to cope, advice how to do the role

> **Commented [TL23]:** Peer forum- CPD, meet other PSWs,

> **Commented [TL24]:** Senior PSW- issues which can't be resolved in team, discuss concerns, talk to someone

> **Commented [TL25]:** Lots of support in place

Interviewer: Yeah. It sounds as though it's a very supportive set up there.

Respondent: Yeah.

Appendix L   Frequency of Themes Across Participants

Themes ↓	Participant Number →	1	2	3	4	5	6	7	8	9	10	11	12
A Double Edge Sword													
Drawing on your own Experiences		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Not doing enough Vs Doing Too Much		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Structure, like any other profession													
Clinical Supervision		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Career Development				✓	✓	✓	✓	✓		✓	✓	✓	
We're not there yet		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓

Culture												
Collegiality and Caring	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Genuinely prioritising wellbeing	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Self-Care												
Taking Care of the Basics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Checking in with yourself	✓				✓	✓			✓	✓		
Knowing your limits		✓	✓		✓	✓	✓		✓	✓	✓	✓

Appendix M   Exerts from Reflective Log

Participant 1:

This was the first interview I did and I felt nervous prior to doing it. I found myself wondering about how the interview would go- what would the participant be like? Were the questions in the topic guide worded correctly? Would the conversation flow? However, I found that once the interview got started, I quickly relaxed and the conversation generally flowed well. On reflection, I think I could have left a few more pauses to give the participant chance to say more, however I think my anxiety about the interview meant that I struggled to leave silences- this is definitely something which I want to be more mindful of in my next interview.

Participant 5:

I noticed that I was feeling much more relaxed prior to doing this interview. I think this was partly because this was the fifth interview I had done, and therefore I felt more confident conducting the interview and generally felt less worried about participants not talking or not understanding the questions. However, I also noticed that this particular participant had come across as particularly warm and friendly in the email communications beforehand and I wonder whether this had a role to play in me feeling more relaxed.

During the interview, the participant was very chatty and friendly and I noticed we very quickly built a good rapport. They were clearly very passionate about peer support and this very much shone through during the interview. At times, I did notice that the conversation went slightly off topic, for example by focusing on how people received peer support rather than their experiences of providing it. I noticed myself questioning whether this was ok or whether I should redirect the conversation. However, given that she gave the impression this was something they felt was important to talk about, we spoke about this for a little while before bringing the interview focus back to the main topic.

Participant 8:

I found it much harder to build a rapport with this participant, although I am not fully sure of why this was. The conversation seemed a bit disjointed at times and the participant sometimes only gave relatively brief answers to the questions I asked. As a result, this interview was noticeably shorter than the other interviews I have done so far. The participant reported feeling a bit nervous at the start of the interview, so I wonder whether this played a role. I was also aware that

this interview, at the participant's request, was conducted during the evening time so I was feeling a little tired and found myself having to work hard to really focus on what the participant was saying. Difficulties with the participant's phone signal also didn't help as it meant the signal cut out at times. I found myself feeling somewhat deflated after the interview as I didn't feel it had gone as well as the others.

Participant 9:

The participant expressed feeling a little anxious about doing the interview and explained that they sometimes find it hard to talk about things. Despite this, they said she wanted to do the interview and were happy to go ahead. At one point near the beginning of the interview, they said they weren't sure whether they was expressing what they wanted to say- I therefore noticed myself making a conscious effort to summarise and reflect back what they had said throughout the interview. Although this seemed to be useful in checking my understanding of what they were saying, I wonder whether this meant I jumped in a little too quickly at times and didn't leave enough silences for them to elaborate or say more. When I did summarise things back to them, they said I had understood what they had meant but I think contacting them again for the member check will be particularly important for this participant.

During the interview, the participant spoke a little about some difficult experiences they had gone through previously. I noticed my urge to jump into "therapist mode" and respond as if I would had I been talking to a client. I had to work quite hard to hold back from doing this, reminding myself that I was speaking to this person as a researcher rather than as a clinician.

Data Analysis

Although I was not able to transcribe all of the interviews myself due to time limitations, I found it really useful to transcribe some of the interviews and to read and re-read the transcripts of those I hadn't transcribed myself. This process helped me to reconnect with what participants' had said during the interviews and also helped me to notice small details which I didn't necessarily notice during the interviews themselves.

Coding the interviews was a time-consuming process and I found myself wondering whether I was "doing it right" at times. I noticed my perfectionist tendencies showing up, particularly as I really wanted to ensure the codes I devised were accurate reflections of what participants had said. I was pleased to have a second person code some of the transcripts to help reassure me that I was on the right track and also realised the importance of carrying out member checks to ensure I had correctly understood what participants were saying.

I really enjoyed analysing the codes which I had identified in the data and trying to come up with themes. Having a meeting with myself, the peer consultant and the research supervisory team was particularly valuable. It was really interesting to see how each person brought a slightly different perspective to the meeting and I really saw the meaning of the phrase "the whole is greater than the sum of its parts". Through a series of meetings and discussions, the themes were refined and renamed several times, something which helped me to see the importance of viewing data analysis as a process or a journey, as opposed to a single task to be done. I'm really pleased with the final themes we have identified and was pleased to hear that participants also agreed with these themes when I conducted the member checks.

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