

# **One-to-one peer support in mental health**

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I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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## Overview

Peer support has been recognised as a valuable resource for individuals with mental health issues; this thesis focuses on one-to-one peer support interventions and naturally occurring peer support. The thesis is presented in three parts.

Part I is a literature review of the effectiveness and characteristics of unidirectional peer support interventions for individuals with mental health issues. Fourteen studies met the inclusion criteria. The quality of reporting of the characteristics of the interventions was good. However, the quality of the studies was mixed. The findings of the studies were also mixed, indicating that an empirical base for unidirectional peer support interventions is yet to be established.

Part II presents the findings of a qualitative study into service users' experiences of naturally occurring peer support in inpatient settings. Twelve service users took part in semi-structured interviews. A thematic analysis yielded nine themes organised into two domains. Participants highlighted the importance of peer support, which provided the opportunity to live out valued personal principles and identities. However, there were a number of challenges and barriers to supportive interactions (e.g. the fear of raising a painful topic meant some participants felt the need to tread carefully around others). Further research is needed to explore staff perceptions of mutual peer support on acute inpatient wards, which would guide the implementation of these ideas to inpatient ward policy and procedure.

Part III is a critical reflection on the process of carrying out the research reported in Part II. It focuses on the challenges of conducting qualitative research in a mental health setting, the impact of researcher position and a consideration of the results in relation to the wider context of the mental health system.

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## **Part I: Literature Review**

### **One-to-one peer support interventions for individuals with mental health issues: A review of the literature**

## **Abstract**

**Aims:** The role of peer support interventions in mental health has been increasingly recognised, but a firm empirical base is yet to be established. This literature review examined evidence for the effectiveness of one-to-one peer support interventions that focused on social support for individuals with mental health issues.

**Methods:** A systematic search of the literature was conducted via PsycINFO and PubMed. Studies were included if they used a comparison group (randomised or non-randomised) or a longitudinal design.

**Results:** Fourteen studies met the inclusion criteria for the review. Eight evaluated peer support interventions for individuals with severe mental illness and six for individuals with a diagnosis of depression. Ten studies used randomised designs, two used non-randomised comparison group designs and two used longitudinal cohort designs. Overall, the quality of reporting of the characteristics of the intervention was good, but the quality of the study designs was mixed. The evidence for effectiveness was mixed; there was no clear pattern either within or across the two clusters of studies to indicate that one-to-one peer support interventions led to improvement in psychological and social outcomes.

**Conclusions:** Future research would benefit from guaranteeing methodological rigor, both in terms of study design and reporting. Studies should include outcome measures informed by the recovery literature. It would also be beneficial to explore whether the quality of the peer relationship is related to outcome. The effectiveness of peer support interventions should be explored across a wider range of settings and for a broader range of mental health issues.

## **Introduction**

Peer support, in which individuals with personal experience of a problem help others with a similar problem, has increasingly been recognised as a potentially valuable complement to professionally-delivered interventions in mental health. Peers have unique qualities, being ‘expert by experience’ (MIND, 2013; Basset, Faulker, Repper & Stamou, 2010) and thus are in a position to understand what it is like to live with a mental health difficulty. Given the isolation and stigma frequently experienced by people with mental health needs (Corry, 2008), peer support may be a particularly useful resource. Although peer support can occur naturally, service users and mental health professionals have advocated for its more formal use in the form of various types of interventions.

### **Theories of peer support**

From a theoretical perspective, peer support is grounded in the literature on social support. Social support has typically been conceptualised as consisting of three components: emotional support (e.g., acceptance, reassurance), informational support (e.g., guidance, advice) and instrumental support (e.g., practical assistance; Cohen, 2004), the provision of which is thought to promote positive health outcomes through buffering the effects of stress on psychological distress. Various mechanisms have been proposed as explanations for this buffering effect: for example, social support may lead to individuals feeling valued and cared for, it may change individuals’ appraisals of the problem, and it may help them to engage in more adaptive coping (Cohen, 2004). When social support is provided by a ‘peer’ who has experienced a similar problem, these mechanisms may be activated in particular ways. By drawing on their ‘experiential knowledge’ (Borkman, 1990), peers may be better able to empathise with difficulties and share their own experiences of coping (Mental Health

Foundation, 2012). The information and advice they provide may be perceived as more 'credible' than that provided by those with no experience of the problem (Mental Health Foundation, 2012).

Drawing on the perspective of Rogerian theory (Rogers, 2004), peer support can also be conceptualised in terms of the key features of 'therapeutic' relationships. Rogers proposed that empathy, positive regard and genuineness are essential in any relationship in which one individual is attempting to help another, whether that be in the context of psychological therapy or in the context of more informal helping relationships, such as friendships or family relationships. Although there are, of course, many differences between psychological therapy and peer support, the experience of a supportive peer relationship may have some similarities to that of a good therapeutic relationship in professionally-delivered interventions. Indeed, peer support projects often highlight the importance of empathy, respect and a non-judgmental approach (MIND, 2013).

### **The characteristics of peer support interventions in mental health**

Peer support interventions can take many forms. They can occur in a group format (often referred to as mutual support groups) or in a one-to-one relationship (Pfeiffer, Heisler, Piette, Rogers & Valenstein, 2011). Peer support can occur naturally between individuals or it can be set up more formally as an intervention (Solomon, 2004). It can be provided by employed and trained peer support workers (often integrated into professional services) or by individuals voluntarily offering their time to others (Eng, Parker & Harlan, 1997). It can occur between individuals at similar stages of their journey with mental or physical health issues (often referred to as bi-directional peer support), or an individual at a later stage of their recovery

journey can provide support to someone at an earlier stage (often referred to as uni-directional peer support; Solomon, 2004). Finally, whilst peer support most commonly occurs face-to-face, it can also take place through other modalities such as over the telephone or the internet (Pfeiffer et al., 2011).

Alongside the variability in format, peer support interventions can also vary according to content. Some interventions focus on emotional support, whereas others aim to be more educational. Some emphasise the advocacy role that peer supporters can play, representing the experiences, needs and opinions of service users to mental health professionals or other organisations. Still others are in fact psychological interventions (e.g. psychoeducation interventions or interventions designed to teach individuals new coping strategies) that have been designed by mental health professionals but are delivered by a peer. Finally, some peer support interventions employ peers (usually former service users) to help in the delivery of services, either in a supporting role (e.g. as a health care assistant) or indeed as case managers. Given this diversity, it is imperative to clearly define and specify the nature and format of the peer support intervention under study ([Simoni](#), Franks, Lehavot & Yard, 2011).

### **The evidence base for peer support interventions in mental health**

Although widely advocated (Bradstreet & Pratt, 2010; Faulkner & Basset, 2012), peer support has a limited and mixed evidence base. Qualitative studies and service user-led research consistently indicate that peer support is experienced as beneficial by recipients (e.g., Coatsworth-Puspoky, Forchuk, & Ward Griffin, 2006; Smith-Merry, Freeman, & Sturdy, 2011) as well as by providers (e.g., Repper & Carter, 2011; Salzer & Sheer, 2002). The reported benefits include feeling accepted,

gaining a sense of hope and empowerment, learning new skills, and providing a forum to challenge stigma and discrimination (MIND, 2013). Furthermore, peer support can help build the capacity of local communities and promote collective action, which appears to be particularly valued by members of marginalised communities (MIND, 2013).

However, quantitative studies of effectiveness show a much more mixed picture. Several reviews have examined the empirical literature on peer support interventions in mental health (summarised in Table 1). These cover a broad range of interventions, in terms of their format as well as their aims and content. The populations under study mainly include individuals with severe mental illness or depression. Overall, the evidence for the interventions' effectiveness is mixed, both within and across studies. Some reviews conclude that there is insufficient evidence for peer support due to inconsistent outcomes across studies, poor methodological quality and a high risk of bias (Lloyd-Evans et al, 2014; Pitt et al., 2013). Other reviews suggest there are small positive effects that favour peer interventions, particularly with regards to quality of life and hope outcomes (Bryan & Arkowitz, 2015; Fuhr et al., 2014; Pfeiffer et al., 2011; Pistrang, Barker & Humphreys, 2008; Simpson & House, 2002). Most conclude that whilst there is limited evidence, peer interventions appear to do no harm, although all highlight the need for further high quality research studies.

A major challenge in making sense of the findings of these reviews is that the interventions studied, both within and across reviews, are quite heterogeneous. The inconsistent findings may therefore be due, at least in part, to the fact that very different interventions are being treated as one entity. Some reviews have helpfully

Table 1: Summary of reviews for peer support interventions in mental health

Review	Focus of review	Types of interventions included	Target mental health issue	Main difference from current review
<b>Bryan &amp; Arkowitz (2015)</b>	Efficacy of peer-administered psychosocial interventions	Mutual peer support groups 1:1 peer support Telephone peer support Online peer support	Depression	Included group and online interventions Included physical health and bereavement interventions
<b>Fuhr et al. (2014)</b>	Efficacy of peer support interventions	Mutual peer support groups 1:1 peer support	Depression Severe Mental Illness	Only included RCTs Included group interventions
<b>Lloyd-Evans et al. (2014)</b>	Efficacy of peer support interventions	Mutual peer support groups 1:1 peer support Peer-delivered services	Severe Mental Illness	Only included RCTs Included group interventions Included peer delivered standard care services

and  
peer-  
delivered  
services

**Pistrang et al. (2008)**

Efficacy of mutual peer support groups

Mutual peer support groups

Severe Mental Illness  
Depression  
Anxiety

Only focused on group interventions; did not include 1:1 peer support interventions

**Pitt et al. (2013)**

The impact of employing peer supporters in statutory services

Case management  
Advocacy  
Coaching  
Group social support

Severe Mental Illness

Only included RCTs  
Included group interventions  
Only focused on statutory services interventions

*Table 1 (continued)*

<b>Review</b>	<b>Focus of review</b>	<b>Types of</b>	<b>Target mental health issue</b>	<b>Types of methodologies included</b>	<b>Main difference from current review</b>
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		<b>inter venti ons inclu ded</b>				
<b>Pfeiffer et al. (2011)</b>	Efficacy of peer support interventions for depression	Mutu al peer supp ort grou ps 1:1 telep hone peer supp ort	Depression		RCTs only	Only included RCTs Included group interventions
<b>Repper &amp; Carter (2011)</b>	The benefits and challenges of employing peer support workers in statutory services	Case mana geme nt Advo cacy Mutu al peer supp ort grou ps Telep	Unspecified		RCTs Comparative studies Qualitative studies Literature reviews	Included group interventions Included qualitative studies Only focused on statutory service interventions

		h o n e p e e r s u p p o r t O n l i n e p e e r s u p p o r t			
<b>Simpson and House (2002)</b>	Impact of and challenges to involving service users in the delivery and evaluation of mental health services	Case management Advocacy Counselling Staff training Involvement in research	Unspecified	RCTs Comparative studies Descriptive studies	Included qualitative studies Only focused on statutory services Focused on efficacy for the peer workers and the teams they were working in, rather than the service users being supported by the team

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stratified the studies being examined into the different formats of the intervention (e.g. Fuhr et al., 2014 and Lloyd-Evans et al., 2014). However, even in these cases the interventions that have been clustered together are still quite heterogeneous or the outcomes are sometimes presented as a whole. For example, Lloyd-Evans et al. (2014) separate out the interventions included in their review into three clusters: mutual peer support groups (where support is understood to be more reciprocal and mutual in nature), peer support services (where support is primarily uni-directional) and peer mental health services (where peers are employed in roles usually held by mental health professionals). Yet, of the 11 studies in the peer support services category, five studies provided structured, psycho-educational group programmes (Barbic, Krupa, & Armstrong, 2009; Cook et al., 2011; Cook et al., 2012; Proudfoot et al., 2012; Van Gestel-Timmermans, Brouwers, Van Assen, & Van Nieuwenhuizen, 2012), two employed peer individuals to provide one-to-one support of various kinds to individuals as part of a standard care team (Chinman et al., 2013; Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004), two provided one-to-one support to individuals outside of statutory services, particularly focusing on social support (Davidson, Shahar, Stayner, Chinman, Rakfeldt & Tebes, 2004; Rivera, Sullivan & Valenti, 2007) and one provided online coaching support (Simon et al., 2011). A further issue that makes it difficult to make sense of the findings is that the aims and characteristics of the interventions under study are not usually specified in the reviews.

### **The current review**

The present review examines the evidence for the effectiveness of one-to-one, uni-directional peer support interventions in mental health. More specifically, it focuses on those interventions aiming to provide one or more components of social

support, rather than those in which a peer delivers an intervention or service that would normally be delivered by a professional. Compared to the latter, social support-focused interventions are less structured and draw primarily on the peer supporter's experiential knowledge and potential for empathy. Thus, they are particularly interesting because they are arguably more similar to naturally occurring peer support. Previous reviews have not examined in detail this type of peer support intervention.

Unlike some previous reviews, the review examines evidence from studies using a range of designs, including randomised and non-randomised designs, as well as uncontrolled longitudinal designs. Although randomised designs are considered the 'gold standard' when it comes to efficacy research, non-randomised and uncontrolled designs can contribute to the evidence base, particularly when research in an area is in its early stages (e.g. Barker, Pistrang & Elliott, 2016). In assessing the findings of studies, the review will take into account the types of designs used and their respective strengths and limitations.

In summary, the review addresses the following questions, in relation to one-to-one peer support interventions that focus on social support for individuals with mental health issues:

1. What are the aims and characteristics of these interventions, and how well are they specified?
2. What is the evidence of the effectiveness of these interventions?

## **Methods**

### **Search strategy**

Initial search terms were generated based on previous reviews (Fuhr et al., 2014; Lloyd-Evans et al 2014) and preliminary scoping searches. The titles and abstracts of studies identified in previous reviews were also searched for relevant terms.

The final set of search terms broadly mapped onto two conceptual clusters: one set of terms to target the peer support component of potential studies (peer support terms) and another cluster to target the mental health aspect of potential studies (mental health terms). To allow for variations in keyword terms (e.g. anxious and anxiety) truncated terms were used. Alternative keywords were also included to identify studies in both British and American publications (e.g. American publications mainly use the keyword ‘consumer’ whereas British publications mainly use the keyword ‘peer’). The final set of search terms is shown in Table 2.

*Table 2: Summary of final search terms*

	<b>Peer support terms</b>		<b>Mental health terms</b>
<b>Peer</b>	<b>Consumer</b>		
peer support	consumer* employee*		mental health
peer social support	consumer* provider*		mental illness
peer staff	consumer* assist*		psychiatr*
peer educat*	consumer* partner*		depress*
peer delivered	employ* AND service		anx*
peer specialist	consumer*		bipolar
peer expert	employ* AND service user		personality disorder
peer advisor	consumer*		schizophren*
peer volunteer	employ* AND mental health		psychosis
	consumer*		psychotic
			(dual* AND
			diagnos*)

Individual peer, consumer and mental health terms were combined together using OR; the following search strategy was then used:

*(peer terms OR consumer terms) AND (mental health terms)*

The databases of PsycINFO and PubMed were systematically searched for relevant articles published from September 1995 and up until September 2015. Given the number of previous reviews and the relatively recent research interest in peer support, it was decided that this 20 year limit would allow for the most up to date literature to be reviewed. The search was limited to English language, peer reviewed journals with human, adult populations (18 years+).

### **Inclusion and exclusion criteria**

The inclusion and exclusion criteria map onto four broad areas, detailed below.

**Characteristics of the peer support intervention.** Studies were included if the peer support intervention met all of the following criteria:

- (1) It aimed to provide emotional, informational, and/or practical support that was additional to or separate from standard care provided by mental health services
- (2) It was delivered by individuals who had past and/or current lived experience of mental health issues (peer supporters)
- (3) Support was primarily uni-directional (i.e. peer supporters offered support to participants)
- (4) Peer support was provided on a one-to-one basis via face-to-face meetings, over the telephone or a mixture of both

Studies were excluded if the peer support intervention was a structured intervention designed by mental health professionals or it was not possible to isolate the one-to-one aspect of the peer support intervention (e.g. it included both one-to-one and group support).

**Target population and issues.** Studies were included if the peer intervention provided support to adults with mental health issues. This criterion included studies that targeted specific mental health issues (e.g. depression, psychosis or anxiety) and those where issues were described in more general terms (e.g. severe or chronic mental illness). Studies that aimed to support individuals facing bereavement were included if they also focused on connected mental health issues, such as depression and anxiety. Peer interventions for carers were excluded, given their focus on reducing carer stress. Studies of peer support for individuals with physical health issues (e.g. cancer or multiple sclerosis) were excluded, given their focus on adjustment. Peer support interventions for substance misuse issues were also excluded given that this is a distinct specialism with its own large body of peer support literature; however, dual diagnosis studies were included given their focus on both chronic mental health issues and substance misuse.

**Outcome measures.** Studies needed to report at least one mental health outcome measure to be included. Outcome measures could cover a variety of different areas including (1) psychological symptoms; (2) rates of hospitalisation or length of hospitalisation; (3) adherence to treatment or engagement with services; (4) quality of life; (5) social functioning.

**Research design.** Studies were included if they used a comparison group (randomised or non-randomised) or a longitudinal design with measures taken at two or more time points.

### **Study Selection**

Figure 1 summarises the study selection process. The electronic search resulted in 490 hits. These were initially screened using title and abstract and 421 papers were excluded. Following this, 69 papers were read in full and

*Figure 1: Study selection flowchart and main exclusion reasons*

considered according to the inclusion and exclusion criteria, resulting in a further 56 papers being excluded. There were multiple reasons for exclusion, which are documented in Figure 1. On the whole, decisions regarding eligibility were made by the author, with the exception of unclear cases which were judged in collaboration with her supervisor. An additional study was identified from a manual search of the bibliographies of relevant papers and reviews.

### **Quality Appraisal**

The CONSORT and TREND statements were used as a framework for making judgements about the quality of reporting (Des Jarlais, Lyles, Crepaz & the TREND Group, 2004; Schulz, Altman & Moher, 2010). Given the heterogeneity of included studies, a formal quality appraisal checklist was not used to judge study quality. However, the Downs and Black (1998) checklist, for randomised and non-randomised studies of interventions, was consulted. This particularly informed the assessment of internal and external validity; for example, how sample recruitment may have introduced bias and the representativeness of the sample.

All studies, but specifically those that used randomised designs, were assessed on the use of and reporting of randomisation methods, blinding and data collection methods, intention-to-treat (ITT) analyses, power analyses and whether the required sample size was recruited for the study to be considered sufficiently powered. The nature and quality of comparison groups was appraised, alongside how representative they were of the population of interest. Outcome measures were assessed on suitability and reporting of psychometric properties. The reporting of appropriate statistics, such as effect sizes and reliable and clinically significant change, was also judged.

Given the diversity of peer support interventions and the potential impact this could have on the research findings, it was judged important that studies provided sufficient detail of the intervention in order to be able to make appropriate comparisons. Studies were also assessed on the depth of description of the peer support intervention, its aims and connection to underlying theory, the intended frequency of contacts and duration of the intervention alongside the achieved frequency of contact and duration of the intervention, as well as the training and supervision that peer supporters received.

## **Results**

Table 3 provides an overview of the 14 studies that met the criteria for inclusion in this review. Eight studies focused on peer support for severe mental illness and six on peer support for depression. All of the severe mental illness studies made use of face-to-face peer support interventions, whereas four of the six depression studies made use of telephone-based peer support. All of the studies were based in English speaking, northern hemisphere countries: seven in the USA, five in Canada and two in the UK. Ten of the studies employed randomised designs; the remaining studies used a non-randomised comparison group (two studies) or a longitudinal cohort design (two studies).

The studies of peer support for severe mental illness are reviewed first, followed by those focusing on depression.

### **Peer support for severe mental illness**

**Nature of the intervention.** Most of the eight studies in this cluster provided a detailed account of the nature of the peer support intervention. Six explicitly discussed aims, how these aims were put into action, the peer supporter role, and

Table 3: Overview of included studies

Severe Mental Illness studies

Authors	Peer Support Characteristics	Sample Characteristics	Study Design	Outcome Measures
Craig et al. (2004)	Face-to-face support over a 12 month period (frequency unspecified) to provide: - Advocacy - Social support - Emotional support	N = 45 Mean age = 37 years 66% male	Randomised Controlled Trial	R Camberwell Assessment of Need (client and staff) C Verona Satisfaction Questionnaire T Social Networks - Significant Others Scale Life Skills Profile ( DNA Rate 1 Number of inpatient hospital admissions ) Attendance at social activities

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Davidson et al. (2004)	Face-to-face support for 2-4 hours per week over a period of 9 months to provide: - Social support - Engage in community activities	N = 260 Mean age = 42 years 43% male	A U  ( n = 2 1 ) R Center for Epidemiologic Studies-Depression Scale C Global Health Questionnaire T Wellbeing Scale Rosenberg Self-Esteem Scale ( Social Functioning Scale, Modified 1 Brief Psychiatric Rating Scale ) Global Assessment of Functioning-Modified Client Satisfaction Measure P Global Adherence Rating e e r  s u p p o
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*Table 3: Severe Mental Illness studies (continued)*

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<b>Authors</b>	<b>Peer Support Characteristics</b>	<b>Sample Characteristics</b>	<b>Outcome Measures</b>
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Klein et al. (1998)	<p>The 'Friend's Connector' programme            Face-to-face support, 2-3 times a week over a 6 month period to provide:</p> <ul style="list-style-type: none"> <li>- Emotional support</li> <li>- Social support</li> <li>- Leisure activities</li> </ul>	<p>N = 30            Mean age = 40 years            80% male</p>	<p>Number of 'Crisis Events' (Requests for hospital admission, attendance at A&amp;E, contacts to Mobile Emergency Team)            Number of inpatient hospital admissions            Social Functioning (GAF Score)            Use of community resources            Lehman Quality of Life Inventory</p>
Min et al. (2007)	<p>The 'Friend's Connection' programme            Face-to-face support for 2-5 hours a week            (duration determined by individuals)</p>	<p>N = 484            Mean age = 37 years            65% male</p>	<p>Number of inpatient hospital admissions            Pattern of inpatient hospital admissions</p>

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to provide:  
 - Emotional support  
 -  
 Information/skills sharing  
 - Social support  
 - Engage in community activities

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*Table 3: Severe Mental Illness studies (continued)*

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<b>Authors</b>	<b>Peer Support Characteristics</b>	<b>Sample Characteristics</b>	<b>Outcome Measures</b>
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Rivera et al. (2007)	Face-to-face support (frequency and duration unspecified) to provide: - Social support - Emotional support - Engage in community activities	N = 203 Mean age = 38 years 51% male	Attendance at appointments and activities Pattison Network Inventory The Behavioral Health Care Rating of Satisfaction Lehman Quality of Life Inventory Brief Symptom Inventory
Simpson et al. (2014)	Face-to-face peer support for four weeks (frequency unspecified) to provide: - Emotional and social support on discharge from hospital	N = 46 Mean age = 29 years (range, 20 - 57 years) 78% male	Beck Hopelessness Scale UCLA Loneliness Scale EuroQol (EQ-5D) Quality of Life Questionnaire Client Service Receipt Inventory Peer Support Activity Diaries

Sledge et al. (2011)	Face-to-face support for nine months (frequency determined by peer support dyads) to provide: - Social support Based on recovery principles	N = 74 Mean age = 40.5 years 51% male	Number of inpatient hospital admissions Length of hospital stays
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*Table 3: Severe Mental Illness studies (continued)*

<b>Authors</b>	<b>Peer Support Characteristics</b>	<b>Sample Characteristics</b>	<b>Study Design</b>	<b>Outcome Measures</b>
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Wroblewski et al. (2015)	Face-to-face support two hours per week for 26 weeks to provide assistance to achieve recovery goals	N = 21 Mean age = 53 years 14% male	P Lehman Quality of Life Interview–Brief Version i Number of inpatient hospital admissions l Length of hospital stays o Use of crisis services t Use of short term residential facilities
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*ICM = Intensive Case Management; MHW = Mental health worker; PSW = Peer support worker; TAU = Treatment as usual*

Table 3: Depression Studies

Author	Peer Support Characteristics	Sample Characteristics	Study Design	Outcome Measures
Conner et al. (2015)	Face-to-face support a minimum of three times over a three month period to provide: - Psychoeducation - Social support - Motivation and hope	N = 19 Mean age = 67 years 37% male	Longitudinal cohort T1 = Intake T2 = Intervention end (approx 3 month later)	Public Health Questionnaire - 9 Devaluation Discrimination Scale (Perceived public stigma) Internalized Stigma of Mental Illness Scale
Dennis et al. (2003)	One-to-one telephone based support (frequency subsequently determined by dyads) to provide: - Information - Social support - Emotional support	N = 42 Mean age and range not clearly specified	RCT (1) Peer support and TAU (2) TAU	Edinburgh Postnatal Depression Scale Rosenberg Self-Esteem Scale Child-Care Stress Checklist UCLA Loneliness Scale Peer Support Evaluation Inventory Peer Volunteer Experience Questionnaire Peer Volunteer Activity Log

Dennis et al. (2009)	One-to-one telephone based support (minimum of four contacts; frequency subsequently determined by dyads) to provide: - Information - Social support - Emotional support	N = 701 Mean age and range not clearly specified	RCT (1) Peer support and TAU (2) TAU	Edinburgh Postnatal Depression Scale Structured Clinical Interview - Depression State-Trait Anxiety Inventory UCLA Loneliness Scale Use of services
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Table 3: Depression studies (continued)

<b>Authors</b>	<b>Peer Support Characteristics</b>	<b>Sample Characteristics</b>	<b>Outcome Measures</b>
Hunkeler et al. (2000)	Unrestricted face-to-face or telephone support over a 6-9 month period to: - Model/share skills - Emotional support - Model hopefulness	N = 302 Mean age = 55.4 years (range, 19-90 years) 31% male	At intake: Hamilton Depression Rating Scale-Self Report Beck Depression Inventory SF-12 Mental Functioning Scale Patient Satisfaction With Treatment Scale Medication adherence  At intervention end: Hamilton Depression Rating Scale-Interview Beck Depression Inventory Patient Satisfaction with Treatment Scale Medication adherence

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for recovery

Letourneau et al. (2011)	Face-to-face support and telephone support for 12 weeks (frequency unspecified) to provide: - Informational support - Emotional support - Practical support - Mother-infant interaction teaching	N = 60 Age range, 17 - 39 years	Nursing Child Assessment Satellite Training Scales Edinburgh Postnatal Depression Scale Bayley Mental Development Index Infant Characteristics Questionnaire Social Provisions Scale Salivary Cortisol levels Field Notes Activity Logs
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Table 3: Depression studies (continued)

Authors	Peer Support Characteristics	Sample Characteristics	Outcome Measures
Letourneau et al. (2015)	One-to-one telephone based support, at least one contact to provide: - Emotional support - Information about depression and treatment - Social support Dyads could decide the frequency	N = 64 Mean age = 26.3 years (range, 17 - 43 years)	Edinburgh Postnatal Depression Scale Social Provisions Scale Study specific satisfaction measure

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and duration  
of calls  
following  
the initial  
contact and  
could be in  
contact for  
up to 12  
weeks

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*TAU = Treatment as usual*

training and supervision arrangements. Of the remaining two, Davidson et al. (2004) did not specify how the aims were put into practice and Simpson et al. (2014) did not provide any detail of the intervention.

Overall, the studies had three main aims: to explore the impact of peer support on hospitalisation rates (Klein, Cnann & Whitecraft, 1998; Min, Whitecraft, Rothbard & Salzer, 2007; Sledge, Lawless, Sells, Wieland, O'Connell & Davidson, 2011), engagement with services (Craig et al., 2004; Klein et al., 1998; Rivera et al., 2007) and outcomes for service users, particularly with regards to recovery, hope and quality of life (Craig et al., 2004; Davidson et al., 2004; Klein et al., 1998; Rivera et al., 2007; Simpson et al., 2014; Wroblewski, Walker, Jarus-Hakak & Suto, 2015). All studies embedded these aims in the recovery literature. Recovery models highlight the importance of supporting individuals to reconnect with life in meaningful ways; they seek to move away from the sole focus on the management and treatment of symptoms, emphasising the role of hope and empowerment in improving quality of life (MIND, 2013; Slade, 2010). Recovery models also emphasise the importance of viewing this process as a unique journey for each individual, making collaboration and partnership key (MIND, 2013; Slade, 2010).

Three studies also drew on theories of engagement (Craig et al., 2004; Rivera et al., 2007; Sledge et al., 2011); namely, the recognition that individuals with a lived experience of severe mental illness appear to be more willing and able to engage service users (Nikkel, Smith & Edwards, 1992). Although a clear theoretical framework is yet to be established, some have attributed this to qualitative differences in the interactions between consumers (Solomon & Draine, 1995), whilst others argue the importance of role modelling hope and empowerment (Lyons, Cook, Ruth, Karver & Slagg, 1996). From a more contextual perspective, six studies also

highlighted the growing popularity of peer support from both service user and governing body perspectives and argued for the importance of situating this in an empirical base (Craig et al., 2004; Min et al., 2007; Rivera et al., 2007; Sledge et al., 2011; Simpson et al., 2014; Wroblewski et al., 2015).

All but one study aimed to provide service users with social and emotional support (i.e. offering friendship, arranging and attending social activities, listening to and validating service user experiences). The one exception, the study by Wroblewski et al. (2015) was slightly different in that it aimed to use peer support to help service users achieve a specific, pre-agreed occupational therapy goal, such as getting a job or learning a new skill. However, even in this study it could be argued that peer supporters used social and emotional support to assist service users with goal attainment. Only four studies explicitly documented that peer supporters were encouraged to use and talk about their own experiences of mental health issues and recovery when supporting individuals (Craig et al., 2004; Klein et al., 1998; Min et al., 2007; Sledge et al., 2011).

The intended duration and frequency of peer support varied across the eight studies, as shown in Table 4. In four studies peer supporters were asked to meet weekly with individuals for a period of six months, nine months or a period of time determined by the service user. The other four studies did not specify contact frequency, with one study explicitly emphasising that leaving this for peer support pairs to decide was an important part of the intervention approach (Sledge et al., 2011). Only four studies provided data on the actual frequency of contact between peer support pairs. Two studies also reported the percentage of participants who had no contact with their peer support partners: 36% in Davidson et al. (2004) and 34% in Sledge et al. (2011). From a quality perspective, the lack of information makes it

Table 4: Duration and frequency of peer support (severe mental illness studies)

<b>Study</b>	<b>Intended frequency</b>	<b>Intended duration</b>	<b>Mean no. contacts (range)</b>	<b>Mean contact hours (range)</b>
Craig et al. (2004)	NR	12 months	-	-
Davidson et al. (2004)	2-4 hours per week	9 months	-	-
Klein et al. (1998)	2-3 times per week	6 months	-	-
Min et al. (2007)	2-5 hours per week	Determined by individual	80.91 (NR)	-
Rivera et al. (2007)	NR	NR	-	26.4 (NR)
Simpson et al. (2014)	NR	4 weeks	5.62 (1-15)	0.84 (0.25-1.25)
Sledge et al. (2011)	Determined by peer support pairs	9 months	13.43 (1-39)	24.15 (2-61)
Wroblewski et al. (2015)	2 hours per week	6 months	-	-

NR = Not reported

difficult to determine if the peer support interventions occurred as intended. This also makes it challenging to explore the intensity of interventions in relation to outcomes.

The training and supervision that peer supporters received varied across the eight studies. With one exception (Simpson et al., 2014), all studies reported that peer supporters received training before taking up their roles. Of these, only four specified the amount of training received (Davidson et al., 2004; Rivera et al., 2007; Sledge et al., 2011; Wroblewski et al., 2015), which ranged from one orientation and training session (Davidson et al., 2004) to 16 days completed over four weeks (Sledge et al., 2011). Only two studies provided information about the content of training programmes (Craig et al., 2004; Klein et al., 1998), which covered subjects such as counselling skills, crisis management and identifying social needs. All but two studies (Craig et al., 2004; Min et al., 2007) specified that peer supporters were provided with supervision. Of these, two did not specify the frequency, duration or nature of supervision (e.g. group vs. individual; Simpson et al., 2014; Wroblewski et al., 2015) and one specified the nature of supervision, but not the frequency or duration (Rivera et al., 2007). Of the three remaining studies, two provided group supervision on a weekly (Sledge et al., 2011) or monthly (Davidson et al., 2004) basis, and one provided weekly, individual supervision for peer supporters (Klein et al., 1998).

**Sample characteristics.** All eight studies focused on individuals with severe mental health issues that were typically chronic and had a significant impact on daily functioning. All but three studies provided specific data on participant diagnosis (Klein et al., 1998; Min et al., 2007; Wroblewski et al., 2015). The predominant diagnosis was psychosis. Only one study included individuals with a diagnosis of

personality disorder (Simpson et al., 2014). Two studies focused specifically on ‘dual diagnosis’ individuals, i.e. with severe mental health issues and co-morbid substance misuse (Klein et al., 1998; Min et al., 2007); only two other studies reported on the rates of problematic substance use in the sample (Craig et al., 2004; Davidson et al., 2004). Across all eight studies, there were more men than women, with four studies reporting a substantial majority (> 65%) of men. Only six of the eight studies reported on the ethnicity of individuals. Of these, five were predominantly composed of members of black and minority ethnic communities. With the exception of one study (Simpson et al., 2014) all study samples had a mean age of greater than 35 years. Table 5 summarises the sample characteristics.

*Table 5: Sample characteristics (severe mental illness studies)*

<b>Study</b>	<b>Age Mean (range)</b>	<b>% Male</b>	<b>% BME</b>	<b>% Drug and alcohol issues</b>
Craig et al. 2004	37.6	66	58	29
Davidson et al. 2004	42	43	14	44
Klein et al. 1998	40.5 (26-59)	82.5	69	100
Min et al. 2007	36.8	69	70	100
Rivera et al. 2007	38.3	51	72	-
Simpson et al. 2014	28.7	78.3	67.4	-
Sledge et al. 2011	40.6	51.5	-	-
Wroblewski et al. 2015	52.4	14	-	-

*\* SD shown in brackets where reportable*

**Study Design.** Six of the eight studies used randomised controlled designs; the remaining two used uncontrolled comparison group designs.

*Randomised Studies.* Of the six randomised studies, four compared peer support with treatment as usual. One study compared peer support and monetary support, non-peer support and monetary support with monetary support alone (Davidson et al., 2004). The final study compared peer support with support from a

mental health worker (Wrobleski et al., 2015). Across all six studies, the peer support intervention was offered in addition to treatment as usual.

Only three studies reported their randomisation methods (Craig et al., 2004; Simpson et al., 2014; Sledge et al., 2011). Of these, one sequentially numbered potential participants and then used random number tables to allocate them to group; no details were provided about how participants were informed of their allocation (Craig et al., 2004). Another used a software package to allocate group; these allocations were transferred to sealed envelopes and opened following the provision of consent (Sledge et al., 2011). In the final study participants were allocated using distance methods in a block format (Simpson et al., 2014).

Four studies employed independent research assistants to collect data. Of these, two explicitly stated that the research assistants were blinded to treatment condition (Craig et al., 2004; Rivera et al., 2007), whereas the other two did not mention if blinding occurred (Davidson et al., 2004; Simpson et al., 2014). In the other two studies, researchers were responsible for the collection of data; Sledge et al. (2011) acknowledged that researchers were not blinded to group allocation, whereas Wrobleski et al. (2015) did not mention blinding. Furthermore, Wrobleski et al. (2015) noted that two of the researchers were also part of the clinical team delivering the intervention and acknowledged that they had a vested interest in the success of the project.

Five studies compared participant outcomes pre- and post- intervention, with two of these including an additional measure halfway through the intervention period (Davidson et al., 2004; Rivera et al., 2007). One study compared outcomes across the nine-month intervention period with the previous 18 months (Sledge et al., 2011).

Of note, only one study included a follow-up period: Simpson et al. (2014) followed up individuals two months after completing the intervention.

All studies reported their inclusion and exclusion criteria. With the exception of one study that was limited by lone working policies (Simpson et al., 2014), inclusion and exclusion criteria seemed appropriate for the recruitment of suitable samples. All studies conducted between-group analyses at baseline to establish whether the experimental and control groups were equivalent. No studies reported significant differences between the experimental and control groups in terms of age, gender, ethnicity and diagnosis.

Four studies documented an intent-to-treat (ITT) analysis; all reported no significant differences between individuals who dropped out and those who completed (Craig et al., 2004; Davidson et al., 2004; Rivera et al., 2007; Simpson et al., 2014). Of the remaining two studies, one did not have consent to use the data of individuals who dropped out and so were unable to complete an ITT analysis (Sledge et al., 2011), whilst the remaining study did not mention ITT analysis (Wroblewski et al., 2015). Only two studies explicitly stated that they conducted a power analysis to inform sample size (Rivera et al., 2007; Simpson et al., 2014); of these, only one was able to recruit a sufficient sample size to detect a moderate effect (Rivera et al., 2007).

*Non-randomised studies.* Two studies employed non-randomised designs, comparing the provision of peer support (alongside treatment as usual) with treatment as usual (Klein et al., 1998; Min et al., 2007). In both studies, the comparison group was drawn from the same case management team of individuals in the experimental group (Klein et al., 1998, Min et al., 2007). Between group

analyses indicated there were no differences between the experimental and comparison groups at baseline in terms of age, gender, ethnicity, diagnosis and previous hospital history (Klein et al., 1998; Min et al., 2007).

In the Klein et al. (1998) study, data were collected both across the intervention period of six months and pre- and post- intervention. The researchers were unable to collect pre- and post- outcome measures for 60% of the comparison group (Klein et al., 1998). One individual dropped out of the peer support intervention before completion; they were not replaced and their data was included in analyses (Klein et al., 1998). In comparison, the Min et al. (2007) study was a retrospective three-year analysis of rates and lengths of hospital admissions for individuals who had been part of a peer support programme compared to contemporaries who had not. Both studies did not state who was responsible for data collection.

Furthermore, although the Klein et al. (1998) study reported that individuals were initially randomly selected from an intensive case management team caseload to receive the peer support intervention, most of the original sample declined the peer support programme and were instead included in the comparison group. Other individuals were then selected from the same pool of participants; it is unclear whether they were randomly selected (Klein et al., 1998). In the Min et al. (2007) study, individuals could self-refer or be referred to the peer support intervention by their case manager. Therefore, for both studies, it is possible that the experimental group were self-selecting, meaning they were potentially more likely to engage with peer support and experience it as helpful.

**Outcome measures.** Studies mainly used self report measures or data from electronic recording systems (i.e., hospital admissions), although some also used measures that were specifically designed for the study (e.g., study specific satisfaction measure, Davidson et al., 2004). Six of the eight studies used psychological or social functioning measures, such as quality of life or network inventories (Craig et al., 2004; Davidson et al., 2004; Klein et al., 1998; Rivera et al., 2007; Simpson et al., 2014; Wroblewski et al., 2015). Six studies tracked rates and lengths of hospital admissions (Craig et al., 2004; Klein et al., 1998; Min et al., 2007; Rivera et al., 2007; Sledge et al., 2011; Wroblewski et al. 2015). Apart from rates and lengths of inpatient hospital admissions and the Lehman Quality of Life Inventory which was used by two studies, no studies used the same outcome measures. Such variability makes it challenging to compare findings across studies.

Of the six studies that used psychological or social outcome measures, only three commented on the psychometric properties of the chosen measures (Craig et al., 2004; Davidson et al., 2004; Simpson et al., 2014). The Simpson et al. (2014) study provided the most comprehensive analysis, commenting on the reliability and validity of measures both in the context of research and clinical practice. Of the six studies that tracked the rates and lengths of hospital admissions, two used electronic databases and insurance claims to track rates (Min et al., 2007; Sledge et al., 2011), whilst one study used participant self-report (Rivera et al., 2007) and the other three studies used case manager report to document use of services (Craig et al., 2004; Klein et al., 1998; Wroblewski et al., 2015).

**Outcomes.** Outcomes will be considered in terms of statistical significance, effect sizes and, if relevant, clinically significant change. The outcomes connected to

rates and lengths of hospital admissions will be considered first, followed by those associated with psychological and social functioning.

*Rates and lengths of hospital admissions.* Three of the six studies found statistically significant differences in rates and lengths of hospital admissions between groups; individuals with peer support were less likely to be admitted to hospital, and if admitted, spent a shorter amount of time in hospital (Klein et al., 1998; Min et al., 2007; Sledge et al., 2011). Of the three studies that did not find a statistically significant effect, two were not sufficiently powered (Simpson et al., 2014; Wroblewski et al., 2015). In the final study, Rivera et al. (2007) found a reduction in rates and lengths of hospital admission for participants across all three conditions (peer support and community-based treatment as usual, community-based treatment as usual and clinic-based treatment as usual). The authors suggest that the robust programme of strengths-based case management, alongside individual and group therapy across all conditions could account for this finding, making it difficult to detect the impact of the peer support intervention (Rivera et al., 2007).

*Psychological and social outcomes.* Six studies investigated the impact of peer support on psychological and social outcomes. Table 6 summarises the findings of the between group effects; main effects of time are discussed in the body of the text. Of the six studies, three (all randomised designs) found no significant differences between the groups (Davidson et al., 2004; Simpson et al., 2014; Wroblewski et al., 2015). However, two were underpowered (Simpson et al., 2014; Wroblewski et al., 2015). The other found a main effect of time on general functioning, psychiatric symptoms and self-esteem; participants in all conditions improved on each of these measures from baseline to completion (Davidson et al., 2004).

Table 6: Psychosocial outcomes and effect sizes for between-group comparisons (severe mental illness studies)

Study	Measures	Main finding	ES <sup>a</sup>
Craig et al. (2004)	<i>Social Outcomes:</i>		
	Social Networks - Significant Others Scale		
	Life Skill Profile - Staff version		
	Social contact	PS > TAU	0.63
	Communication	PS > TAU	0.81
	Other 4 subscales		
	Social Participation	PS > TAU	-
	<i>Psychological Outcomes:</i>		
	Camberwell Assessment of Need - Staff version		
	Total needs		
	Unmet needs	PS > TAU	0.88
Camberwell Assessment of Need - Client version			
Total needs			
Unmet needs	PS > TAU	0.68	
Satisfaction with staff and services			
Davidson et al. (2004)	<i>Social Outcomes:</i>		
	Social Functioning Scale, Modified		
	Global Assessment of Functioning		
	<i>Psychological Outcomes:</i>		
	Centre for Epidemiologic Studies - Depression scale		
	Global Health Questionnaire		
	Wellbeing Scale		
	Brief Psychiatric Rating Scale		
Rosenberg self-esteem scale			

Table 6 (continued)

<b>Study</b>	<b>Measures</b>	<b>Main finding</b>	<b>ES<sup>a</sup></b>
Klein et al. (1998)	<i>Social Outcomes:</i>		
	Global Assessment of Functioning	PS > TAU	-
	Use of community resources		
	<i>Quality of Life Outcomes:</i>		
	Lehman Quality of Life		
	Living	PS > TAU	-
Rivera et al. (2007)	Income	PS > TAU	-
	Health	PS > TAU	-
	Remaining 2 subscales		
	<i>Social Outcomes:</i>		
	Pattison Network Inventory		
Simpson et al. (2014)	Number of contacts	PS > TAU	0.11
	Remaining 4 subscales		
	<i>Quality of Life Outcomes:</i>		
Simpson et al. (2014)	Lehman Quality of Life		
	<i>Quality of Life Outcomes:</i>		
	EuroQol (EQ-5D)		
Simpson et al. (2014)	<i>Psychological Outcomes:</i>		
	Beck Hopelessness Scale		
	UCLA Loneliness Scale		

Table 6 (continued)

<b>Study</b>	<b>Measures</b>	<b>Main finding</b>	<b>ES<sup>a</sup></b>
Wroblewski et al. (2015)	<i>Quality of Life Outcomes:</i> Lehman Quality of Life - brief version		

*Note: Min et al. (2007) and Sledge et al. (2011) are not included in the table as they did not use any psychological and social outcome measures.*

*<sup>a</sup>Effect sizes (Cohen's *d*) were calculated by the reviewer, apart from Rivera et al. (2007) who reported effect sizes. Where no effect size is given in the table, insufficient data was provided by the study authors for computation*

The results of the remaining three studies (two of which used randomised designs) were mixed and highly variable. Two studies found that individuals with peer support were significantly more likely to have greater levels of social contact compared to their controls (Craig et al., 2004; Rivera et al., 2007). However, when one study explored this further it was accounted for by increased number of contacts with staff members, rather than an increase in social contacts (Rivera et al., 2007). This is consistent with the Craig et al. (2004) finding of no significant differences between groups in the self-reported size of social networks. However, Craig et al.'s (2004) finding that individuals with peer support had significantly fewer unmet needs, both from a staff and self-report perspective, following completion of the intervention. Rivera et al. (2007) found a main effect of time on the other four subscales of the Pattison Network Inventory; that is, participants in all conditions improved on each on these subscales from baseline to completion (Rivera et al., 2007).

Only one study reported improvements in quality of life for individuals with peer support (Klein et al., 1998); however, this was a non-randomised study with a small sample size. One of the most methodologically robust studies did not find any significant differences between groups in terms of quality of life (Rivera et al., 2007). However, as previously noted, Rivera et al. (2007) suggest that the strength of other conditions may have made it difficult to detect between group effects.

Interestingly, Davidson et al. (2004) found that when the frequency with which individuals met with their supporters was included in the analysis, a different pattern of results emerged. Individuals assigned a peer partner showed greater improvement in psychological and social outcome measures if they did not meet with their partners, whereas individuals assigned a non-peer partner showed greater

improvements if they did. Only the non-peer partner condition showed improvements above and beyond the money stipend control, and this was only with regards to social functioning.

Of note, only one study provided effect sizes (Rivera et al., 2007); where possible effect sizes were calculated by the reviewer using Cohen's *d* (Cohen, 1992). Effect sizes for between-group differences ranged from small to medium (0.11-0.88). Given that none of the outcome measures used by studies have established clinical cut off points, reliable and clinically significant change was not reported.

### **Peer support for depression**

**Nature of the intervention.** The majority of the six depression studies provided a good account of the peer support intervention. Four explicitly discussed the aims of the intervention and how these aims were put into practice, the peer supporter role, and the training and supervision arrangements. The exceptions were of Dennis et al. (2009) and Letourneau, Secco, Colpitts, Aldous, Stewart and Dennis (2015), who did not specify the aims of the intervention or the nature of the peer supporter role.

Four studies explored the impact of peer support for postnatal depression (PND); of these, two focused on individuals considered to be at a high risk of developing PND (Dennis, 2003; Dennis et al., 2009) and two focused on women who had already been given a diagnosis of PND (Letourneau, Stewart, Dennis, Hegadoren, Duffett-Leger & Watson, 2011; Letourneau et al., 2015). The other two studies in this cluster examined peer support for individuals with a diagnosis of depression and supported by primary care services (Conner, McKinnon, Ward, Reynolds III & Brown, 2015; Hunkeler et al., 2000). Most studies explored the

impact of peer support on depressive symptomology (Dennis, 2003; Dennis et al., 2009; Hunkeler et al., 2000; Letourneau et al., 2011, 2015). One study also sought to explore the impact of peer support on feelings of self worth (Letourneau et al., 2015), and one aimed to explore the impact of peer support on internalised stigma (Conner et al., 2015). Of the four studies that reported aims, all intended to provide individuals with emotional and social support (Conner et al., 2015; Dennis, 2003; Hunkeler et al., 2000; Letourneau et al., 2011). Only two studies reported that peer supporters were encouraged to share their experiences of depression, treatment and recovery (Conner et al., 2015; Hunkeler et al., 2011). One study also instructed peer supporters to support individuals to engage with primary care services (Hunkeler et al., 2000). Another trained peer supporters to deliver a manualised version of parent-infant interaction training alongside the peer support (Letourneau et al., 2011).

All studies embedded their aims in the literature connected to their target population. Four studies based their aims in the PND literature (Dennis, 2003; Dennis et al., 2009; Letourneau et al., 2011, 2015). This emphasises how isolated mothers with post natal depression can feel, highlighting the protective nature of social support and the importance of providing a safe space to talk (Dennis, 2010; Eastwood, Jalaludin, Kemp, Phung, & Barnett, 2012). The other two studies drew on theories of engagement and an acknowledgement of the limitations of primary care services (Conner et al., 2015; Hunkeler et al., 2000), i.e., that people with a lived experience of mental health issues can have greater personal authority, which can improve the acceptability and therefore the accessibility of mental health support (Segal, Gomory & Silverman, 1998).

Table 7 summarises the delivery of peer support across the six studies. In three studies support was provided solely over the telephone. The other three studies

Table 7: Medium, duration and frequency of peer support (depression studies)

<b>Study</b>	<b>Medium</b>	<b>Intended frequency</b>	<b>Intended duration</b>	<b>Mean no. contacts (range)</b>	<b>Mean contact time, minutes (range)</b>
Conner et al. (2015)	Telephone support Home visits	Minimum 3 contacts At least 1 in person	12 weeks	9 (NR)	-
Dennis (2003)	Telephone support	Determined by study participant	8 weeks	5.4 (NR)	34.4 (6-90)
Dennis et al. (2009)	Telephone support	Minimum 4 contacts	Up to 12 weeks	8.8 (NR)	14.1 (1-180)
Hunkeler et al. (2000)	Telephone support Home visits	Minimum 1 contact	Up to 6 months	NR (1-20)	-
Letourneau et al. (2011)	Telephone support Home visits	Not documented	12 weeks	8.72 (NR)	< 20 (NR)
Letourneau et al. (2015)	Telephone support	Weekly calls	12 weeks	8.84 (1-14)	38.1 (NR)

*NR = Not reported*

aimed to provide support over the telephone and in person (home visits); two of these did not document the ratio of contacts made in person verses those made over the telephone (Conner et al., 2015; Letourneau et al., 2011) and the other reported that only six out of 42 individuals had at least one in-person contact (Hunkeler et al., 2000). The majority of studies reported the intended frequency and duration of contacts and all provided some information about the actual number of contacts achieved. The figures reported indicated that most of the studies were able to achieve the intended frequency of contact, with some studies exceeding intended levels. Most studies (five out of six) aimed to provide peer support for between eight to twelve weeks. Although studies varied in the intended frequency of contact, the average number of actual contacts reported was similar across four of the six studies (i.e. eight or nine contacts).

All studies reported the amount of training peer supporters received, which varied across the six studies ranging from one four-hour session with a supplementary manual (Dennis, 2003; Dennis et al., 2009) to 20 hours over several sessions (Conner et al., 2015; Hunkeler et al., 2000). All studies provided information about the content of training programmes, which covered subjects such as support skills, problem-solving skills and managing crisis and suicidality. Only two studies reported that peer supporters were provided with supervision (Conner et al., 2015; Letourneau et al., 2011). In one study individuals were provided with bi-weekly supervision groups (Conner et al., 2015); the frequency, duration and nature of supervision were not specified in the other study (Letourneau et al., 2011).

**Sample characteristics.** Studies required individuals to either have been given a diagnosis of depression or PND from the service they were recruited from, or for individuals to score in a particular range on a screening measure. Two studies

excluded individuals if they were taking antidepressant or antipsychotic medication (Dennis, 2003; Dennis et al., 2009) or if they had received psychotherapy in the previous 12 months (Dennis, 2003). There were more women than men across the studies (even in the two not focusing on PND, the majority were women). As would be expected, the average age of individuals was much younger in the four PND studies compared to the primary care depression studies. Not all studies reported participants' ethnicity; of the three that did, samples were predominantly composed of White-Caucasian individuals. Of note, for one study the sample was predominantly Non-Hispanic, White (74%) despite recruiting from what was described as a predominantly low-income African-American community (Conner et al., 2015). Table 8 summarises the sample characteristics.

*Table 8: Sample characteristics (depression studies)*

<b>Study</b>	<b>Age Mean (Range)</b>	<b>% Male</b>	<b>% BME</b>
Conner et al. (2015)	67	37	26
Dennis (2003)	(25-34)	0	-
Dennis et al. (2009)	(20-34)	0	19
Hunkeler et al. (2000)	55.4 (19-90)	31	32
Letourneau et al. (2011)	(26-35)	0	-
Letourneau et al. (2015)	26.3 (17-43)	0	-

**Study design.** Four of the six studies used randomised designs; the remaining two used uncontrolled longitudinal cohort designs.

*Randomised studies.* Of the four randomised studies, two compared peer support with treatment as usual (Dennis, 2003; Dennis et al., 2009). One compared peer support with a wait-list control (Letourneau et al., 2011) and one compared treatment as usual, treatment as usual plus nurse telephone support, and treatment as usual plus nurse telephone support augmented by peer support (Hunkeler et al., 2000). Three of the four studies reported their randomisation methods. Of these,

two used sealed, sequentially numbered, opaque envelopes (Dennis, 2003; Letourneau et al., 2011); the other used a centralised, web-based system to randomise participants into treatment and control groups (Dennis et al., 2009). All studies documented who collected data, but only two studies explicitly mentioned whether individuals collecting data were blind to treatment group (Dennis, 2003; Dennis et al., 2009).

All studies compared participant outcomes pre- and post- intervention, with two studies including an additional measure halfway through the intervention period (Dennis, 2003; Letourneau et al., 2011) and another study including an additional measure six weeks into the six month intervention period (Hunkeler et al., 2000). Of note, only one study included a follow-up period: Dennis et al. (2009) followed up individuals 12 weeks after completing the intervention. All studies conducted between-group analyses at baseline; no significant differences between the experimental and control groups were reported. Three studies documented an ITT analysis; all reported no significant differences between individuals who completed the intervention and those who dropped out or were lost to follow-up (Conner et al., 2015; Dennis, 2003; Dennis et al., 2015). Only two studies explicitly reported the power analysis that was conducted to inform sample size (Dennis et al., 2009; Letourneau et al., 2011); of these, only one was able to recruit a sufficient sample size to accommodate for losses to follow-up (Dennis et al., 2009).

*Uncontrolled studies.* Two studies employed uncontrolled longitudinal cohort designs, comparing outcomes for participants before and after the peer support intervention (Conner et al., 2015; Letourneau et al., 2015). Both studies made use of self-report questionnaires to collect data (Conner et al., 2015; Letourneau et al., 2015). Neither study completed an ITT analysis; furthermore there was no

documentation of drop-out rates or individuals lost to follow-up, although Letourneau et al. (2015) did document reasons for non-completion.

Both studies recruited samples from appropriate community-based services. Inclusion and exclusion criteria were clearly documented in each study. Participants were screened using appropriate measures. In the Conner et al. (2015) study individuals had to score ten or above on the PHQ-9 to be eligible to participate; that is, they endorsed at least moderate symptoms of depression. To meet the eligibility criteria in the Letourneau et al. (2015) study, individuals had to score between 12-19 on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987), which is considered indicative of major depression (Gibson, McKenzie-McHarg, Shakespeare, Price & Gray, 2009).

**Outcome measures.** All six studies mainly used self-report measures to track outcomes, although some did make use of observational measures (e.g, Nursing Child Assessment Satellite Training, used by Letourneau et al., 2011) and interview measures (Hamilton Depression Rating Scale-Interview Form, used by Hunkeler et al., 2000). Some studies also used information from electronic recording systems to capture use of services (Dennis, 2003; Dennis, 2009; Letourneau et al., 2011) and adherence to medication (Hunkeler et al., 2000). Two studies also attempted to capture satisfaction with services; one using a validated scale (Hunkeler et al., 2000) and another using a study specific measure (Letourneau et al., 2015). Apart from the three studies which used the Edinburgh Postnatal Depression Scale (Dennis, 2003; Dennis et al., 2009; Letourneau et al., 2015) and the two studies that used the UCLA Loneliness Scale (Dennis, 2003; Dennis 2009), no two studies used the same outcome measure. This level of variability makes it difficult to compare findings

across studies. With the exception of Letourneau et al. (2015), all studies discussed the psychometric properties of the chosen measures.

**Outcomes.** Outcomes were considered in terms of statistical significance, effect sizes and, where relevant, clinically significant change. Table 9 summarises the findings of between-group comparisons for the four controlled studies. Main effects of time are discussed below.

Two of the four studies that used randomised designs found that individuals with peer support reported significantly lower levels of depressive symptomology compared to their controls (Dennis, 2003; Dennis et al., 2009). One study reported that the addition of peer support to nurse tele-healthcare did not significantly reduce depressive symptomology (Hunkeler et al., 2000). The authors suggest the poor implementation of the peer support condition (only 50% had more than one contact and less than 10% had face-to-face contact) could account for these findings.

The other study that used a randomised design found the significant reduction in depressive symptomology favoured the control group in comparison to the intervention group, although all groups were observed to have a significant reduction in depressive symptomology over time (Letourneau et al., 2011). This result was also observed for social provision, with individuals in the control group reporting significantly greater levels of social support compared to individuals receiving peer support (Letourneau et al., 2011). The authors suggest that higher severity of depressive symptomology in the intervention arm could account for these findings (Letourneau et al., 2011). Furthermore, the peer support intervention in this study also included a peer-delivered manualised maternal-infant interaction teaching component, which was not found to be effective in improving mother-child

Table 9: Outcomes and effect sizes for between-group comparisons (depression studies)

Study	Measures	Main finding	ES
Dennis (2003)	Edinburgh Postnatal Depression Scale > 9	PS > TAU	-
	Edinburgh Postnatal Depression Scale > 12	PS > TAU	-
	Rosenberg Self-Esteem Scale		
	Child-Care Stress Checklist		
	UCLA Loneliness Scale		
Dennis et al. (2009)	Edinburgh Postnatal Depression Scale	PS > TAU	0.19
	State-Trait Anxiety Inventory		
	UCLA Loneliness Scale		
	Use of services		
Hunkeler et al. (2000)	Hamilton Depression Rating Scale-Interview		
	Beck Depression Inventory		
	Patient Satisfaction with Treatment Scale		
Letourneau et al. (2011)	Edinburgh Postnatal Depression Scale	TAU > PS	0.09
	Nursing Child Assessment Satellite Training Scales:		
	Feeding Scale		
	Teaching Scale	PS > TAU	0.08
	Social Provisions Scale	TAU > PS	0.08
	Salivary Cortisol levels (maternal and infant)		

Note: Conner et al. (2015) and Letourneau et al. (2015) are not included in the table as they are longitudinal cohort studies.

<sup>a</sup>Effect sizes (Cohen's *d*) were calculated by the reviewer, apart from Letourneau et al. (2011) who reported effect sizes. Where no effect size is given in the table, insufficient data was provided by the study authors for computation

interactions (Letourneau et al., 2011). It is possible that this may have reduced the impact of the peer support intervention, making it less effective than peer support alone.

Both studies that used uncontrolled designs found that individuals with peer support reported significantly lower levels of depressive symptoms on completion compared to pre-intervention self-report (Conner et al., 2015; Letourneau et al., 2015). Of note, only one of the six studies reported effect sizes (Letourneau et al., 2011). Where possible, effect sizes were calculated based on the data provided by the study using Cohen's *d* (Cohen, 1992). Across the six studies, effect sizes were small (range = 0.08-0.19). No studies reported reliable and clinically significant change. This is noteworthy given that a number of the outcome measures have clinical cut-off points.

## **Discussion**

This review examined 14 studies of one-to-one peer support interventions, organised into two clusters: eight studies of peer support for severe mental illness and six for depression. All interventions aimed to provide emotional and social support, and were embedded in theoretical models relevant to the target population (e.g. the recovery model for those with severe and enduring mental health issues, and social support for postnatal depression). Of great strength, the majority of studies reported in detail the characteristics of the intervention, enabling the reader to understand what was being evaluated; this is particularly important given the heterogeneity of peer support interventions.

The findings of the studies, both within and across the two clusters, were mixed. For severe mental illness, there was no consistent evidence of peer support

leading to an improvement in psychological and social functioning, or to a reduction in rates or lengths of hospital admission. Similarly, the depression studies showed variable results in terms of a reduction in depressive symptoms, with some finding improvement and some not. This broad picture of mixed findings is consistent with previous reviews of peer support (e.g. Fuhr et al., 2014; Lloyd-Evans et al., 2014), highlighting that despite rising prominence in service provision, peer support is yet to rest on a secure empirical base.

The methodological quality of the studies was also mixed. Of the 14 studies, ten used randomised designs, two used uncontrolled longitudinal cohort designs and two used non-randomised comparison designs. There were some serious flaws in several of the randomised studies included in this review. In particular, two were statistically underpowered, with very small sample sizes (Simpson et al., 2014; Wroblewski et al., 2015), which means that any possible effects of peer support would not be detected. Another study using a randomised design was unable to implement the peer support intervention as planned (Hunkeler et al., 2000), whilst one found that the baseline severity of depressive symptoms was higher in the peer support arm compared to the control group, which confounded the between-group comparison post-intervention (Letourneau et al., 2011).

There was no clear pattern regarding the relationship between the methodological quality of the studies and their findings. Even for the best-designed RCTs, some outcomes showed improvement and others did not. However, it is of note that the four studies that employed non-randomised designs produced more favourable results: peer support was associated with a significant reduction in the rates and lengths of hospital admissions for severe mental illness (Klein et al., 1998; Min et al., 2007) and significant reduction in depressive symptomology (Conner et

al., 2000; Letourneau et al., 2015). Yet this evidence must be interpreted cautiously as the studies were open to bias, particularly self-selecting bias.

Despite the mixed findings, there was one interesting trend suggesting that peer support for severe mental illness has the potential to reduce the rates and lengths of hospital admission. Although there were six studies that explored this, two were significantly underpowered (Simpson et al., 2014; Wroblewski et al., 2015). Three of the four remaining studies found that peer support significantly reduced the rates and lengths of hospital stay, although two of these three studies were non-randomised (Klein et al., 1998; Min et al., 2007). The authors of the other study found a main effect of time for all the conditions and suggest that the alternative arms of the study may have been too robust to find a statistically significant between-group effect (Rivera et al., 2007).

One could hypothesise that a reduction in rates and lengths of hospital admission could be brought about by improvements in psychological and social functioning. However, this review found no consistent evidence for improvements in these domains. It may be that the measures of psychological and social functioning used, which tend to assess distal outcomes, do not tap into the particular mechanisms that underpin peer support for people with severe and chronic mental health issues. The recovery model, which was drawn on by all of the severe mental illness studies, emphasises the role of hope and empowerment in the journey of recovery and seeks to move away from the focus on the reduction of symptoms. This perspective encourages service users to find ways to live meaningful lives (whatever this means to them), even if the presence of their symptoms persists or fluctuates. Arguably symptom- or functioning-focused outcome measures do not capture or measure these concepts, which could perhaps explain the mixed findings of this review and of the

literature base as a whole. If future peer support studies continue to embed their ideas in the recovery literature, then there should be a move away from symptom-related measures and a move towards measures central to the recovery model, such as hope and empowerment.

It should be noted that two studies in this review suggested that, in certain contexts, peer support interventions may be less effective than those delivered by non-peers. In exploratory analysis Davidson et al. (2004) found that when the rate at which individuals met with their peer supporter was taken into account, individuals with a non-peer supporter improved if they met with their partner, whereas individuals with a peer supporter appeared to improve if they did not meet with their partner at all. The authors suggest that non-peer partners provide an avenue out of the confines of the mental health system and introduce them to a more normative social circle that is valued by individuals with mental health issues. Letourneau et al.'s (2011) study of postnatal depression found significant between-group effects that favoured the control group rather than the intervention group. The authors suggest that maternal-infant interaction teaching (which was a substantial component of the intervention) may be difficult for peers to deliver or may not be well received by mothers. These two studies highlight the importance of examining for whom, and in what contexts, peer support is ineffective or actually unhelpful.

Overall, there were a number of important differences between the peer support interventions for severe mental illness and those for depression. All of the severe mental illness studies made use of face-to-face interventions, whereas almost two-thirds of the depression studies made use of telephone-based support. Typically, the severe mental illness peer support interventions were implemented over much longer periods of time. With a few exceptions, the depression interventions met

intended frequency targets compared to the severe mental illness interventions. Again, this could reflect a difference in the severity of the different diagnoses and the difficulties that can be encountered in engaging individuals with chronic mental health issues. However, this also points to the importance of tailoring peer support interventions to their particular target populations; the nature and format of peer support that is most appropriate or effective could vary from one population to another. From a research perspective, it is therefore particularly important that studies report in sufficient detail the nature of the peer support intervention and the target population.

With regards to the samples of participants, the severe mental illness studies were largely composed of men from black and minority ethnic communities, whereas the depression studies were largely composed of women from white communities. It could be argued that these study samples are representative of individuals who are more likely to receive those particular diagnoses. However, the fact that the samples differed in such a way may also say something about how the mental health issues of members of black and minority ethnic groups are expressed and understood, alongside the ability of services to engage individuals from these communities earlier on in their mental health journey or in less coercive ways (Bhui & Morgan, 2007).

### **Methodological considerations and quality of reporting**

All studies provided detailed information about the nature of the peer support intervention, which enabled similarities and differences across the studies to be considered. However, not all studies documented whether peer supporters were encouraged and supported to share their own experiences of mental health and recovery with participants. As this is hypothesised to be a central tenant of peer

support, future studies would benefit from ensuring this is included in interventions and documented accordingly. Furthermore, only half of the severe mental illness studies reported the achieved frequency of contact between peer supporters and participants, which made it difficult to explore whether the intensity of the intervention was related to outcome. Future studies would benefit from documenting how the aims of the intervention translated into practice in order for this to be considered.

In general, the quality of methodological reporting was also good, with the majority of studies meeting the guidelines of the CONSORT and TREND statements (Schulz et al., 2010; The TREND Group, 2004). However, future randomised studies would benefit from clearer documentation of randomisation methods and blinding of data collection. It would also be helpful for future studies to clearly document the power analysis that informed the choice of sample size. Future non-randomised studies, particularly those that employ uncontrolled designs, would benefit from reporting information on non-completers and those lost to follow-up.

As noted earlier, the quality of the design of the studies was mixed. There were several strengths: the majority of studies that used randomised methods chose appropriate comparison conditions, although some conditions may have been too robust to detect between-group difference (Rivera et al., 2007). However, over three quarters of the studies did not include a follow-up period in their design. Future randomised studies of one-to-one peer support interventions would benefit from including follow-up periods in order to capture longer term outcomes. With regards to the non-randomised studies, participants were recruited from relevant community samples and, where appropriate, comparison groups were also drawn from a similar pool to the participants. However, the nature of the recruitment and referral

processes in these studies potentially introduced self-selecting bias, meaning that participating individuals may have been more likely to engage in the intervention in the first place and experience it as helpful.

There was high variability in the choice of outcome measures which added to the complexity of interpreting results. Not all of the studies commented on the psychometric properties of their outcome measures, although the depression studies were much better at doing this compared to the severe mental illness studies. Of note, only two studies out of the 14 reported effect sizes and none of the relevant studies reported reliable and clinically significant change even though their outcome measures had clinical cut-off points. These issues typify some of the challenges that face the peer support literature and make it difficult to discern whether non-significant results are evidence of inefficacy or problems with design and measurement.

### **Limitations of the review**

Several studies included in this review were methodologically weak, e.g. statistically underpowered. Whilst these could have been screened and excluded from the beginning, given the small number of studies that were found during the systematic search, it was decided not to employ more restrictive exclusion criteria. Furthermore, although it was difficult for these studies to contribute to the consideration of the outcomes for one-to-one peer support, they did contribute to the assessment of the aims and characteristics of one-to-one peer support and how these were specified and reported.

The review did not include studies published in the 'grey' literature. This may explain why so few uncontrolled and non-randomised studies came up in the

search, as these types of studies are less likely to be published in peer-reviewed journals. Although they are less methodologically rigorous than randomised studies, non-randomised and uncontrolled studies can be particularly informative in the preliminary stages of gathering an evidence base (Barker et al., 2016).

Finally, this review excluded studies that employed qualitative methods. Although qualitative studies come with their own limitations, they can be a useful part of the research process particularly when there is a limited understanding of how and in what contexts an intervention is effective (Barker et al., 2016). Given the mixed nature of the results of the current review, perhaps returning to the qualitative literature could provide some useful direction for future research into one-to-one peer support.

### **Implications for research and clinical practice**

Future research studies would benefit from ensuring appropriate methodological rigor, both in terms of design and reporting, in order to overcome the challenges that face the peer support literature currently. Although the majority of the studies in this review provide an excellent overview of the nature of the interventions they investigated, methodological issues, particularly around statistical power, make it challenging to interpret the findings of the studies.

Some of the findings of this review tentatively suggest that peer support can reduce the length and rate of hospital admission for individuals with chronic mental health issues. Given the cost and challenges of acute hospital admission, this is a finding that warrants further research, in particular because it does not appear to be explained by a concurrent reduction in psychological symptoms or an improvement in the social networks of individuals. Perhaps qualitative studies could provide some

insight into how individuals with severe mental illness understand this, which could inform future quantitative studies.

Although all of the studies in this review situated their research within a theoretical framework, it could be argued that the theory underlying peer support is still not fully understood or translated appropriately into research. Most studies embedded their research in recovery principles or the role of social connectedness and social support in promoting mental wellbeing. Yet the varied and at times confusing results of this review suggest that these theories perhaps do not fully account for the mechanisms of peer support. Perhaps the recovery principles are not reflected in the outcome measures used. Future research should include measurement of outcomes that are more closely linked to the recovery model, such as hope and empowerment.

It would be beneficial for future research to explore whether the quality and nature of the relationship between peers impacts on the outcomes observed. All of the studies in this review evaluated social relationship interventions which were expected to improve outcomes for participants, implying there was a therapeutic element to the interactions between peer supporters and participants. Yet, none of the studies explored whether the quality of the relationship between peer supporters and their recipients had an impact on outcomes. It was Rogers (1957) who first suggested there were core components which needed to be present for a relationship to be therapeutic, regardless of the formality of the context in which this occurred. Similar to that which has been observed in the psychotherapy process literature (i.e. Martin, Gaske & Davis, 2000), perhaps the quality of a one-to-one peer relationship is a significant factor in outcomes for participants. This could potentially account for

the mixed and variable results observed in this review, but also in the literature base as a whole.

All of the studies in this review explored one-to-one peer support in community settings. Indeed, this seems to be the main setting in which peer support is applied and researched; there has been little research into peer support in other mental health settings, such as inpatient environments or supported accommodation. Future research would benefit from widening the setting in which peer support is studied, not only to improve the services available to individuals at each stage of their mental health journey, but also to contribute to the evidence base. Furthermore, the studies in this review focused on severe mental illness and depression (in particular PND), which do not represent the full spectrum of mental health issues faced by individuals. Future research would benefit from exploring one-to-one peer support for other prevalent mental health issues, such as anxiety or personality disorder.

In terms of planning and delivering services, it is important for clinicians to hold in mind that one-to-one peer support interventions do not yet rest on a sound empirical base. However, this should be balanced with the feedback from service users and service user organisations, which consistently emphasise the importance of this type of peer support and advocate for its place in recovery. Clinicians may find it challenging to have these types of services commissioned without empirical support; yet it could be argued that without the commissioning of services, the evidence base is less likely to develop further. This review has identified several promising avenues for future research. Given the popularity of peer support and the theoretical rationale for why it might enhance psychological wellbeing, collaborative

efforts between service users, researchers, clinicians and commissioners are needed to promote further research into its effectiveness.

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## **Part II: Empirical Paper**

**Naturally occurring peer support in inpatient mental health settings**

**Service users' experiences**

## **Abstract**

**Aims:** Research on peer support in mental health inpatient settings has focused on formalised peer support interventions. Less attention has been given to the ways in which service users naturally support one another during their inpatient stay. This study aimed to explore service users' experiences and perceptions of mutual, naturally occurring peer support in acute inpatient settings.

**Methods:** Twelve service users from five inpatient wards took part in semi-structured interviews. Their experiences of giving and receiving support were explored, including both helpful and unhelpful aspects as well as barriers to peer support. Interview transcripts were analysed using thematic analysis.

**Results:** Participants described a range of mutually supportive interactions that were highly valued. Themes included "Responding to distress", "Talking about personal stuff" and "We're stronger if we work together". They also described several barriers and challenges, such as having to "tread carefully" and "personal difficulties", which made it difficult to engage in both giving and receiving support.

**Conclusions:** The findings highlight how important naturally occurring peer support can be for service users during their inpatient stay, and how it can contribute to their recovery. Participants' accounts could be used to inform ward strategy, policy and procedure, e.g. by creating an environment for peer support opportunities to occur and addressing the challenges and barriers to peer support. Further research is needed to understand staff perceptions of peer support in this setting.

## **Introduction**

Over the past decade there has been a growing recognition of the potential role for peer support in mental health services. This coincides with the development of the recovery model, which privileges improving the meaning and quality of the lives of those who face mental health issues over the sole focus on symptom reduction (Shepherd, Boardman & Slade, 2008; Slade, 2010). With this has come an appreciation of the knowledge and expertise of service users, particularly their ability to engage one another where professionals may struggle. Whilst the development and evaluation of peer support in mental health services has largely focused on community settings, such as employing peer support workers in community mental health teams (Repper & Watson, 2012), there have been some steps towards exploring the potential role of peer support in inpatient settings.

### **Inpatient mental health provision in the UK**

Acute care is a significant component of mental health services and expenditure in the British NHS (Healthcare Commission, 2008). Although the number of admissions to inpatient wards has remained stable over the past three years, since 1998 the overall number of acute beds has decreased by 39%, putting pressure on the availability of inpatient resources (Independent Mental Health Task Force, 2016). Not only does this mean there is now a higher threshold for admission, but it has also been linked to an increase in the severity of distress on admission and the number of admissions by detention under the Mental Health Act (Independent Mental Health Task Force, 2016).

These pressures are likely to have impacted on the quality of care provided by inpatient units. Inpatient care continues to be one of the largest sources of complaints from service users, who frequently report their experiences of inpatient

admission to be unhelpful, frightening and aversive (MIND 2004, 2011; Wood & Pistrang, 2004). Indeed, qualitative and service-user led research commonly cite that service users report acute inpatient settings to be disempowering, degrading and counter-productive to their recovery, particularly because of the coercive practices that are used (Gilbert, Rose & Slade, 2008; Kumar, Guite, & Thornicroft, 2001).

It is out of this context that peer support in inpatient services has developed. From a theoretical perspective, living through an experience gives an individual “experiential knowledge” (Borkman, 1990). Service users are thought to draw on their knowledge of mental health issues and inpatient admission as they support one another, using it to normalise experiences and share resources and coping strategies (Solomon, 2004). As well as providing validation of their abilities to cope, these interactions also bring opportunities for individuals to support others (Solomon, 2004). Being in the helper position can confer status and ability on service users, boosting their confidence and self-esteem (Reissman, 1965; 1990). In this manner, these processes can be viewed as empowering practices: they encourage service users to be active agents in their recovery rather than simply passive recipients of support (Solomon, 2004).

### **Peer support in inpatient settings**

Whilst still in its infancy, the literature on peer support in inpatient settings has centred on the development and evaluation of formalised, intentional and unidirectional interventions, i.e., the employment or voluntary contribution of peer support workers on wards. Peer support workers have a ‘lived experience’ of mental health issues and are typically further ahead in their recovery journey compared to those admitted to the ward (Bradstreet, 2006). They can be integrated into the ward team or part of another organisation (often from the voluntary sector) that works in

partnership (Bradstreet, 2006; Ockwell, 2012). The roles they undertake can vary widely and are often negotiated between the peer support worker, the service users on the ward and the ward staff (Bradstreet, 2006). This can include, but is not limited to: socialising and talking to those on the ward, helping to promote attendance at therapeutic groups, meeting practical needs, and supporting relationships between staff and service users (Bradstreet, 2006; Ockwell, 2012).

Unidirectional and formalised peer support interventions have been shown to bring benefits for service users, staff members and peer support workers alike (Ockwell, 2012; Repper, Aldridge, Gilfoyle, Gillard, Perkins & Rennison, 2013; Repper & Carter, 2010). For example, one programme found that employing peer support workers on acute wards improved the mood of service users on the ward, increased the amount of meaningful and engaging activities that occurred on the ward, freed up staff time to support those most in need, and also improved the confidence, self-esteem and employability of the peer support workers themselves (Ockwell, 2012).

Despite the growing interest in formalised, unidirectional peer support interventions, less attention has been given to the naturally occurring mutual support that service users give to and receive from one another during their time on the ward. This has perhaps been influenced by the current climate of acute care: with the decrease in the number of inpatient beds, individuals are often more acutely unwell on admission and therefore it is assumed that they are less able to support one another during their inpatient stay (Ockwell, 2012).

### **Mutual peer support in inpatient settings**

Several qualitative studies point to the potentially important role of mutual, naturally occurring peer support on acute wards. Two studies that explored the

therapeutic experiences of service users in inpatient settings highlighted that service users valued peer support as more beneficial than the support they received from staff members (Shattell, Andes, & Thomas, 2008; Thomas, Shattell, & Martin, 2002). Service users have also reported that inpatient settings do not always explicitly encourage or make use of mutual peer support in the way in which other settings do, such as therapeutic communities (Loat, 2006).

It was observed in a piece of service-user led research that participants largely spoke about their inpatient experiences in the context of the people they met (Gilbert et al., 2008). Whilst they noted instances of poor communication between themselves and staff members, there were no such negative references to supportive interactions between service users. Although participants highlighted that the challenges of others could make the ward a difficult place to be, they also spoke of the understanding and companionship they gained from making connections with other service users whilst there (Gilbert et al., 2008).

However, whilst the results of the above studies highlight the potential role for mutual peer support in inpatient settings, mutual peer support was not the specific focus of the research. Only one study has specifically explored service user experiences of mutual peer support in inpatient settings. Bouchard and colleagues (Bouchard, Montreuil & Gros, 2010) interviewed ten service users from two short-stay and two long-stay wards about their experiences of mutual peer support and the barriers and facilitators of helpful interactions. The findings of their 'descriptive analysis' indicated that peer support in inpatient settings included sharing material goods, helping with activities of daily living, sharing a social life, providing information and advice, and offering emotional support (Bouchard et al., 2010). The giving and receiving of peer support had a number of perceived benefits including

feeling safer on the ward, feeling more hopeful regarding recovery, and increased participation in ward activities, such as therapeutic groups (Bouchard et al., 2010).

Although the Bouchard et al. (2010) study provides a broad picture of peer support in inpatient settings, it does not examine in detail the nature of supportive interactions between peers. For example, it mentions that “emotional support” occurred, with little elaboration of what this consisted of. Furthermore, the study presents a uniformly positive picture; it is unclear whether Bouchard et al. (2010) explored potentially unhelpful aspects of mutual peer support. This could be particularly important given the concerns and beliefs that mental health practitioners voice about peer support; namely that it is unsafe, risky and often counters the advice of professionals (Salzer, Rappaport & Segre, 2001).

### **Aims of the current study**

The current study aimed to build on the findings of the study by Bouchard et al. (2010) by paying close attention to the nature and processes of supportive interactions between service users on the ward. The study aimed to elicit detailed accounts of interactions involving the giving and receiving of peer support, and participants’ thoughts and feelings about these interactions. It also aimed to provide a more balanced picture by explicitly asking about the possible unhelpful or challenging aspects of these experiences.

The study took a qualitative approach, using semi-structured interviews. Qualitative methods enable the gathering of rich, in-depth and complex information regarding personal experience and understanding (Barker, Pistrang & Elliott, 2016; Geertz, 1973). They can be used to understand and capture the views and perspectives of individuals in all their complexity, as they experience and live through situations (Elliott, Fisher & Rennie, 1999). In this way, qualitative

approaches are also valuable in “giving voice” to participants, particularly those whose views are not represented (Barker et al., 2016).

The study addressed the following research questions:

- (1) What are service users’ experiences of both giving and receiving naturally occurring peer support during their time on an acute inpatient ward?
- (2) In what ways are these interactions perceived as helpful or unhelpful?
- (3) What (if any) are the barriers to engaging in supportive interactions in an inpatient setting?

## **Method**

### **Setting**

The study took place in an outer London psychiatric hospital, which provided acute inpatient care to adults experiencing mental health difficulties. There were five single-sex short stay wards (two female and three male) that provided assessment and treatment; this included pharmacological interventions, talking therapies and follow-up support in the community. The average length of stay was five to six weeks, although some service users were admitted for much longer periods of time due to issues with accommodation. Wards employed a variety of professionals including doctors, psychiatric nurses, occupational therapists, support workers, psychologists and other psychotherapists, such as art therapists.

### **Ethical approval**

The study was part of a broader programme of research on psychological support in inpatient settings, which was approved by a committee of the National Research Ethics Service (see Appendix A). Approval was also obtained from the local research and development department of the NHS Trust of the hospital (see Appendix B).

## **Recruitment**

Service users were eligible to participate if they: (1) were aged 18 years or older; (2) spoke English well enough to participate in a semi-structured interview; (3) had been on the ward for at least two weeks; and (4) were considered well enough to participate, as judged by a member of the ward multidisciplinary team (MDT).

Eligible participants were recruited from each of the five acute wards and identified through consultation with members of the ward MDT (including clinical psychologists, psychiatric nurses, support workers and occupational therapists). Given the heterogeneity of peer support, it was considered important to recruit a range of participants and therefore a purposive sampling procedure was used. Purposive sampling enables researchers to recruit participants based upon desired characteristics, with the aim of increasing the likelihood that a variety of perspectives and experiences will be included (Barbour, 2000). In this study, the researcher kept a record of participant demographics as the sample was recruited and used this to recruit as diverse a sample as possible according to age, gender, ethnicity, diagnosis and length of stay.

It was assumed that the longer individuals had been on the ward the more experiences they would have to reflect on, and therefore service users were invited to participate towards the end of their stay on the ward. Potential participants were initially approached and informed about the study by an MDT member of staff. Those who expressed an interest in participating were introduced to the researcher by the same member of staff. Individuals were then provided with verbal and written information regarding the nature and purpose of the study, particularly highlighting

*Table 1: Participant Characteristics*

<b>Participant Number</b>	<b>Age</b>	<b>Gender</b>	<b>Primary Diagnosis</b>	<b>Length of stay (weeks)</b>	<b>First inpatient admission</b>
1	20s	Male	Paranoid Schizophrenia	8	No
2	30s	Male	Paranoid Schizophrenia	18	No
3	20s	Male	Depression	5	Yes
4	50s	Male	Schizoaffective Disorder	24	No
5	30s	Male	Drug induced mania	4	No
6	50s	Female	Depression	10	Yes
7	20s	Female	Emotionally Unstable Personality Disorder	20	No
8	40s	Male	Bipolar Affective Disorder	8	Yes
9	50s	Female	Depression with psychotic symptoms	4	No
10	20s	Male	Paranoid Schizophrenia	9	No
11	20s	Female	Bipolar Affective Disorder	8	Yes
12	20s	Female	Depression	24	Yes

that this was independent from the care they received and that they were free to withdraw at any point without giving a reason (see Appendix C for the service user information sheet). Interviews were arranged at the convenience of the participant. They provided written consent on the day of the interview (see Appendix D for the consent form).

### **Characteristics of participants**

Of the 16 service users invited to participate from the five acute wards, 12 consented to take part and four declined. The main reasons for declining were being discharged from the ward and not wishing to return for an interview; not having time for an interview; and not wishing to be audio-recorded.

The characteristics of participants are summarised in Table 1. The seven men and five women ranged in age from 20 to 58 years ( $M = 34$ ). Seven (58%) were White British, two (16%) were White European, two (16%) were Black British and one (8%) was Asian British. Five (42%) had a primary diagnosis of a mood disorder and four (33%) had a primary diagnosis of psychosis. One individual had a primary diagnosis of personality disorder and one individual had a primary diagnosis of drug induced mood disorder. Two individuals also had neurodevelopmental diagnoses of Autism Spectrum Disorder and Mild Learning Disability. The length of time participants had been on the ward at the time of interview ranged from four to 24 weeks ( $M = 12$  weeks).

### **Interviews**

A semi-structured interview schedule was developed specifically for this study (See Appendix E). It explored experiences of being supported by and providing support to other services users whilst on the ward and aimed to gather both positive and negative experiences, barriers and facilitators to peer support, and how

staff played a role (if any) in facilitating these interactions. The first two interviews with service users highlighted how the concept of ‘support’ did not seem to help participants to think about and discuss their experiences. In response to this, the interview schedule was altered and questions were re-worded based on more tangible concepts, such as ‘making connections with other service users’ or ‘talking about what is on your mind’. Additional prompts were also added to try to elicit detailed descriptions of peer support interactions, i.e. concrete examples rather than general statements.

Interviews were conducted in a semi-structured style. Questions from the interview schedule were used in a flexible manner, with no set order and the opportunity to follow up on participant responses using prompts. Participants were explicitly encouraged to contribute their own experiences and opinions not covered by the interview schedule. Interviews with service users followed a number of best practice guidelines (Clinks, 2015; Faulkner, 2004; Holloway & Wheeler, 2013), including:

- Discussing the researcher role at the beginning of each interview
- Returning to discussing confidentiality throughout the interview, as and when needed
- Beginning with ‘small talk’ and some easy open-ended questions in order to make participants feel as comfortable as possible
- Providing regular, encouraging feedback to the service user throughout the interview
- Following up short answers with prompts, such as “can you tell me more about that?” or the repetition of a key phrase followed by a pause
- Offering regular breaks throughout the interview

- Clearly signposting changes in topic
- Not interrupting, even if answers were long
- Being prepared to ask the same question in different ways
- Clarifying misunderstandings as soon as possible
- Being aware of possible sensitive topics

It was hoped this would support service users through the interview process and encourage them to be as candid and detailed as possible in their responses.

All interviews were arranged at the convenience of participants. They took place in a quiet room on the ward and were audio-recorded. The length of interviews ranged from 50 to 80 minutes (Mean = 66 minutes). At the end of each interview there was a debriefing period for participants to talk about their experience of being interviewed and any difficult feelings that may have been brought up. Participants received a £10 voucher for a local supermarket to thank them for their time.

### **Analysis**

Audio-recordings of the interviews were transcribed verbatim. Half of the transcripts were transcribed by the researcher. The remaining transcripts were transcribed by research assistants and a transcription service. In order to ensure accuracy and quality, the researcher reviewed each transcript whilst listening to the audio-recording of the interview.

Transcripts were analysed using thematic analysis (Braun and Clarke, 2006). Thematic analysis was chosen because, of major strength, it is not tied to any one theoretical framework and therefore, is compatible with a range of epistemological approaches (Braun & Clarke, 2006). The analysis aimed to generate a rich understanding of participants' experiences, taking an inductive approach (i.e. starting with a close examination of the descriptions given by participants) in order to stick as

closely to the data as possible. However, because of the impact that mental health issues and medication can have for individuals, some interpretation of participant accounts was also necessary.

The analysis followed the steps outlined by Braun and Clarke (2006). In order for the author to familiarise herself with the data, the first stage of analysis involved reading and re-reading each transcript. At this stage, preliminary thoughts and ideas, as well as key words or phrases, were noted down. In the second stage of analysis, initial codes were developed in an inductive manner, based upon participants' actual words (please see Appendix F for examples of initial annotations and codes). Areas of uncertainty that might require a more interpretative approach were also noted down. In the third stage, initial codes for each transcript were grouped together into preliminary themes and summarised in a 'summary sheet' for each participant (see Appendix G). All of the summary sheets were then examined to generate a tentative thematic framework, which was mapped out using a table (see Appendix H). In the final stage of analysis, the author returned to each individual interview transcript to cross-check that participant accounts mapped onto the thematic framework. Theme labels were then adjusted or refined, and some initial themes were amalgamated or dropped if there was insufficient data to support them.

Each stage of the analysis was completed in a cyclical and iterative manner (Braun & Clarke, 2006). Of note, the analysis did not solely focus on the most prevalent themes, but sought to reflect the depth and the nuances both across and within participant accounts; it was considered important to include salient participant experiences even if they were not common across the dataset.

**Credibility checks.** Credibility checks were included in the analysis in accordance with good practice guidelines (Barker & Pistrang, 2005; Braun & Clarke,

2006). The researcher undertook the analysis, but a consensus approach was used: a subset of the transcripts were coded by both by the author and the research supervisor and then compared and discussed; supervision was also used to examine areas of uncertainty from the second stage of the analysis that required interpretation. This allowed for other interpretations of the data to be considered and insured an inductive approach was taken as much as possible. The author and the research supervisor also explored a number of different ways of synthesising codes and themes before the final overarching thematic framework was generated. This framework was closely cross-checked with participant accounts to ensure it was representative. Quotations from participants have been used throughout to ensure interpretations were grounded in the data. Unfortunately, it was not possible to carry out respondent validity checks (i.e. asking for participant feedback on the results; Barker & Pistrang, 2005) given the nature of setting in which the research was carried out and the constraints of the research project.

### **Researcher perspective**

I am a white woman in my late twenties and carried out this research as part of my doctorate in clinical psychology. At the time of the study, I was based at the psychiatric hospital in which the research took place for my final year clinical placement. Over the course of the doctoral programme, I had developed an interest in community psychology principles, such as empowerment, choice and the importance of context (Holmes, 2010; Orford, 2008). Furthermore, one of my siblings had experienced a first episode of psychosis and was admitted to psychiatric hospital under section. These personal experiences and interests drew me towards service user-led research and practice, including peer support. As a result of these experiences and interests I came to the research with a number of preconceived

assumptions. Namely, I thought that individuals on the ward would experience peer support as helpful, particularly with its potential to normalise experiences. I also thought that, given the reduction in power differentials, peers would enable individuals to discuss things that they might not otherwise feel able to talk about with professionals.

In any form of research, it is not possible to be totally free from bias (Elliott et al., 1999). However, I tried to minimise the impact of my assumptions and beliefs by adhering to good practice guidelines for qualitative research methods. Reflexive practices, such as keeping a research journal and using supervision, increased my awareness of my assumptions and enabled me to think about their impact on my research (Mays & Pope, 2000). I also attempted to 'bracket' my ideas; that is to put them to one side without discounting them completely (Fischer, 2009). Bracketing can enable researchers to remain open to participant experiences, ensuring that it is not driven by personal ideas, whilst concurrently providing the opportunity for it to be informed by them (Fischer, 2009; Willig, 2013). I explicitly sought to explore negative experiences of peer support in the interviews and tried to use curiosity throughout data collection and analysis in order to remain open to difference (Cecchin, 1987). Finally, I only recruited individuals with whom I had not worked clinically.

## **Results**

Overall, participants described a range of experiences of mutual peer support in the inpatient setting. The majority of accounts were mixed, with participants describing both helpful and unhelpful aspects of supporting one another in this environment. The analysis yielded nine themes, which were organised into two domains: (1) peer support interactions and (2) challenges and barriers to peer

support. The domains, themes and subthemes are summarised in Table 2. Each theme will be presented in turn, alongside quotations from participants to illustrate them.

### **Domain 1: Peer support interactions**

Most participants spoke of the importance of the relationships they had formed with other service users during their time in hospital, with one describing such relationships as “*vital like water*” (P8). These relationships appeared to be built on a foundation of companionship and friendship, which enabled participants and service users to look out for one another, respond to distress in each other and provide the space to talk about personal issues. They also provided opportunities for personal development and inspired hope for the future.

#### **1.1 Companionship and friendship**

All participants spoke of at least one relationship they had formed with other service users during their time on the ward, although the closeness of these friendships varied. Relationships appeared to be built on small acts of kindness that service users carried out both on and off the ward. The majority of participants highlighted how their relationships with other service users developed a family-like quality over time.

**“I get attached to people”.** All participants expressed a sense of closeness to one or more service users on the ward; as Participant 3 said: “*I get attached to people*”. Commonality or shared experience appeared central to this, engendering trust and providing a basis for supportive relationships to develop.

Table 2: Summary of domains, themes and subthemes

<b>Domains</b>	<b>Themes</b>	<b>Subthemes</b>	<b>Prevalence</b>
1. Peer support interactions	1.1 Companionship and friendship	“I get attached to people”	12
		It’s “the little things”	12
		Family-like relationships	8
	1.2 “Stepping in”	Providing protection	7
		Navigating the ward	5
		Attending to physical needs	2
	1.3 Responding to distress	Attending to physical needs	3
		“Just being there”	8
		Providing a different perspective	7
	1.4 Talking about ‘personal stuff’	Getting staff to help	5
		Talking about problems	10
		Listening not doing	9
	1.5 “We’re stronger if we work together”	Recognising sensitive issues: knowing when to back off	6
		Encouragement	6
		Promoting helpful choices	7
Learning from each other		5	
	Planning for the future	5	

Table 2 (continued)

<b>Domains</b>	<b>Themes</b>	<b>Subthemes</b>	<b>Prevalence</b>
2. Challenges and barriers	2.1 Ward context		12
		“It’s...manic in the centre of the ring”	9
		Staff discourage “getting involved”	3
	2.2 Treading carefully		8
		“It’s always a bit dangerous to go and poke too deeply”	8
		“I get scared of what they might say”	3
	2.3 Personal difficulties		8
		“I’m not feeling 100%”	4
		“My brain” gets in the way	7
		It’s hard to trust others	2
	2.4 Helping others can be distressing		7
		“It got a bit heavy”	7
“You have to try and look after yourself as well”		4	

*“And I think that there have been real friendships formed here, so it’s been a good experience in that respect also, because I’ve been able to... As we spoke about earlier, experience the same thing, which is being here, but then also understand the things that some people have been through in their lives through conversations.” (P11)*

*“The eating disorder, the similar diagnosis, the similar age, the similar...I dunno personality...It’s just...a lot in common. And we both went through a court case as well and she was supporting me through mine, coz hers was a few years ago. But it’s just like we have so much in common, it’s easy to talk to her.” (P7)*

Indeed, some described the loss they experienced when friends moved on from the ward. This appeared to be particularly challenging for individuals who said that they found it difficult to make friends.

*“Now it’s really glum... because no one here wants to meet... it always used to be piggy in the middle...I used to be in the middle so it’s really hard for mixing with friends... they’re not participating. They’re not being a friend. They’re not showing their feelings. They’re not saying who their names are. That’s how I feel left out by that.” (P12)*

However, the closeness of these relationships varied across participant accounts. For some, these friendships were very close; participants described other service users as their “*best friend*” (P7), or their “*main man*” (P5). Others spoke about “*real friendships*” (P11) that “*represents 100% trust*” (P8). There was an expectation that these relationships would continue on after discharge. At the other end of the spectrum, some participants described these relationships as “*connections*” (P9). For these participants, maintaining a sense of distance was important to them during their time on the ward. However, although these connections were not as close for some compared to others, all participants spoke of how they were an important part of their time on the ward.

**It’s “the little things”.** Participants described the importance of “*the little things*” (P11) that service users did for one another. These included practical

assistance, such as sharing food and cigarettes; emotional support, such as greeting one another and asking how they were; and social engagement, such as doing activities together and chatting, or as one participant described it, “*pub talk*” (P2) - the opportunity to share jokes or talk about “*silly stuff*” (P6). Participants spoke of how these opportunities to socialise and connect with others in meaningful but light-hearted ways significantly contributed to their wellbeing and brought a therapeutic aspect to their time on the ward which they greatly appreciated.

*“Well you know he would come up and shake my hand. He would give my wife a cuddle and give me a cuddle, which sounds very trite but not at all really, not at all.” (P4)*

*“It makes a big difference, man. I never knew how healthy socialising could be, as long as it’s with the right people...It feels like a cure, like therapy. I didn’t know that...Mental, mental, mental healing.” (P10)*

“*The little things*” also provided a useful distraction from what participants described as a difficult, and also at times boring, environment. Participants spoke of how it helped to “*sugar coat the situation*” (P2), which made time pass more quickly and enabled them to feel more optimistic about the future.

*“[Being with another service user helps] to be optimistic and happy about what we’re going through just by keeping a light-hearted view about...it helps forget where we are or forget the problems that we’re facing.” (P2)*

*“It’s funny, it’s humour, it passes the time. It gets you to know each other more. It’s an ice breaker. You know, it’s a lot of things.” (P10)*

**Family-like relationships.** Participants described family-like relationships with others on the ward that were associated with age. For example, younger participants described looking up to older service users as parent-like figures, and older participants described how they enjoyed living out these parental roles with younger service users.

*“He treats me like a son sort of thing...he’s like a father figure sort of thing to look up to so.” (P1)*

*“We would sit and we would talk...I was just there like a mum really that would sit and listen to her while she was a bit down, which was quite nice.” (P6)*

These family-like relationships seemed to provide an important framework for service users to support one another. Some described these roles as bringing a sense of connection and a feeling of homeliness. For others these relationships provided the opportunity to live out a valued role, which contributed to their own happiness as well as others.

*“I have...no sisters...I was braiding her hair this morning and she felt like my little sister...She always come to me for that...it makes me feel happy I can help her and make her feel happy.” (P7)*

*“everybody like...family...everybody helps everybody. People that never help here before would eventually come and help you...so it’s kind of like a home from home sort of thing.” (P9)*

## **1.2 “Stepping in”**

Participants described a mutual process of “stepping in” (P1) to help one another on the ward. The examples that participants gave appeared to divide into three distinct types: providing protection against the aggressive behaviour of others, helping to navigate the ward and attending to the physical needs of others. There was an active and protective quality to each of these types of support.

**Providing protection.** Several participants, the majority of whom were male, described occasions when they (or another service user) defended or protected others on the ward. These situations appeared to be triggered by the aggressive behaviour – either verbal or physical – of others. For example, Participant 5 described how whilst playing a game of pool, a service user (with whom he had a difficult relationship) misunderstood his intentions and made a physically aggressive move

towards him. Another service user stepped in straight away to calm the situation down.

*“He thought I was going to go for him and he just took it well over the top and went to go for me from the other side of the pool table...it’s a good thing that [another service user] has got a good rep with me that he sort of went what are you doing, chill your beans scenario, in his own words and straight away he did, he did so that was er good in a way.”*  
(P5)

At times like these, participants also described how they or others confronted, diverted or appeased the individual, as well as going to get staff members for support.

*“I say to people erm erm back off, let them know they’re screaming or shouting or let’s go to a different room, or shall we go shall we go and do something else...When someone’s being restrained or two patients are shouting at each other. Sort of pull the other ones away from the situation... sometimes I call staff to come and be witnesses to what is happening as well, I call either [name] or [name] or [name] to come and help the situation.”* (P2)

**Navigating the ward.** Two participants highlighted the importance of being orientated to the ward by other service users within their first few days of being admitted. This type of support appeared to be cyclical and reciprocal in nature, with these participants explaining that this was something that they then offered to “new people” (P6) once they had been on the ward for some time. Not only did this type of support include help with practicalities, such as information about meal times, but it also included examples of more emotional support, such as offering to sit next to individuals at meal times, asking if they wanted to talk, and identifying when it would be helpful to raise an issue with staff on another service user’s behalf, particularly when the service user appeared to be struggling with their wellbeing.

*“He helped me find my way and brought me a packet of cigarettes the first week I come in...[I] give [other service users] time to help, find out what they need. Because*

*sometimes they're very unwell and need help with the staff, they don't know how to ask. I've gone and asked staff about if a particular patient that needs something, a blanket or a tea or a towel, or how to get a razor or how to get something to eat out of hours and stuff." (P2)*

*"You get taken under someone's wing, it's something you know if you're sitting on your own at dinnertime, somebody will come by and will talk to you...we do that to new people who are on the ward it's just what happens anyone who's new on the ward you say 'can I sit with you' and if they say 'no', that's fine, and if they say yes...you start conversation so it's just what happens." (P6)*

**Attending to physical needs.** Some service users also described attending to the physical needs of others on the ward. For these participants, this appeared to occur in the context of staff not always being available to help, given the demands on their time. These instances seemed to be small and practical in nature, such as taking someone's dinner to the table or moving a cushion to make them more comfortable.

*"...he was very ill and people were feeding him. He was sitting down once and there was no-one feeding him his food, no-one was there with him. So I stepped in and sat down with him and I started feeding him...So I helped him in that way, I fed him because there was no nurse with him at the time." (P1)*

*"Sometimes, patients helps patient...one patient, she can't take her dinner from the... We put it on the table for...she ask you kindly, and so you do...or to accompany her to the toilet or whatever. It's because of the nurses. Short staff as well, again, comes into it." (P9)*

Participant 1 described how the opportunity to do these things for others *"makes me a more mature person, instead of being like a kid. It makes me more mature"*. It also provided the opportunity for another service user to praise him:

*"Yeah well um [A] when he saw me helping [D] he said 'Well done [participant name], [D]'s never done that before, ate all his food that quickly...with you he didn't take as long. He was very quick with his eating.' [A] praised me for that and so I was happy." (P1)*

### 1.3 Responding to distress

The majority of participants spoke about times when they had responded to signs of distress in others. Half of these participants also reported receiving support from other service users during their own experiences of distress on the ward. As would be expected, participants first had to notice distress before they could respond to it. The signs of distress that participants picked up on included crying, sad facial expressions, closed body language and changes in mood.

**“Just being there”.** In responding to distress, participants highlighted the importance of providing, or being provided with, the space to be upset. A key component of this appeared to be simply being with an individual: they described offering (or being offered) physical comfort, such as a pat on the back or a cuddle. For example, Participant 6 noticed another service user was upset because *“she was crying, well she was dancing but she was crying whilst she was dancing”*. She described how she then attempted to comfort her:

*“[I] went over to her and I just said to her are you alright or do you need a hug and she went can I have a hug. So we ended up I was sitting on the floor and she was laying on the floor with her head on my lap and I was just comforting her, yeah, but she was holding onto me so I knew, I knew she wanted me to be there...rubbing her back so she'd calm down.” (P6)*

Participant 11 spoke about a time a friend on the ward was trying to talk to her about the distress she was feeling; the friend couldn't find the words to describe it and so Participant 11 suggested she try writing it down. She described her reaction to what her friend had written:

*“Something told me to just give her a hug, just be there. Don't think that you have to give her words that are going to make everything better, because maybe you don't have the words to make everything better...And sometimes that's all we need. We don't need someone to start telling us, oh, you know, maybe if you had done this, then you wouldn't have*

*been in this situation. Or you know, that sort of thing is not helpful. It's better just to, you know, be there.” (P11)*

Another example of this type of interaction was relayed by Participant 3, who described an occasion when he was sitting on the floor in the corridor feeling “*pretty down*”. During this time “*most of the patients really asked if I was okay, put [their] hands on my back and stuff*”. Participant 3 also described other occasions when “*I just get confused and I don't know what I'm feeling or anything and I start crying for ages and that*”; during these experiences three service users, who Participant 3 described as his close friends, would always come to him and ask if he was okay.

**Providing a different perspective.** Participants reported that, once the situation had calmed, they offered or were offered comforting words and advice. These included normalising statements and reflections on the situation. These exchanges seemed to allow service users to consider alternative ideas about the situation, which appeared to contribute to the reduction of distress.

For example, Participant 3 spoke of how he found it helpful when one of his friends on the ward told him “*everyone gets like this sometimes*”, following a period of being quite upset. Participant 8 described how a friend on the ward helped him when he was feeling upset by changing the subject of conversation in order to help him through this experience:

*“I made to smile. When I alone, he's coming in my room, after two or three minutes he's coming to change the subject, try to put in something not necessary happy, but changing to putting me up on the right line...It's dazzles me, dazzles me very much.” (P8)*

Participant 6 spoke of a situation where one of the women on the ward was “*worried [staff] were gonna take her leave away from her*”, following a ‘bad night’ when the

woman had been upset. Participant 6 attempted to provide a different perspective on the situation:

*“I said to her ‘But you weren’t naughty last night you were just down, you just had a bad night, you cried, there’s no naughtiness involved in that. They’re not gonna stop you seeing your dogs just because you cried’ ...[following this conversation the woman] ...put her happy face on...she went ‘no’ ...we started talking about the dogs and she put the smile back on her face so she’s alright so.” (P6)*

**Getting staff to help.** Some participants described how their peers helped them during times of distress by alerting the staff and getting them involved in the situation. At these times, the distress participants were experiencing prevented them from being able to seek support from staff for themselves. Participant 12 described how one of her friends got the nursing staff after she started having an epileptic fit on the ward: *“she helped me, because I was having a fit so she called the nurses”*. Participant 7 described how a service user fetched a member of staff when she was feeling *“really upset”*: the service user had initially tried to comfort her, but because Participant 7 *“wasn’t calming down”* the service user went to find a member of staff, who then administered medication.

Others spoke of their own efforts to alert staff to the distress of others on the ward. Participant 1 explained that he helped another service user on the ward who was *“struggling to breathe”* by asking staff *“can you help this guy, have you got anything that can help him with breathing and that”*. Participant 9 described how she sought help from staff when another service user requested assistance in their room. Participant 9 had just supported the service user to walk from the lounge to their bedroom, when the service user asked her to stay and help. Because Participant 9 was unsure about what help the service user wanted, and did not feel comfortable about the situation, she went to inform a staff member:

*“I said I’m going to get a nurse. And I quickly came, told the nurse, and the nurse said ‘Thank you, [participant name]’. And...they went to her assistance.” (P9)*

#### **1.4 Talking about ‘personal stuff’**

Participants reported a range of experiences with regards to talking about personal issues. For the majority of participants, there appeared to be at least one individual on the ward with whom they talked about important personal problems. In contrast, a few participants explicitly chose not to share personal issues with others; this appeared to be connected to concerns about the possible response of other service users.

**Talking about problems.** Most participants described sharing important personal problems with other service users; these tended to focus on family issues and relationship difficulties, current challenges, and difficult beliefs and experiences. For example, Participant 10 described talking to another service user about how he felt when he smoked cannabis:

*“I said how I felt. I said I feel like, I said I feel like Jesus Christ. I said I feel like a soul, something spiritual that affects me in the physical... That I can feel in the physical but isn’t physical itself. In me, it gets heavy.” (P10)*

This appeared to be particularly important because Participant 10 explained that, on admission, he *“felt like I was going through things I needed to talk to someone about, but I had no-one to talk to about it.”*

Talking about problems was a reciprocal process, with the majority of participants also giving examples of issues that other service users had talked to them about. For example, Participant 5 described a conversation he had with a friend on the ward whose child had refused to speak to him; this left the service user feeling understandably upset:

*“he said about his [child] and he was sat on the phone and [they] didn’t want to speak to him and he thought that was a bit peculiar and I said how old [are they], [are they] young and he said yeah [age], and I said I’d be surprised if my [child] wanted to not speak to me, even if [they were] that age but it doesn’t matter what age, you’re going to be a bit heartbroken.” (P5)*

Talking about problems did not happen only through conversation. For example, Participant 4 recounted how a service user had given him his autobiographical journal to read. Although Participant 4 found it difficult to concentrate on reading the journal, he reported that he still tried to read it and comment on what the service user had written:

*“I read, I sort of read what [name] had written...he’s done some writing...he just sort of mentioned it and said erm, he just handed it over to me to read, so I read it.” (P4)*

Participant 4 wondered whether the service user was looking for reassurance about the validity of his experiences: *“I suppose it was because erm he just wanted some sort of reassurance I suppose that it seemed valid.”*

**Listening not doing.** Participants emphasised the importance of actively listening to the issues service users spoke about; the space to talk and someone who listened were highly valued. Participant 11 gave an eloquent account of the process of active listening:

*“Well I’ve learnt that when someone is speaking, I have to be quiet...and be active in listening to what they’re saying by actually being quiet and still enough to listen to what they’re saying. Because I think sometimes our perceptions and our already-formed ideas can be informing what it is that we’re hearing from that person, and we’re not actually listening to them...it’s making that conscious decision to block out everything else that may be around me... if you really want to listen to the person, you’ll try and make that effort to focus on what it is that they’re saying. And I think through that, you’ll be able to understand even more than what you can see on the surface. Maybe someone’s expressing hurt, even though it looks like anger.” (P11)*

For several participants, another important aspect of listening was not feeling the need to provide a solution. There was a respect for the personal nature of people's problems and their decision making capabilities, which seemed to free up participants to simply listen and be listened to. Several participants also spoke of how the process of being listened to was therapeutic in and of itself.

*“[I was] just being supportive really, just nodding... You know...Just smiling and nodding. [There's] not much I can say, cause you know, that's her family that's up to her what she does with [them].” (P6)*

*“Just having someone you know that you've never talked to is help, rather than you know she doesn't like sit there and say oh I suggest you do this, but it's just being there and having someone to talk to is nice. So that's help in itself.” (P6)*

**Recognising sensitive issues: knowing when to back off.** For some participants, other service users had shown sensitivity by “pulling back” (P4) when a difficult topic of conversation was raised. For example, Participant 4 highlighted that talking about work was difficult for him because he was ashamed of his work record “supposedly because of mental ill health”. He felt other service users had quickly realised that this was a difficult topic for him:

*“[they] didn't probe any deeper...I think I've mentioned before that I haven't worked all the time, people stand off usually. They won't press the issue. That's what I've noted, that they tend to do that.” (P4)*

Not only was this a relief for Participant 4, but he also felt it communicated an acceptance and respect that made his inpatient experience “more palatable”:

*“There was an acceptance to a certain extent... I think it's just that sense that someone is mindful about what you might be sensitive about.” (P4)*

Other participants spoke of how they tried to show this sensitivity to others. It was important that the offer of the space to talk about personal problems was also accompanied by the respect that an individual might not want to talk:

*“It just so happened that I saw her later on, and I just asked her and then I kind of realized that she didn’t want to speak, so I just gave her her personal space. Because sometimes, we... You need to...respect people’s space if they say, please, I don’t want to talk about it.” (P11)*

### **1.5 “We’re stronger if we work together”**

There was a sense of camaraderie in participants’ accounts. Peer relationships on the ward provided a space to learn and grow. Supported by encouragement, service users helped one another to consider the consequences of their behaviour and think about alternative options. Having someone to plan the future with also appeared to inspire hope in participants and give them something to look forward to in moving on from the ward.

**Encouragement.** Celebrating successes provided the opportunity for participants to give and receive encouragement. For example, Participant 5 described an occasion when a friend on the ward, who often went for two weeks without washing, mentioned that he had managed to shower. Participant 5 wanted to show that *“I respected him for doing that”*, but also felt it was important not to respond in an *“over the top”* way. He described how he tried to calibrate his response so that it was acceptable for his friend:

*“I was thinking that anyone would be dancing for joy and giving him a high five. But me I couldn’t, I had to sit literally and refrain myself from being so chirpy and just confine myself and just give him a well done. Just a well done you know because if I was to go over the top then I know he probably wouldn’t then have another shower if he fancied one. And if I went below and started going yeah you dirty bastard you should be showering anyway there’s totally no way he’s going to have a shower, so I had to go in the middle with him.” (P5)*

Participants also described receiving encouragement from others. Participant 7, who struggled with an eating disorder, described how her “best friend” on the ward, who had similar difficulties, encouraged her to eat:

*“[she would say] nourish not punish, that’s her favourite saying. And she’s...always encouraging me to eat, and I encourage her to eat.” (P7)*

**Promoting helpful choices.** Peer support also involved promoting helpful choices for participants. The comments and responses of other service users helped individuals to think about alternative actions and consider the consequences of their behaviour. For example, Participant 2 described how the actions of another service user, in response to an aggressive situation on the ward, helped him to think about his own actions:

*“[A service user] was shouting at a female member of staff and [another service user] just said ‘why can’t they just leave people alone and get on with it’ and he did walk out of the room and went to his room. And I thought about what he was saying for a little while...[seeing that] ...prevented me from attacking people that misbehave again.” (P2)*

Participant 7 described how having a friend on the ward who also struggled with eating helped her to think about how her eating behaviour impacted on others. This enabled her to make a helpful change that benefited both herself, but also the other service user:

*“Before she came I was really restricting and now she’s here I’m a bit more careful coz I don’t want to trigger her...So I’ve been eating more [now] that she’s here.” (P7)*

Participants also described examples of times when they had attempted to help others to think about their behaviour and promote safe choices, particularly during times of distress. For example, Participant 2 described how he spoke to other service users when they were being verbally aggressive towards others:

*“There’s been times when I’ve said to other patients ‘what you do this for? Why are you doing that?’ and usually they do think ‘yeah why am I doing that. Why am I shouting? Why am I being rude to staff’...It makes them realise and question what they’re doing, why they are misbehaving as well.” (P2)*

Participant 7 described her response to a friend, who had been discharged, when she called to say she was feeling suicidal:

*“[I] told her to go and give the pills to her [family member] ...Go to A&E if you feel unsafe, don’t take an overdose. Stuff like that for 20 minutes.” (P7)*

**Learning from each other.** For some, being with others on the ward had enabled them to learn new skills. Participants 2, 5 and 8 all felt that their friends on the ward had helped them to learn “*how to relax*” (P2):

*“He’s very mellow as well...he’s more mellow than me so I learn you know I learn...I’ve learnt a lot how to be a more mellow person by erm by his vibe.” (P5)*

*“[Service user] is more calm. I don’t know which zodiac he is...it’s very, very good in cooperation with me. I am very, very, very calmer patient now.” (P8)*

Participant 11 spoke of how her interactions with others had taught her about mental health, both with regards to others as well as herself:

*“I’ve learnt a lot about mental health in particular and how wide the definition of mental health is, and how people’s perceptions of mental health can be really quite different to what it is that you perceive about yourself.” (P11)*

She considered it important to try and apply some of the lessons she had learnt from her relationships on the ward to the relationships she had with her friends and family:

*“But it is a reminder to me that actually, I need to be aware of the fact that if I have friends or family, I should remember things that they’ve been through. So that if I do see them, we can address, oh, yes, you went through that. Or how are you feeling now? And even just that thought, it means so much.” (P11)*

**Planning for the future.** Planning for the future was an important component of some conversations on the ward. Participants described drawing up “discharge plans” together: they thought about activities they wanted to do following discharge, made plans to see one another again and, for one participant, even talked about the possibility of sharing accommodation.

*“We talk about opportunity, if it’s possible to stay together, to rent a room together to share to give something to work... We try to help one another out when we go out from here.” (P8)*

These conversations provided hope for the future and helped to combat fears about discharge.

*“It’ll be good to see each other on the outside and that, share the issues we’re going and sort of pass the time I guess. Get to socialise with each other again and have some good memories hopefully of this place.” (P2)*

*“It gives you something to look forward to when you get out because being discharged is really scary. So it gives you something to look forward to, and knowing that you won’t be alone when you get out as well” (P7)*

## **Domain 2: Challenges and barriers**

A number of challenges and barriers to both giving and receiving peer support were described. The ward context and atmosphere left participants feeling scared and made it more likely to “*be on guard*” (P5). The personal difficulties that participants faced also impacted on their ability to form and maintain mutually supportive relationships with peers. Participants also highlighted that supporting others could be distressing for them too, which sometimes made it less likely for them to feel able to or want to help others on the ward.

### **2.1 Ward context**

The majority of participants commented on the impact that the ward environment had on their desire and impetus to interact with others. Some

participants also felt that staff discouraged them from supporting others and did not understand the importance of this for them.

**“It’s...manic at the centre of the ring”.** The violence, anger, and aggression that could occur on the ward made it an intimidating place to be; as one participant put it, *“it’s...manic at the centre of the ring”* (P5). In addition, the lack of personal space meant the ward could be a frustrating place, which had a negative impact on the wellbeing of participants. For example, Participant 12 described her need for time on her own:

*“Sometimes I need some time alone because people disturb me...I can’t relax. I can’t sleep when someone’s knocking at my door...I lose my temper and then I just go to boom... I just get wound up and wound up and then I get... I lose it, I lose it all.”* (P12)

Two participants also spoke about racial tensions on the ward, which made it difficult for service users of different ethnic backgrounds to interact. As Participant 10 commented:

*“He [said he] don’t like black people and he wants to kill black people....one minute he tried to come to me like friendly, friendly...Then the next minute he’s like ‘I’m going to kill you [name], I’m going to kill you’. So it’s like no, tell him to get away from me.”* (P10)

All of these experiences, which participants felt occurred in the context of mental ill health, meant that the ward atmosphere was not always conducive to positive and helpful peer interactions. The changeable, and at times scary, environment meant that participants did not always feel comfortable and confident to interact with others, as Participant 7 explained:

*“When manic patients come in it’s hard coz it means you have to hide in your room or feel scared, which isn’t what you want to feel in hospital...everyone’s sick on the ward and some people are violent and some people aren’t.”* (P7)

**Staff discourage “getting involved”.** For two participants, the responses of staff made it more difficult or actively blocked them from “*getting involved*” (P1) in supportive peer interactions. For example, Participant 2 spoke of how staff members discouraged him from talking to other service users about issues of conflict. He felt this prevented the chance to engage in discussion, which meant that issues were not resolved:

*“Usually I find if you share the issue with someone and sort of talk it over with someone they can be resolved... When I’m trying to talk to another patient about an issue or an argument that I need to resolve, but a staff member says go to my room, don’t get involved... It blocks opportunity to talk over a problem with someone.” (P2)*

Participant 1 described how supporting others on the ward provided an opportunity to enact personal values that contributed to his recovery. He felt that how staff responded to his actions illustrated they did not understand the value of peer support for him:

*“They like to tell people to stay out of people’s situations but they don’t understand like it’s a good thing to love people, to love people in that way, it’s something good and it makes people feel good doing it as well.” (P1)*

This participant wondered whether staff discouraged supporting others because they were worried about the potential impact on service users. In some instances, he felt this worry was unfounded, as he described:

*“When it comes to helping others, even if I’m poor I’ll still reach into my pockets and give my best for them... That’s my principles... [However staff said] stay out of the situation... I’ve stopped doing it... [because] actually I can’t afford to keep doing it myself... but at the time I was ok financially to be able to help him, just a little bit... they were worried that I was spending all my money... but they shouldn’t worry about that.” (P1)*

In contrast, Participant 9 highlighted how it was helpful for her when staff discouraged peer interactions. She explained that, as talking about problems with

other ward members was not something she felt comfortable doing, she appreciated the protection staff provided in negotiating this boundary for her:

*“If they do [ask about personal problems] and the nurses overhear, then nurses will tell them that it’s the patient’s business and you’re not suppose...Because you’re a patient as well, so... I should think this is where the nurses protects us, because we are patients.” (P9)*

## **2.2 Treading carefully**

For some participants, not knowing others, or indeed others not knowing them, meant they felt the need to tread carefully when interacting with people on the ward. Coupled with concerns about the responses of others, several participants expressed a preference for keeping their distance. This made it more difficult for them to give and receive peer support.

**“It’s always a bit dangerous to go and poke too deeply”.** Some participants felt acutely conscious of the need to be careful around others for fear of *“treading on painful ground”* (P4). Not only did this make it more likely for them to keep to themselves, but it also meant they did not feel comfortable or confident to offer their support to others. From the other perspective, some participants did not want to share their personal problems with people on the ward; they preferred not to receive support from others.

Being careful around others was connected to a sense of not knowing who people were, where they had come from and why they were admitted. This left some participants worrying about activating sensitive issues for others, which ultimately left them feeling that it was safer not to offer support in the first place. As Participant 4 explained:

*“And generally sometimes you don’t know the risk assessments for others really...You don’t know if you’re treading on painful ground if you mention something, which is also something I don’t want to do...it’s always good to give*

*someone a lift...but sometimes you don't want to aggravate things that you don't know about you know...it's always a bit dangerous to go and poke too deeply.” (P4)*

Not asking for the support of others on the ward was connected to an awareness of the possibility (or indeed an actual experience) of others activating their own sensitive issues and causing them pain. Feeling as though what they had to talk about was too much for others and a desire to protect their privacy also meant that some participants did not feel comfortable talking about their own issues with others and, therefore, did not want to make use of the potential support of ward members. It seemed important to these participants that their personal choices regarding disclosure were respected:

*“I've got a lot of baggage and it's where do you stop and where do you start and it's so much that it's just not I just don't feel comfortable talking to people about it... Yeah, and it got a bit messy so I [don't] talk about all the history...I just like to be the person who people talk to, rather than I talk to them.” (P6)*

*“You don't expose yourself too much... Confidentiality. Just want to keep yourself to yourself sort of thing and not to expose yourself too much, because people can read so much into your body language and all that.” (P9)*

Shame or embarrassment about personal problems also made it hard for participants to talk to others. Participant 5 described his discomfort when another service user asked him about the circumstances surrounding his admission:

*“so he piped up and said what are you in here for and I was just going to say a brief thing like oh you know I [did something to a family member] and even that sounded too odd for me, that I was like I stopped, but I said it and for the first time in here I thought I shouldn't have said it...Because it sounds like a hint or you know that I'm hostile to my [family member].” (P5)*

**“I get scared of what they might say”.** Worry about what others might think, say or do made it particularly difficult for some participants to receive support

from peers on the ward. The negative judgement of others appeared to be the main feared response. Not only did this mean that participants did not feel comfortable sharing personal problems with others, it also made it difficult to receive support during times of distress:

*“[I don’t say what is on my mind because] maybe, maybe he would think I’m a freak. I would be worried about what [he] would think...[which] makes me feel like totally alone... [and] probably made me go quiet.” (P3)*

Concern about how others would respond also made it difficult for participants to build and maintain friendships during their time on the ward, which left them feeling quite lonely and isolated:

*“It’s very hard to speak along with new people and [get] to know them well. It’s very hard...I get scared of what they might say...they might say you’re a bit ugly or something. That’s what I’m scared about...They might try to hurt me... Like they might hit me.” (P12)*

Participants also described directly experiencing responses from peers that were difficult to manage and caused them problems. For example, Participant 6 explained that when she once told another service user about a personal issue with her husband, they tried to give her advice that she did not want and in a manner that she found overbearing and forceful:

*“She was trying to get me to leave him, yeah....[saying] things like ‘I don’t know why you’re still married to him, why don’t you leave, you’re young enough to get off and start on your own’...I think that’s why somebody came round and got involved...[they] said that it was my choice and it was up to me to do what I wanted...[and] she stopped, she stopped preaching at me, and she left me alone.” (P6)*

These types of experience made it less likely for participants to engage with peers, particularly when it came to talking about personal problems, and also brought distance to friendships that had already been formed. As participant 6 explained:

*“We weren’t as friendly afterwards. I just don’t think she understood...we used to sit and talk all the time, but then we sort of like drifted apart.” (P6)*

### **2.3 Personal difficulties**

For some participants, their own personal difficulties made it hard to give and receive peer support on the ward. Symptoms of mental ill health; unhelpful thoughts, feelings and beliefs; and a lack of trust all made it tricky for participants to make connections with others, engage in helpful interactions and be helped in return.

**“I’m not feeling 100%”.** Several participants commented on how their own ill health, or as Participant 4 put it *“not feeling 100%”*, made it difficult to connect with others on the ward. At times, the severity of mental ill health symptoms made it hard for participants to concentrate on talking and interacting with others, which ultimately prevented them from being able to give and receive support.

For example, when Participant 4 was asked by another service user to read the service user’s autobiographical journal, he felt unable to concentrate on it because of the symptoms he was experiencing and the side effects of his medication. Participant 4 said that he could not take in what was written and, therefore, felt unable to talk to the service user about the journal in any great detail or offer any kind of support. As he explained:

*“I found it very difficult to concentrate on [the journal] as well, so I didn’t take in most of it. But er I just mentioned about his [family member] was mentioned, she’s from [place], I said oh your [family member] is from [place]. That was what I remembered was one of the main details from it because the rest was really er, er...it was reflecting his time here...I wasn’t taking much notice fully I wasn’t concentrating fully at the time...the medication can be strong sometimes...during this time I was worried about breathing properly.” (P4)*

Others also commented on how the side effects of their medication made it difficult for them to engage with others, although this was also something that provided an opportunity for participants to talk together:

*“[the medication] sedates me to the point where I can’t even open my eyes and look at you...[a service user was saying] ‘This medication is vomiting me. It’s killing me’. That’s what he was saying. And [another service user] was like ‘yes I know, I know, I know’. And I was like ‘yes man, its making me put on weight’. And [he] was like ‘it’s making me sleep’ and I was like ‘yes, same, same, same’.” (P10)*

**“My brain” gets in the way.** How participants were thinking and feeling could also significantly impact on their ability to give and receive peer support. Thoughts could get in the way of participants seeking support from others, and could also make it challenging to feel supported, even when they sought reassurance. For example, Participant 3 held a belief that he was *“a bad person”*; when he asked others (including one of his close friends) what they thought of him, his experience was that *“my brain”* got in the way of feeling reassured by their opinions:

*“I would ask a lot of people in here if they liked me or if they thought I was a nice person...he [another service user] would talk about like being nice and nice people and stuff and said that he thought I was a nice person. But that would make me feel bad because...[my mind] would be saying like you know you are a bad person, you know there’s something wrong with you.” (P3)*

For others, feelings such as anger and frustration made it difficult to be around others, which ultimately meant they were unable to give or receive peer support:

*“When I’m angry or shouting at other patients, if I’m not in a good mood or sort of erm taking things out on other people. I’m a bit of a rebel, I can shout at certain individuals as well erm. Thinking short-mindedly and selfishly. Cause usually when I’m angry I want to be on my own really and I don’t just want to give time to others.” (P2)*

For some participants, the beliefs they held about their ability to communicate with others were difficult to overcome and made it hard for them initiate interactions.

*“It's very hard to speak along with new people and getting to know them well. It's very hard...I'm very difficult...You know, I'm very like...I'm not easy-going...I'm not easy-going on myself. I do things wrong...I'm not an easy-going person...I feel nervous.” (P12)*

For these individuals, having someone who took the time to communicate, communicated with them on their level and put them at ease facilitated the formation of peer relationships on the ward:

*“he wouldn't like be on edge you know and just like he's just like I found that easier to be around...It probably made me feel more comfortable...with him being laid back and not really talking all the time it was pretty cool.” (P3)*

**It's hard to trust others.** For two participants their previous experiences made it hard to trust others, which included peers on the ward. Not only did this reduce the likelihood of them offering to support service users on the ward, but it also meant they were less likely to experience positive helping experiences from others in return. As Participant 8 described, his previous experiences of being “betrayed” made him acutely aware of the minutiae of interactions and left him seeking proof of trust from others:

*“long of my life when I think I have a friend, real friend, betrayed me...And believe me now I so precautious, I so very, very concentrate [on] details, risks, paranoia...you can, must be...very, very honest when I put one question because after 10 days when I put same question and if you don't give me same answer you are not my friend.” (P8)*

Participant 7 highlighted how it was particularly difficult to trust others when she was first admitted. A sense of not knowing who people were, along with

witnessing and experiencing violence and aggression on the ward, left her feeling cautious about interacting with others:

*“I was just hiding in my shell at the start...In a way because you’re not vulnerable to anyone. It’s just you, you have to rely on, you can’t let yourself down. And you can’t hurt well you can hurt yourself, but you can’t... like other people can hurt you. You’re safer by yourself.” (P7)*

## **2.4 Helping others can be distressing**

Some participants felt that there were occasions when it was not possible, or appropriate, to offer support to others on the ward. High levels of distress in others could be challenging to witness; supporting others during these times often left participants feeling distressed too. Seeing their own problems in others could also trigger issues for participants. With all of this mind, participants spoke of the importance of looking after themselves and recognising when it was not helpful for them to offer their support.

**“It got a bit heavy”.** Several participants highlighted just how challenging it could be to support others in distress, especially when the level of distress was quite intense. Suicidal thoughts and feelings, intense mood swings and physically aggressive behaviour could be hard to witness in others, as Participant 7 explained:

*“She just keeps crying and not listening to what we’re saying. And then she gets aggressive and then she gets restrained, and it’s just so hard to watch someone like that... we’re always trying to comfort her, but she just does it again and again and again and it gets exhausting...one minute she’s crying at you, the next she’s swearing at you...I don’t know how to help her when she doesn’t want to help herself.” (P7)*

These situations often stimulated uncomfortable emotions for participants, leaving them feeling trapped and helpless. Not knowing what to say or feeling like there wasn’t anything they could do to help made it particularly challenging for

participants to support others. In these situations participants would either experience distress themselves or choose not to offer support, as Participant 9 described:

*“She was like that [makes sad face] by herself, and say that she wants to kill herself... she’s pounding her head and all that...I couldn’t bear to see her doing it, she was still doing it. But at the time, when she was doing it, I wasn’t... I didn’t go and give her a hug then. Because sometimes, you know, when you like that, you need somebody to...the nurses are very good with them. They have one-to-one, so the nurses tried their best.” (P9)*

In another example, Participant 7 spoke of a time when a former service user on the ward called to say she was feeling suicidal. Although Participant 7 offered support over the telephone, the level of risk and uncertainty was difficult to deal with, leaving her feeling quite distressed and overwhelmed:

*“There was nothing I could do to help her, I just felt really trapped... She was just saying ‘I’ll try, I’ll try, I’ll try’. But she wasn’t giving me any reassurance that she was gonna be ok once I hung up the phone. And I just started to cry...I started crying...they gave me some PRN to calm down.” (P7)*

Whilst many participants highlighted the advantages of being supported by and supporting peers who had faced similar difficulties, Participant 7 spoke of how challenging it could be to see the issues she struggled with in others. In particular, seeing another service user struggle with an eating problem sometimes re-activated these issues for her. Not only was this distressing to deal with, it also made it more difficult for her to continue to support her peer:

*“Sometimes they trigger you...into old behaviours. Like when [a service user] was admitted before and she wasn’t eating, it was triggering me not to eat...It’s hard when she’s not eating coz my head tells me to copy her...when someone makes me upset or something I find it really hard to speak about it. I’d just rather keep it inside...[so] it makes it*

*harder, you just have to deal with it [but] it's made a bad impact on my stay." (P7)*

**“You have to try and look after yourself as well”.** Participants spoke of the importance of balancing being there for others with needing to look after themselves. For participant 6 this involved the recognition that although it was easy for her to fall into her valued role of “*being a mummy*”, it was important to remember that this was not what she was on the ward for:

*“I know that I’m like a mummy who will...that’s just my... that’s what I’m like...But we’re not here for that are we, we’re here to get better.” (P6)*

For other participants, looking after themselves involved making a conscious effort to not get involved with others on the ward, even when faced with frustrating situations:

*“I [try] to keep a balance and when I don’t have any option, like table in the dining room or TV when [I see] something and started one discussion, one louder discussion, to leave. Leave quiet and don’t say nothing.” (P8)*

Looking after oneself also involved remembering that it was the staff’s role to provide support to service users during their time on the ward as well:

*“It sounds really mean... but you have to try and look after yourself as well. And you know that you’re here because you’re not well, you’re not here to look after other people, it’s the staff’s job” (P7)*

## **Discussion**

Overall, participants described a range of mutually supportive interactions – involving both giving and receiving support – that were highly valued. Building upon a foundation of companionship, participants spoke of how they, and other service

users, looked out for one another on the ward. They responded sensitively to distress in others, offering opportunities to talk and showing understanding and respect. Peer interactions also provided opportunities for personal growth and encouraged hopeful and future-oriented thinking. However, there were also barriers and challenges to giving and receiving support. The changeable and, at times, frightening atmosphere of the ward was not always conducive to supportive interactions. Personal problems and the lack of knowledge about others' problems meant there were times when participants felt the need to tread carefully when interacting with others. Participants also spoke of how distressing it could be to support service users, and the importance of balancing looking after others with looking after themselves.

Although the relationships that service users formed with each other varied in their degree of closeness, all participants highlighted how vital these relationships were to their inpatient stay. Small acts of kindness provided a welcome distraction from personal problems and the reality of being an inpatient, but more importantly they also enabled participants to make connections and socialise. Several participants highlighted how therapeutic the opportunity to socialise was in and of itself. This is particularly pertinent given that social isolation remains one of the most significant issues for individuals diagnosed with mental health problems, especially those whose difficulties are more severe and enduring (Morgan, Burns, Fitzpatrick, Pinfold & Priebe, 2007; Social Exclusion Unit, 2004; Tew, Ramon, Slade, Bird, Melton, & Le Boutillier, 2011). Whilst social isolation has often been attributed to the consequences of mental health issues, leaving individuals apathetic towards relationships with others (Davidson, Stayner & Haglund, 1998), service user accounts in several studies suggest otherwise. Not only do service users highlight a deep desire for companionship and intimacy, but they also note repeated experiences

of loss and rejection in attempts to socialise with others, often as a consequence of the social stigma surrounding mental health (Davidson, Haglund, Stayner, Rakfledt, Chinman & Tebbs, 2001; Davidson et al., 1998).

The accounts of participants in the current study suggest that inpatient units by their very nature provide opportunities for individuals to socially engage with one another in ways that can promote their recovery. The benefits of social support, particularly in stigmatised populations, have been well documented: a sense of belonging and connection can be an important buffer against adversity and is associated with better recovery outcomes in mental health (Cohen and Wills, 1985; Solomon, 2004; Thoits, 2011). Although inpatient units of course need to focus on managing risk and alleviating crisis, the findings of the current study point to the central role of social participation and engagement in promoting wellbeing.

A striking aspect of participants' accounts was how thoughtfully they, and other service users on the ward, responded to one another when in distress and when talking about personal problems. Participants described in themselves and others the ability to: spot signs of distress; calibrate their responses to meet the needs of others; provide the space to be upset without needing to offer a solution; actively listen to one another; and acknowledge when a difficult issue had been raised by pulling back. Such sensitivity appeared to be based on a foundation of acceptance and respect, and was perhaps also influenced by having a first-hand experience, or 'experiential knowledge' (Borkman, 1990), of mental health issues. Tuning into the needs of others and understanding their distress are qualities which are not often attributed to service users by professionals, but are frequently highlighted by service users as characterising the helpful and supportive interactions they have with one another (Basset, Faulkner, Repper & Stamou, 2010; Faulkner & Layzell, 2000). Given the

links between these qualities and those that are thought to form the foundation of any therapeutic relationship (Rogers, 1957), it is perhaps unsurprising that these interactions were experienced by participants as promoting wellbeing.

The findings of this study also highlight how peer interactions on the ward can encourage personal learning and growth. Participants described how their interactions with other service users enabled them to learn new skills, expand their knowledge of mental health issues, consider the consequences of their actions, and think about and try out alternative choices. Some participants described how they tried to encourage these things in others. The findings thus suggest that mutual peer support on the ward can provide an arena in which service users can learn through interaction, rather than in isolation. This is, perhaps, unsurprising given that this is thought to be one of the core components of peer support (Mead & Copeland, 2000). From a social learning perspective, individuals who have a shared experience or background are often given greater credence, which can create a forum for the exchange of effective coping strategies and facilitate learning novel ways to overcome difficulties (Solomon, 2004).

Another important aspect of the results was how valuable participants found the opportunity to give to others. It enabled them to live out valued personal principles and problem-free identities, and it contributed to their sense of wellbeing. Several studies have documented the positive impact helping others can have on wellbeing (Greidanus & Everall, 2010; Maton, 1988; Roberts, Salem, Rappaport, Toro, Luke & Seidman, 1999; Roman, Lindsay, Moore, & Shoemaker, 1999; Zemore, Kaskutas, & Ammon, 2004). These findings are consistent with 'helper-therapy principle' (Reissman, 1965; 1990) which suggests that helping others can promote a greater sense of self-efficacy and capability; being put in an active role can

combat feelings of dependency and confer status on an individual, promoting wellbeing through the development of a positive identity (Reissman, 1990; Salzer & Shear, 2002; Skovholt, 1974). This may be particularly important considering the social stigma individuals with mental health issues face (Davidson et al., 2001). They are often encouraged to be passive recipients of support, rather than being seen as individuals who can contribute, including contributing to the wellbeing of others (Mead & Copeland, 2000).

However, despite the many types of supportive interactions that were described, it was not always easy for participants to give and receive support. Barriers to supportive interactions included the chaotic and, at times, frightening environment of the ward, as well as personal difficulties, such as not feeling well enough to listen to others. One particular challenge in both giving and receiving support was the perceived need to “tread carefully” in order to avoid topics that might be too painful to discuss. However, participants showed an awareness of these barriers and challenges. For example, several described instances of calling on staff to help when they knew peer support was not sufficient, and some recognised the importance of looking after themselves as well as supporting others.

Recognition of these challenges and barriers is particularly important, given the concerns that some professionals have expressed about service users supporting one another: namely that peer support can cause harm, encourage an anti-professional stance, make individuals dependent rather than independent, and is essentially the ‘blind leading the blind’ (Lee, 1995; Salzer et al., 2001). Service users have also reported that inpatient settings typically do not encourage or make use of mutual peer support in the way in which other settings, such as therapeutic communities, do (Loat, 2006). Consistent with this, a small number of participants

in the current study felt that staff actively discouraged mutual peer support on the ward, preventing them from having the opportunity to enact valued personal principles or learn about resolving interpersonal conflict.

It could be argued that there is the potential for these challenges and barriers to be addressed if mutual peer support were to become a recognised component of an inpatient stay. Increasingly, services are being asked to take a more holistic approach to recovery, concentrating on other aspects of wellbeing and identity rather than solely focusing on the reduction of symptoms (DoH, 2001; MIND, 2013; Slade, 2010). Peer support in the community often aligns itself with this recovery approach (e.g., Simpson et al., 2014) and the results of this study suggest there is no reason why mutual peer support in inpatient settings could not do the same. Not only could this provide a framework within which to understand and promote the role of mutual peer support in the inpatient setting, it could also help staff to identify how to assist service users in overcoming the barriers and challenges to peer support, thus enabling more individuals to experience the benefits of helping others and receiving help in return.

### **Limitations**

There are a number of limitations to this study. Firstly, whilst efforts were made to recruit a diverse sample, the participants are unlikely to be representative of the adult inpatient population from which the sample was drawn. Participants were recruited via the ward clinical psychologists, who may have selected service users who they viewed as further on in their recovery and more likely to engage in an interview. Not only does this mean that participants may have been more likely to engage in supportive peer interactions and experience them as helpful, but it also means it is not possible to draw conclusions about the experience of peer support at

more critical points of mental health crisis. In addition, the average length of stay for the sample was much longer than was typical for the setting. Whilst longer stays were usually due to service users experiencing a greater severity of symptoms on admission or having to wait for accommodation issues to be resolved, a longer period of time on the ward might have provided more opportunities for supportive interactions.

Secondly, all participants were recruited from the same hospital site. Caution must therefore be exerted in generalising the findings to other acute units, which might operate differently. Furthermore, it is unclear whether the findings can be generalised to other types of inpatient settings, such as long-stay rehabilitation wards.

Thirdly, the setting of the interviews may have also impacted on the findings. Interviews were conducted on site, for the majority of participants in a quiet room on the ward that they were part of. Whilst every effort was made to ensure confidentiality and anonymity, it is possible that some participants did not feel they could be open and honest about their experiences. Furthermore, the researcher was completing a clinical placement at the hospital site during recruitment and analysis. Whilst steps were taken to minimise this potential source of bias, it may have influenced what the researcher paid attention to when generating themes from participant accounts.

Finally, the interviews asked participants to reflect on complex processes and required a degree of self-reflection and awareness. Every effort was made to minimise the potential impact of mental ill health on the participants' ability to engage in the interview process; however some participants continued to experience issues with their wellbeing at the time of the interview and found it challenging to

focus on the interview topics. This also impacted on the analysis. Some interpretation of participants' accounts was needed, which could have brought bias into the results. Furthermore, interviews relied upon participants' subjective recall of occasions that were potentially quite distressing and difficult to remember, which may also have limited the accounts that they were able to provide.

### **Implications for service delivery and future research**

The findings of this study have a number of potential implications, both from a clinical and research perspective. Firstly, they highlight how important and valuable the experience of mutual peer support can be for service users during their time on the ward, and how it can contribute to their recovery. Whilst there are a number of important challenges to be acknowledged, the benefits for giver and receiver alike would suggest it should be considered as a component of an individual's admission to hospital.

The accounts of participants in this study could be used to contribute to the development of inpatient practices and inform ward strategy, policy and procedure. They suggest that the focus should be on creating an environment for peer support opportunities to occur, noticing and encouraging them when they do, and trying to support service users to overcome some of the more challenging aspects. For example, one participant highlighted that although it was helpful to attend the groups run on the ward, many of these did not encourage casual conversation between service users. She wondered whether having a dedicated group where participants discussed hobbies and interests, such as films or books, would help ward members to get to know one another a bit better. As the findings of this study suggest, companionship is one of the foundations of supportive interactions. Making it a

discussion topic during ward rounds, one-to-one named nurse interactions and handover discussions could be another way of achieving this and providing a forum to discuss any issues that arise.

However, it is important to remember that participant accounts varied in the extent to which, and the manner in which, they gave support to others and received it in return. Respecting individual preferences will be important: any implementation of the results of this study in a clinical context should take this into account. It will also be important to ensure that the principles that underpin peer support more generally, such as mutuality, choice and respect, are maintained and that any implementation of these ideas is not done in a coercive manner or in a fashion which feels forced for service users.

Finally, it is likely that any implementation of the results of this study to a clinical context will need to address the concerns of staff. As has been noted, staff members often express unease at the idea of service users supporting one another, being understandably apprehensive about the nature and content of this support (Salzer et al., 2001). However, this apprehension may be due, in part, to a lack of knowledge and awareness. The findings of the present study could be used to develop the knowledge and awareness of inpatient staff about the nature of mutual peer support, its potential role in supporting recovery and the associated challenges for service users. Supporting staff to understand these issues is likely to be central to developing an inpatient atmosphere which encourages helpful supportive interactions between service users.

There are a number of avenues for future research which would enable a fuller understanding of the phenomenon of naturally occurring peer support, as well

as providing a foundation for the implementation of the principles and ideas of mutual peer support to clinical contexts. One key area would be to explore staff perspectives of mutual peer support in inpatient settings. Not only could this identify potential barriers or challenges specific to staff, but it could also clarify concerns they may have with regards to service users supporting one another in these environments.

Secondly, given the challenges some participants encountered with reflecting upon their experiences in an interview setting, it could be helpful to complement the findings of this study with one that employed ethnographic and observational methodologies. Such approaches seek to understand a phenomenon by the researcher 'immersing' themselves in a setting and using detailed field notes to record observations, experiences and reactions (Barker et al., 2016; Harvey, 2006). Thirdly, any application of the findings of this study to a clinical context should be accompanied by an appropriate evaluation in order to explore impact. For example, a brief pre-, post- questionnaire could be used to evaluate the impact of a staff psychoeducation programme about mutual peer support in inpatient settings.

Overall, the findings of this study highlight the value of mutual peer support for service users during their inpatient admission, although there are some key challenges to be acknowledged and further research is needed to continue to develop our understanding of this phenomenon. Yet the mutual support, hope and encouragement that enables service users to thoughtfully respond to each other, cope with their inpatient stay and engage with valued and problem-free identities is surely something that should no longer be overlooked.

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## **Part III: Critical Appraisal**

This critical appraisal considers some of the challenges in carrying out the research reported in Part 2 of this thesis. Firstly, I will reflect on the challenges of conducting qualitative research in a mental health setting, in particular difficulties encountered using semi-structured interviews with individuals in acute inpatient wards and ethical dilemmas concerning how service user accounts were used. Secondly, I will reflect on two dual roles I held and how these impacted on how I approached the research project: (1) being a carer whilst also a trainee clinical psychologist and (2) conducting research whilst being a member of the clinical team at the recruitment site. Finally, I will reflect on one particular aspect of the findings and discuss this in the wider context of the current mental health system.

### **Challenges of qualitative research in a mental health setting**

One of the strengths of qualitative research is its potential to capture the complexity and richness of an experience or phenomenon (Braun & Clarke, 2006). Grounded in participant accounts, qualitative methodologies can be particularly useful when the aim is to understand and represent the views of mental health service users (Elliot, Fisher & Rennie, 1999). However, there are challenges to conducting qualitative research in mental health settings. Firstly, using semi-structured interviews to gather information from individuals who may still be experiencing distress can be difficult. Secondly, from a critical perspective there are ethical dilemmas, in particular the potential for qualitative research to turn the personal stories of service users into a commodity, something to be mined for details that serve the interests of others (Costa et al., 2012).

### **Conducting semi-structured interviews in acute inpatient settings**

Semi-structured interviews are designed to be used flexibly, allowing participants to tell their story whilst concurrently ensuring the interview covers a number of main areas (Barker, Pistrang & Elliott, 2016). Balancing these, sometimes competing, demands can be tricky and is an important skill of a qualitative researcher (Barker et al., 2016).

In my own experience, this was a major challenge I encountered when interviewing participants. There were times when symptoms of mental ill health, especially those connected to psychosis, meant that participants could get caught up with ideas that were not connected to the interview schedule. I found it tricky to balance, on the one hand, providing the space for participants to speak about what was important to them, and on the other hand, bringing the conversation back to the main areas of the interview. Not interrupting, even if answers were long, and being prepared to ask the same question in different ways without getting frustrated, were ways in which I attempted to manage this. The interpersonal aspects of the interview could also be difficult for the participants to manage, particularly when they seemed worried about their answers being negatively appraised. During these occasions, I found it was important to provide lots of reassurance, reminding participants that I was interested in their opinions and views and, therefore, there was no right or wrong answer. I also found it helpful to use the de-briefing period at the end of the interview to discuss these issues with participants.

Throughout the interviews I was keen to minimise any power imbalance between the participants and myself. However, at least two factors may have limited my ability to do so. Although I only interviewed individuals with whom I did not work clinically, I was still introduced to participants as a trainee clinical psychologist. Being identified as a clinical member of staff, even if it was one who

was outside of the ward team, could have set up a dynamic whereby the interviews mirrored service users' interactions with ward staff. Furthermore, I also approached participants through the ward clinical psychologists and all interviews were conducted on the ward. Being the setting of their inpatient admission, it is unlikely this was a neutral or comfortable environment for participants. A preferable alternative would have been to interview participants in a community site not connected to mental health services; however, for practical reasons this was not possible.

### **Ethical dilemmas**

Over the past three years, my personal and professional experiences have highlighted the social and political context of being a 'service user' (Newnes, Holmes & Dunn, 1999; Orford, 2008; Smail, 1994, 1995, 2005). My interest in service-user movements, empowerment practices and community psychology has developed as a consequence of feeling that these aspects are still largely ignored. In light of this, I felt it was important to reflect on some of the ethical dilemmas they highlight for me when thinking about the research project itself. As a trainee clinical psychologist, I am required to submit a piece of empirical research in order to achieve qualified status. I wonder about the impact this may have had on the way in which I approached the research and my intentions in using participant accounts. I also wonder how much this research project may reflect some of the wider issues about service user involvement in research more generally.

Service user involvement in research, whether as collaborators or as informed participants, has historically been considered a universally positive thing (Beresford, 2002). Without wishing to detract from attempts to recognise the value of service

user perspectives and experiences, or redress the imbalance of power that naturally exists within services, taking a wholly uncritical approach to involvement can be equally problematic (Beresford, 2002). There are a number of different ways in which service users can be involved in research, but a distinction can be made between collaboration and involvement (Trivedi & Wykes, 2002). Service user collaboration in research often identifies itself as inherently political; it seeks to influence and change research paradigms, placing service user interests at the heart of the research process (Lindow, 2001). In contrast, service user involvement in research feeds the knowledge and experience of service users into existing structures (Lindow, 2001). This makes it much more likely that service user accounts are used for the intentions and purposes of others, to confirm or promote the ideas, services or structures of professionals rather than those of the service users themselves (Costa et al., 2012; Lindow, 2001). The ethical dilemmas of treating service user accounts in this way are particularly poignant when one considers the deeply personal, and often quite painful, nature of these stories and mirrors many of the disempowering practices that occur within services.

I have relished the opportunity this research project has afforded to develop my knowledge of peer support. However, before I read the critical literature on service user involvement, I had not fully appreciated the ethical dilemmas of using service user accounts and, as such, had not considered this in terms of my own project. It is hard to deny that, whilst it has certainly been something I feel passionately about, one of my intentions in completing this project was to pass my doctorate programme. Given the time limitations this imposed, I could not consult with service users when planning the project to explore their interests in naturally occurring peer support in inpatient settings and what they would want this research

project to be used for. Furthermore, as the project progressed I became increasingly interested in using the findings of the study to promote peer support in inpatient settings, particularly among staff members.

Reflecting on these intentions makes me acutely aware of how I have used service user accounts for my own purposes and advantages. Not only have their stories furthered my professional career, but this project has served my own interests and those of the academic literature, rather than those of service users. Even though I may not have fully appreciated these dilemmas throughout the course of the project, I hope that I have been able to remain respectful of the service user stories I have borne witness to. At the very least I feel it has taught me some valuable lessons about service-user inclusion, namely the difference between being informed by service user perspectives and being truly collaborative in research. This is something I hope I can continue to consider and put into practice throughout the remainder of my clinical and research career.

### **Reflections on the researcher position**

Personal reflexivity is considered a core component of good qualitative research (Finlay, 2008; Willig, 2013). One of the salient aspects of personal reflexivity is thinking about the position of the researcher, both in relation to participants and also with regards to the wider setting and context of the research study (Acker, 2000; Asselin, 2003; Breen, 2006; Dwyer & Buckle, 2009). Researcher position can be considered on a continuum of insider-outsider: insider positions involve the researcher belonging in some way to the particular group under study (either by shared experience, identity or role) whereas in an outsider position the researcher is more detached (Berger, 2015; Dwyer & Buckle, 2009). With

advantages and disadvantages to both, qualitative researchers have appreciated that one does not need to be one or the other to conduct good research, but to be open to and aware of to how these different positions may impact on the research (Acker, 2000; Dwyer & Buckle, 2009).

I believe there are two main positions that it is important for me to acknowledge and reflect on as part of this research: (1) being a ‘carer’ whilst concurrently being a trainee clinical psychologist and (2) being a clinician-researcher.

### **Being a ‘carer’ and a trainee clinical psychologist**

For the past few years one of the identities my sister has had is that of a ‘service user’. Whilst I have not personally experienced mental health issues that require hospitalisation, my sister has. This has placed me in a ‘carer’ role. I have witnessed her on-going journey to make sense of her experiences and negotiate these with the services that support her. Alongside this I have spent the past three years training to be a clinical psychologist. This has required me to be part of a variety of different mental health services and provide therapeutic support to both ‘service users’ and ‘carers’.

In relation to the participants of this study, these experiences placed me in both an insider and outsider position. I do not wish to claim to be a full insider, having not been a ‘service user’ in hospital personally. However, I do believe I had an insider perspective of sorts. My sister’s experiences brought me to this research with a desire to promote alternative sources of support outside that of professionals. It also made me keen to explore and acknowledge the identities of participants outside that of ‘service user’, which could have made it likely for me to notice these

aspects in their accounts. Yet, as a trainee clinical psychologist I also sat on the outside. Whilst I was not part of participants' support teams, I was still part of the wider NHS mental health system. I did not disclose to participants my personal experiences as a 'carer'. Throughout data collection I was aware there were times when participants seemed to fear their answers being negatively appraised. I wonder if in deciding to only position myself as an outsider, I missed out on presenting an identity that could have helped participants feel more comfortable.

### **Being a clinician-researcher**

The second position I believe it is important to reflect on is that of being part of the clinical psychology team at the recruitment site, whilst concurrently conducting research there. Although there are several benefits that come with being a clinician-researcher, there are a number of important challenges to be considered too. As well as creating the potential for a clash of agendas, the different ways one interacts with and responds to participants as a researcher compared to clients as a clinician can create a number of internal and ethical conflicts (Thompson & Russo, 2012; Yanos & Ziedonis, 2006). It is important that clinician-researchers have the space to reflect on these conflicts in order to try and reduce any potential adverse effects they may have for participants and the research project as a whole (Thompson & Russo, 2012).

As a trainee clinical psychologist in the inpatient psychology team, I struggled to work in the medically dominated systems of the acute wards. During my time there I witnessed a number of coercive practices, which often meant I felt I had to advocate for the individuals I was working with whilst concurrently trying to forge relationships with the professionals who were part of their support teams. At

times, drawing on a recovery perspective put me at odds with the opinions of other professionals, who seemed to largely work from a biomedical understanding of mental distress. Furthermore, although I was part of the clinical team, I was also an outsider in some ways: being a trainee on placement came with a sense of impermanence.

Usually, clinicians who conduct research at the same site face the dilemma of ensuring their role does not skew them towards the positive aspects of participant accounts so that they overlook negative or contradictory ideas. However, I wonder whether my experiences had the opposite effect. When analysing participant accounts, it was easy for me to notice aspects of the ward environment (including the reactions of staff) that impacted on participants' ability to engage in mutual peer support. It was also easier for me to notice examples of the helpful aspects of mutual peer support, particularly with regards to the valued identities and principles this enabled participants to engage with and how they felt it contributed to their recovery. Having the opportunity to use supervision and self-reflection to think about these two dual roles, particularly during data collection and analysis, have been important steps in trying to minimise the impact of these ideas on findings of the research.

### **Identity, recovery and the role of the wider mental health system**

For me, one of the most poignant and inspiring aspects of the results are the stories of ability: the ability of service users to support others, be thoughtful in their responses and work together to inspire and achieve change. Whilst there is much talk of recovery, at present the mental health system (particularly acute inpatient settings) remain dominated by biological and psychological models of mental ill health. By drawing on narrative perspectives and service user critiques, I hope to

highlight how these models can adversely impact on service users, particularly in terms of their identity. In doing so, I aim to illustrate the potential power of the results to help mental health services see beyond the 'service user' identity and acknowledge and encourage the valuable resources of service users.

### **The impact of the 'service user' identity**

Narrative perspectives can provide a framework for understanding the development of identity. At their very heart, narrative theories assume that in order to make sense and meaning of our daily lives we link events together in a particular sequence to create stories (White & Epston, 1990). Not only do these stories constitute our lives, but life also shapes them (Morgan, 2000). There are many different types of story and they can belong to individuals, families, communities and societies (Morgan, 2000). Narrative perspectives assume that life does not occur in a vacuum: context influences the meaning that stories have (or are given) and can also determine which stories are given preference (Morgan, 2000). In this manner there is an acknowledgement of power (White & Epston, 1990).

Narrative perspectives define problems in a particular way: 'problems' arise when an individual's valued personal stories do not fit with the dominant context. 'Problems' are assumed to mask complexity and draw attention away from the workings of power and context, which can suppress valued personal stories so that they become unheard, disregarded, masked or dormant (Morgan, 2000; White & Epston, 1990). Furthermore, 'problems' can influence how an individual is perceived by others, particularly in terms of their skills, knowledge, resources and abilities (Morgan, 2000). In this manner, 'problems' encourage superficial descriptions of individuals that do not reflect their own valued personal identities and

can continue to grow and impact on future events for an individual (Morgan, 2000; White & Epston, 1990).

Service user critiques of the mental health system frequently highlight how this system can impact on how service users are perceived by others, but also how they perceive themselves (Mead, Hilton & Curtis, 2001). It has been argued that understanding mental distress solely as an expression of neurobiological or psychological problems creates a culture of 'illness' and 'deficit' (Mead et al., 2001; Newnes et al., 1999). Not only does this mean the social and political context of mental distress is ignored (Orford, 2008); it can also lead services to infantilise service users, encouraging them to be passive recipients of support, rather than viewing them as able individuals who can also contribute to the wellbeing of others (Mead et al., 2001; Newnes et al., 1999). In this manner, it is easy to comprehend how being a service user can become one of the main identities of an individual to the detriment of other aspects of their lives.

It is possible to map the principles of narrative theory onto these critical perspectives. One could argue that the dominant context in the current mental health system is one of biological and psychological problems. These problems locate mental health issues within service users. They prevent service users from being able to tell their own stories of distress, mask the social and political aspects that contribute to distress (such as poverty and stigma), and draw attention away from other areas of their lives, such as their family roles and responsibilities or their strengths and abilities. For me, considering the results of the research in light of these ideas highlights their potential importance and value in a number ways.

Firstly, the stories in participants' accounts stand in contrast to the deficit, problem-focused narratives encouraged by biological and psychological models of

mental distress. Rather than simply being individuals in need of support, the results highlight how service users have something worthwhile to offer – something more complex than just “the little things”. Throughout their accounts participants demonstrated a high level of understanding, respect and sensitivity to the needs of others. They were able to sit with distress without feeling the need to provide a solution. They thoughtfully calibrated their responses to situations and individuals. They understood the importance of balancing offering support with respecting personal space. They were a source of comfort, encouragement and hope, even during times of intense distress. In my experience, these are qualities that are not often attributed to ‘service users’.

Secondly, the results illustrate how the opportunity to engage in valued identities can contribute to wellbeing. Demonstrating narrative principles in practice, they highlight why it is important to pay attention to other aspects of service users’ identities and lives. For a couple of participants supporting others enabled them to take a mothering role or live out their faith, which made them feel better about themselves and contributed to their recovery. These results are an encouragement to services to look beyond the sole focus on the management of symptoms and seek to provide opportunities to notice and encourage all aspects of an individual’s identity, particularly those that can contribute to wellbeing.

Thirdly, the results exemplify how peer support is more than simply being nice, but is also about individuals working together to encourage and challenge one another to consider the consequences of their behaviour and choices. Non-professional forms of support, such as peer support, often concern professionals because of the assumption that they will promote unhelpful choices and an anti-professional stance (Salzer, Rappaport & Segre, 2001). Whilst any advocate of peer

support would clearly identify the importance of empathy and understanding in peer relationships, they make no pretence that this is where they end. As Mead and colleagues (2001, p. 136) so eloquently describe: “*Relationships that heal challenge the need to hide and to use defensive, self-justifying explanations in social encounters. Peer support can and should contribute to the challenge, not foster collusion with roles that we have defined ourselves by in the past*”.

All in all, although the recovery model is much talked of, particularly in secondary mental healthcare settings, in my own personal and professional experience I do not believe it is truly put into practice. Biological and psychological models of mental distress continue to dominate the current mental health system to the detriment of the individuals that services purport to support. I hope the results of my research will help professionals understand the importance of seeing beyond the ‘service user’ identity and encourage them to recognise the skills, resources, abilities and strengths of service users. In the words of one participant “we’re stronger if we work together”.

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## **Appendix A**

### **Confirmation of NHS Ethical approval**

09 July 2015

Dr Vyv Huddy  
University College London  
1-19 Torrington Place  
London  
WC1E 7HB

Dear Dr Huddy

<b>Study title:</b>	<b>Service User and Staff Experiences of the Provision of Psychological Support in an Inpatient Mental Health Setting</b>
<b>REC reference:</b>	<b>15/EM/0263</b>
<b>IRAS project ID:</b>	<b>171378</b>

Thank you for your letter of 3 July 2015, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant Tad Jones, [REDACTED]. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [REDACTED]. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” above).

### **Approved documents**

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper	1	27 May 2015
Covering letter on headed paper	2	03 July 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Document]	1	
Interview schedules or topic guides for participants [formal support service user]	1	

Interview schedules or topic guides for participants [Interview schedule about formal support psychological therapist]	1	29 May 2015
Interview schedules or topic guides for participants [informal support service user]	1	29 May 2015
Interview schedules or topic guides for participants [Interview schedule informal support staff member]	1	29 May 2015
IRAS Checklist XML [Checklist_03072015]		03 July 2015
Letter from sponsor [Confirmation from sponsor]	1	
Other [CV Anna Galloway]	1	01 April 2015
Other [CV for student Catherine Small]	1	02 April 2015
Participant consent form	1	01 April 2015
Participant information sheet (PIS) [Staff]	v1	01 April 2015
Participant information sheet (PIS) [Patient]	1	01 April 2015
REC Application Form [REC_Form_27052015]		27 May 2015
Referee's report or other scientific critique report	1	16 December 2014
Research protocol or project proposal	3	03 July 2015
Summary CV for Chief Investigator (CI)	1	01 April 2015
Summary CV for supervisor (student research)	1	01 April 2015

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

**15/EM/0263**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

  
pp.

**Vice-Chair**  
**Mrs Janet Mallett**

Email: 

Copy to: *Mr Dave Wilson*

*Ms Fiona Horton, North East London Foundation Trust*

## **Appendix B**

### **NHS Trust Research and Development approval**

[Redacted]

Date: 1<sup>st</sup> September 2015

Dear Anna Galloway and Catherine Small,

**RE: Service user and staff experiences of the provision of psychological support in an impatient mental health setting**  
**R&D Reference Number: 2371**

I am pleased to inform you that the above named study has been granted approval and indemnity by [Redacted] NHS Foundation Trust. You must act in accordance with the [Redacted] NHS Foundation Trust's policies and procedures, which are available to you upon request, and the Research Governance Framework. Should any untoward events occur, it is **essential** that you contact your Trust supervisor and the Research and Development Office immediately. If patients or staff are involved in an incident, you should also contact the Governance and Assurance department, in [Redacted] Hospital, and complete the Incident and Reporting Form, namely the IR1 form.

You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

[Redacted Signature]

[Redacted Name]

Research and Development Manager, [Redacted] NHS Foundation Trust

2371 [Redacted]

[Redacted]

**Appendix C**  
**Participant Information Sheet**

## Experiences of Support in Inpatient Settings

You are being invited to take part in a research study. This information sheet explains the purpose of the research study and what participating will involve. Please take time to read the following information and discuss it with others if you wish. If there is anything that is unclear, or if you would like more information, please ask.

### ***What is the reason for the study and why is it important?***

We would like to explore what people think about the support on inpatient wards, both in terms of psychological therapies but also that which occurs between service users. The information we gather may help us to find ways to make services more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

### ***Why have I been invited to take part?***

You have been invited to participate in this study because you are or have been resident on the ward and we are inviting both people who have received psychological therapy and those that haven't.

### ***Do I have to take part?***

Participation is completely voluntary. You are free to withdraw at any point without giving a reason. Your decision will not affect your patient rights or your future care.

### ***What will happen if I take part?***

If you agree to take part, we will arrange a time to meet with you and conduct an informal interview lasting no longer than an hour. During the interview we will ask you questions about your views and experiences of receiving help while on the ward. With your consent, we will audio-record the interviews so that we do not miss anything important that you tell us. These will be arranged at a time convenient for you.

Should you decide to participate in this study, you will be given a copy of this information sheet to keep, and you will be asked to sign a consent form to indicate that you understand the purpose of the study and agree to participate. As a thank you for your contribution to the study we are offering supermarket £10 shopping vouchers.

### ***What will happen to the information I provide?***

All interviews will be typed up and anonymised (your name or any details which could identify you will be changed or deleted). Once the recording has been typed up, the recording will be destroyed. The researchers will listen to all the interviews and identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report. If you would like a copy of the final research report you can contact the research team.

If you decide to withdraw from the study the information you have provided up to the point of withdrawal will remain in the study.

### ***What are the risks and possible benefits of taking part?***

It is possible, but unlikely, that you could find it upsetting to talk about your experience of receiving support whilst being resident on the inpatient ward. If this happens, you can ask

the researcher to take a break or stop the interview at any time. You do not have to answer any questions you do not feel comfortable answering.

You may find that talking about and reflecting on your experiences is interesting and helpful. We also hope that our findings from this study will benefit other people who may wish to get psychological support whilst receiving inpatient care.

***Confidentiality and anonymity***

All data will be collected and stored in accordance with the Data Protection Act 1998. Audio recordings from the interviews will be stored on a password-protected computer and will be deleted once transcripts have been made. Names and other personally identifiable information will be removed from transcripts to ensure anonymity. We may include direct quotations from interviews in published reports but will not include names of participants and we will make sure that any quotations we use cannot be linked to individuals. We will store the anonymous interview transcripts in a secure location for five years after publication of the results. If you tell the researcher something that leads them to think that you or somebody else is at risk of significant harm, they may have to discuss this with somebody to ensure your safety.

***What if there is a problem?***

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. In the event you wish to complain contact the chief investigators using the details given below.

In the unlikely event that taking part in this study harms you, compensation may be available. If you suspect that the harm is the result of the Sponsor's (University College London) or the psychology service's negligence then you may be able to claim compensation. After discussing with the student researcher, please make the claim in writing to Dr Vyv Huddy who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then pass the claim to the sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

***Contact for further information***

If you would like further information please contact the study chief investigator Dr Vyv Huddy, Lecturer in Clinical Psychology, University College London, [REDACTED]

Research Department of Clinical, Educational and Health Psychology  
University College London  
Gower Street  
London WC1E 6BT

Thank you for considering taking part

**Appendix D**  
**Consent form**

[UCL Logo]

[NHS Trust logo]

**Experiences of Support in Inpatient Settings**

**Version 1, 01/04/2015**

I confirm that my participation in the above project has been explained to me. I have read and understood the information sheet and have had the opportunity to ask questions.

I am aware that (please initial in the boxes):

- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
- I am free to withdraw from the project at any time and to withdraw any data that I have supplied without giving any reason.
- The interview will be recorded and all data or information used for research or publication purposes will be anonymous.

In addition

- I give consent for quotes from the interview I take part in to be included in reports of the research findings.

I agree to participate in the above project.

Participant's Name: .....

Signature: ..... Date: .....

Researcher's Name: .....

Signature: ..... Date: .....

If you would like any further information please contact

Dr. Claire Williams, Clinical Psychologist, [Psychology] Service ([Name] Foundation Trust).

[Contact email] ([Contact number])

## **Appendix E**

### **Semi-structured Interview Schedule**

## **Introduction**

Thank you for meeting with me today. As you know, I'd like to talk with you about your experience of being part of the ward. My aim is to better understand what it is like for you whilst you are here and your experiences of being with other service users, both when it has worked well and when it has been more challenging. I understand being admitted to the ward can be difficult for people. It is up to you how much information you would like to share and please let me know if you would rather not answer a particular question. To begin, it would be really helpful if you could tell me a bit about how you came to the unit.

## **Background/Overview**

- How long have you been on the unit for?
- Have you been to this unit before?
- Can you briefly describe what led to your admission?

## **Experience of the unit**

- What has it been like being in hospital?
  - How do you typically spend your time?
  - How would you describe it to other people?
  - Who have seen or spoken to since you've been here?
    - Staff members?
    - Other ward members?
- Has there been anything helpful about your stay?
  - Can you give me an example?
  - How important was this to you?
- Has there been anything unhelpful about your stay?
  - Can you give me an example?
  - How important was this to you?

## **Receiving**

- Thinking particularly about the other individuals that are on the ward with you, has there been anyone who you have made a connection with?
  - Is there anyone you prefer to spend your time with?
- How do you spend your time together?
  - Can you give me an example of that?
- Do you spend time talking together?
  - Things you have in common?
  - Friends
  - Family
  - Life on the ward?
  - The difficulties that led to you coming to the ward?
- Do you ever just sit down a chat/moan/talk to anyone about what is on your mind?
  - Can you give me an example of that?
  - Do you remember what you said? What did you say?

- Do you remember what he/she said? What did he/she say?
- Is there anything in particular that you enjoy doing together?
  - Can you give me an example of that?
- Have they ever given you any advice or helped you out whilst you've been here?
  - Can you give me an example of that?
- Overall, how do you think these experiences have contributed to your stay on the unit?
  - Has this made a difference to your stay?
    - Made it easier?
    - Made it harder?
    - Can you tell me more about that?
    - Can you give me an example?

### **Giving**

- Thinking particularly about the other individuals that are on the ward with you, has there been anyone who you have:
  - Given your time to?
  - Listened to?
  - Helped through a situation?
    - Can you give me an example?
    - What did you say/do?
    - What did they say/do?
- How do you spend your time together?
  - Can you give me an example of that?
- Do you spend time talking together?
  - Can you give me an example of that?
    - Things you have in common?
    - Friends
    - Family
    - Life on the ward?
    - The difficulties that led to you coming to the ward?
- Is there anything in particular that you enjoy doing together?
  - Can you give me an example of that?
- Have you given them any advice or helped them out whilst you've been here?
  - Can you give me an example of that?
- Overall, how do you think these experiences have contributed to your stay on the unit?
  - Has this made a difference to your stay?
    - Made it easier?
    - Made it harder?
    - Can you tell me more about that?
    - Can you give me an example?

## Ending questions

Just taking all of these examples as a whole, I'm interested in thinking with you about if there is anything we can do to help service users interact with one another in these ways and make it more likely to happen on the ward.

- Has there been anything that has helped other service users to support you?
  - How important was this to you?
- Has there been anything that has got in the way or made it more difficult for other service users to support you?
  - How important was this to you?
  - Are there any ways in which you wish it could be different?
- Has there been anything that has helped you to support other service users to support?
  - How important was this to you?
- Has there been anything that has got in the way or made it more difficult for you to support other service users?
  - How important was this to you?
  - Are there any ways in which you wish it could be different?

## Appendix F

### Examples of initial annotations and initial codes

#### Excerpt from Transcript of Interview 6

Interviewer: "Did being able to talk to [name] make a difference?"

Participant: "It does. It fills time in 'cause otherwise if you can't talk to anybody or you've got no common interest with anybody then it's gonna be really boring, but to have someone you can sit and talk to... You don't have to talk about your problems. I mean, she knows very little about my background. To, to talk to somebody makes the time go quicker it's much better yeah."

Interviewer: "So does she talk more about her problems than you talk about yours?"

Participant: "Yeah, I'm not very good at talking about my background... Cause it's quite a long winded... I've got quite a lot of baggage and it just seems unfair to offload on people all the time, and I get asked the same questions all the time. Everybody always says, 'oh, what about that, what about that'. It just gets a bit boring so I like to be the person who people talk to, rather than I talk to them. Um, it's because I have um, a rocky marriage at the moment so people will ask me if I'm gonna stay with him or whether I'm gonna leave him and you know, 'what does he do' and um, 'why do you think he does it' and so um, it's best that I just don't get into it and then when he comes on the ward people don't know any different so they don't treat him. I'm just a bit worried that if they know what he's like, especially if they're having one of their moments, they might come across and shout at him. So it's best that I don't say anything."

#### Initial annotations

Fills the time  
Common interest  
Gonna be really boring  
Sit and talk, don't have to talk a  
problems  
Time goes quicker, much better

I'm not good at talking  
I've got quite a lot of baggage  
Everyone asks the same question  
I just like to be the person who  
people to rather than I talk to them  
Difficult questions  
I'm just a bit worried  
If they're having one of their  
moments, they might come across  
and shout at him

**Appendix G**

**Excerpt from Interview 6 Summary Sheet**

## **Giving and receiving support**

### **Theme: Companionship**

- Having a laugh together (p. 6, 9, 12, 13)
  - Sharing food (p. 7)
  - Doing group activities together (p. 5)
  - Sitting together at meal times (p. 5)
  - Watching TV/films together (p. 6, 9)
  - “Chit-chatting” (p. 2)/“Bus stop” talk (p. 6)
- “You don’t have to talk about your problems” (p. 2)/ Problem-free talk
- o Family (p. 2, 9)
  - o Pets (p. 2)
  - o Films (p. 6)
  - o News/TV programmes (p. 5)
  - o Music (p. 6, 12)
- Talking about “silly stuff...like make up and girly stuff” (p. 8, 12) “random stuff” (p. 12)
  - Thinking/recognising needs of others (p. 7) “She never had any money so if anyone brought me in any food... I was always I would always slip her some food and like some nibbly bits of it she was well looked after she saw that I was looking after her”  
  
(p. 9) “Like tying her shoelaces. She had problems with bending down so I do that sort of thing for her”  
  
(p. 9) “She was asking about my [child] because she couldn't have any. She had um [pregnancy complication] thing so she couldn't have any children after that so she was talking...she was really interested in my [child] and what [they were] like and what [they were] doing”
- Asking how are you (p. 1/2)
  - Doing nice things for each other (p. 9) “I’d brush her hair for her”
  - Talking about personal circumstances (p. 2, 5-6)

### **Impact of companionship:**

**Times goes quicker** (p. 2, 5) “It fills time in ‘cause otherwise if you can't talk to anybody or you've got no common interest with anybody then it's gonna be really boring”

**It helps/It's nice** (p. 5) “I think just being there has helped just...just having someone you know that you've never talked to is help, rather than you know she doesn't like sit there and say oh I suggest you do this, but it's just being there and having someone to talk to is nice. So that's help in itself”

**It's important to have fun** (p. 8) **Problem-free talk** (p. 8) “so you know when to back off, cause I know when I don't want people to talk to me it's like right, we won't go down that path anymore, we- we'll talk about something else, so yeah. It sounds like she just didn't want to talk about anything heavy, she just wanted to talk about silly stuff so that's fine.”

## **Barriers**

**1. Disclosure example** (p. 3-4) **You've got to be careful** P6 describes how she did once speak to someone about her personal issues and it didn't work out well. P6 describes how the individual start to ‘preach’ at her and felt the SU was telling her to leave her husband. A staff member had to intervene in the situation. P6 also describes how this changed the way the SU interacted with her husband, which made things more difficult for her. This then meant P6 and the SU weren't as close afterwards (p. 4) “We weren't as friendly afterwards. I just don't think she understood why I was still married so...we sort of like drifted apart - we moved on to different people”

(Interestingly P6 offers the same advice to another SU experiencing relationship difficulties, however P6 does back off when she senses that the SU isn't happy to talk more about this)

**Worried about people's reactions** (p. 3) **It's not safe** (p. 3) “she was very friendly towards him before she'd always say hello and then she stopped saying hello and he got the hump, so it's best that I don't do that anymore.”, “people will ask me if I'm gonna stay with him or whether I'm gonna leave him and you know, ‘what does he do’ and um, ‘why do you think he does it’ and so um, it's best that I just don't get into it and then when he comes on the ward people don't know any different so they don't treat him. I'm just a bit worried that if they know what he's like, especially if they're having one of their moments, they might come across and shout at him. So it's best that I don't say anything.”

**Preaching** (p. 4) **Lack of understanding** (p. 3, 4) **judgement** (p. 4) “she couldn't understand why I was still married to him so...She was trying to get me to leave him...[Saying] ‘I don't know why you're still married to him, why don't you leave, you're young enough to get off and start on your own’ and all that sort of stuff. So it got a bit heavy... I think that's why somebody came round and got involved.”

**Feeling like you have to justify** (p. 4) “I just said that I love him, we've been together for thirty years it's just a blip at the moment and it'll get better. And so I mean, I really hope we're gonna get help to make it better. It's my choice I think.”

**Staff intervention needed** (p. 4) **staff intervention helpful** (p. 4) “She didn’t understand why but then a professional came over and sat with us and she said that it was my choice and it was up to me to do what I wanted, and really you know opinions are alright but she shouldn’t be preaching at me so yeah.”

## **Appendix H**

**Excerpt from a table developed in the final stages of analysis summarising the themes, subthemes and supporting quotations.**

**Theme 2.2: Treading carefully – excerpt of supporting quotations for one subtheme**

Theme	Subtheme	Participants	Supporting Quotes
2. Treading carefully	1. “It’s always a bit dangerous to go and poke too deeply” (P4)	P4, P6, P9	<p>P4: “I think you have to be aware of because you don’t actually have any idea about what the risks are, about what their problems may be, it’s all a bit dangerous to know exactly how to treat people all the time. Basically, you have to give a lot of space I think to people, when you can.” (p. 2), “One of the worries sometimes is that you can tell how people are perhaps more than I would think, but if you don’t know the risk assessment, you don’t know what it is that actually...it’s always a bit dangerous to go and poke too deeply.” (p. 10)</p> <p>P6: (p. 15) “when you feel rough the last thing you want is someone to come up and say ‘corr, you look rough today’, do you know what I mean or if you had a bad night, you know, you don’t want people to say, ‘corr, blimey you look really tired today’. You don’t need it, you know how you feel, you know that you probably look really terrible, you don’t need people to come up and tell you about it.”</p> <p>P9: “you could get involved...but I don’t know... you don’t know who you’re being introduced to, or what type of person...we all have our own personalities, and we all have our own troubles... you have to be so careful with” (p. 28)</p>

