"We're stronger if we work together":

Experiences of naturally occurring peer support in an inpatient setting

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Abstract

Background: Research on peer support in mental health inpatient settings has focussed on formalised programmes. Naturally occurring peer support – spontaneous interactions without structure or roles – has received little attention.

Aims: This study aimed to provide a detailed picture of service-users' experiences of giving and receiving support in an acute inpatient setting, and possible challenges encountered in such interactions. Staff perceptions were obtained in order to provide another perspective.

Method: Twelve service-users and seven staff took part in semi-structured interviews. Braun and Clarke's method of thematic analysis was used to analyse the transcripts.

Results: Service-users described a range of 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 challenges and barriers, such as having to 'tread carefully' and 'personal difficulties', which made it difficult to engage in giving and receiving peer support. Staff accounts were broadly consistent with those of service-users, but showed less understanding of the nature of peer support and emphasised its risks.

Conclusions: Naturally occurring peer support should be a recognised aspect of an inpatient stay. Staff education and policy should focus on creating environments for it to flourish.

Keywords: Peer support; Qualitative research; Mental health services; Recovery

"We're stronger if we work together":

Experiences of naturally occurring peer support in an inpatient setting

Peer support comes in many forms. At one end of the spectrum, it occurs naturally in informal interactions between individuals; at the other end, it occurs in formal programmes or services delivered by paid peer support workers. Whatever the form, at its core is the premise that individuals who have gone through similar difficulties can help each other by virtue of their 'lived experience': they can understand each other's distress, share skills and knowledge, instil hope and challenge stigma (Beales & Wilson, 2015; Faulkner & Basset, 2012; Stratford et al., 2017).

Although peer support in mental health originated in grassroots movements of service-users coming together, recent decades have seen an enormous growth (and corresponding research interest) in structured peer support programmes, particularly the employment of peer support workers in mental health services (Chinman et al., 2014; Gillard et al., 2015; Lloyd-Evans et al., 2014). While such programmes have many benefits, they also run the risk of peer support becoming 'professionalised' (Beales & Wilson, 2015; Stamou, 2014) and of a loss of integrity regarding its core values (Stratford et al., 2017). It is important that professionals do not lose sight of support that occurs without their involvement.

Naturally occurring peer support (i.e., spontaneous, help-intended interactions without structure or roles) in inpatient settings has received little research attention. The inpatient setting potentially provides unique opportunities for supportive interactions, given that individuals are living together in a self-contained environment. A rare study focussing on inpatients' experiences of peer support (Bouchard et al., 2010) describes a variety of supportive actions – e.g., sharing material goods, helping with activities of daily living,

sharing information – with perceived benefits for both recipients and providers. Although Bouchard et al. mention 'emotional support', there is little elaboration of the nature of such interactions, or of the potential challenges of giving and receiving emotional support in the context of high levels of distress.

The current, qualitative study aimed to provide a more detailed picture of naturally occurring peer support interactions in the inpatient setting. It focused on service-users' experiences of giving and receiving support, in particular emotional support, and possible challenges encountered in such interactions. Staff perceptions of such interactions were obtained in order to provide another perspective.

Method

Setting

The study took place on five single-sex (three male, two female) adult acute inpatient units at a London psychiatric hospital. The average length of stay was five to six weeks (with longer stays usually due to housing issues). There were no paid peer support workers on the units.

Participants

Service-users were eligible to participate if they: (1) were aged 18 years or older; (2) spoke English well enough to participate in an interview; (3) had been on the ward fo1111r at least two weeks; and (4) were considered well enough to participate, as judged by a member of the multidisciplinary team. Individuals were recruited from each ward through consultation with the multidisciplinary team. Purposive sampling was used to achieve diversity regarding age, gender, ethnicity and diagnosis. When possible, service-users were invited to participate towards the end of their inpatient stay so that they would have more experiences to reflect on.

Staff members were eligible if they had been working on the ward for at least one year as a mental health nurse, occupational therapist or support worker. These staff were

targeted because they spent substantial time on the ward and therefore were more likely to have witnessed, or be aware of, peer support.

Of 16 service-users invited to participate, 12 consented; reasons for declining included not having time and not wishing to be audio-recorded. Ten staff members were invited to participate and seven consented; the main reason for declining was not having time. Participants' characteristics are presented in Table 1.

Interviews

Two semi-structured interview schedules were developed, one for service-users and one for staff. The service-user interview explored experiences of receiving and providing support peer support whilst on the ward, and barriers and facilitators to this. Pilot interviews indicated that the term 'support' was too abstract; questions were therefore re-worded using more tangible concepts, such as 'making connections with other service-users' or 'talking about what is on your mind with other service-users'. Detailed examples of peer support interactions were elicited, including both positive and negative experiences.

The staff interview schedule explored staff perceptions (positive and negative) of naturally occurring peer support on the ward. Examples of any peer support interactions they had witnessed were elicited.

The interview schedules were used flexibly to allow participants to talk at their own pace about what was important to them (Barker et al., 2016). Service-user interviews ranged from 30 to 80 minutes (*M*=46 minutes); staff interviews ranged from 35 to 59 minutes (*M*=44 minutes). All interviews were audio-recorded and transcribed verbatim.

Analysis

Braun and Clarke's (2013) method of thematic analysis was used to identify patterns of ideas across the transcripts. The aim was to generate a rich description of participants' experiences, taking an inductive approach. The analysis followed the recommended steps in

an iterative manner: (1) reading and re-reading each transcript; (2) developing initial codes, based upon participants' actual words; (3) grouping initial codes for each transcript into preliminary themes; (4) generating a tentative thematic framework across transcripts; (5) refining and synthesising themes by comparing them across transcripts; (6) selecting quotations to support each theme. The final set of themes was informed by their frequency across transcripts, as well as how central the ideas were to an individual's account.

Service-users' interviews were analysed first because the study's primary aim was to gain an understanding of their experiences. In order to examine similarities and differences between service-user and staff accounts, staff interviews were analysed in two stages. First, the thematic framework developed from the service-user transcripts was applied to the staff transcripts to identify whether each of the service-user themes occurred in staff accounts. Second, the staff accounts were analysed without this framework (following the steps outlined above) to identify any additional themes.

In accordance with good practice guidelines (Barker et al., 2016), credibility checks were undertaken to ensure the rigour of the analysis. A subset of transcripts was coded independently by AG and NP and then compared and discussed; NP reviewed AG's coding of the remaining transcripts. In the later stages of analysis, AG and NP discussed different ways of labelling, clustering and synthesising themes, in order to reach a consensus on how best to represent participants' accounts

Researchers' background

At the time of the study, AG was a trainee clinical psychologist at the psychiatric hospital in which the research took place. She had an interest in service-users' lived experiences and recovery principles such as empowerment; she anticipated that peer support would be experienced as helpful. NP is an experienced qualitative researcher with an interest in peer support but little experience of inpatient settings. Both researchers engaged in a

process of reflexivity to think about their impact on the research. This included attempting to 'bracket' their assumptions (Fischer, 2009), which was facilitated through a research journal and discussion. Individuals with whom AG had worked clinically were not invited to participate in the study.

Results

Service user accounts

Service-users described many instances of giving and receiving peer support on the inpatient unit, as well as challenges and barriers to peer support (Table 2).

1. Peer support interactions

Companionship and friendship. All service-users spoke of at least one relationship they had formed with other service-users, which contributed to a sense of wellbeing. These ranged from *"real friendships"* (SU11) to less close *"connections"* (SU9), and were often based on *"little things"* (SU11) that promoted social engagement, such as personal greetings, humour and sharing items.

> *"...he would come up and shake my hand... [and give] me a cuddle, which sounds very trite but not at all really, not at all." (SU4)*

Most described family-like relationships that provided a framework for service-users to support each other and to live out valued roles:

> *"I was braiding her hair this morning and she felt like my little sister... She always comes to me for that... it makes me feel happy I can help her..." (SU7)*

"Stepping in". Service-users described a mutual process of *"stepping in"* (SU1) to help one another. Their examples divided into three types: providing protection against the aggressive behaviour of others, helping navigate the ward (especially on admission), and attending to others' physical needs. There was an active and protective quality to each.

> *"You get taken under someone's wing... if you're sitting on your own at dinnertime, somebody will come by and will talk to you…we do that to new people...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 conversations." (SU6)*

Responding to distress. Service-users described times when they responded to signs of emotional distress in others, and when others responded to their own distress. They highlighted the importance of providing the 'space to be upset' and to simply 'be with' the individual:

> *"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." (SU11)*

Service-users sometimes attempted to provide a different perspective on the situation or to normalise the distress. For example, SU3 spoke of how he found it helpful, after being very upset, when another service-user told him *"everyone gets like this sometimes"*.

Service-users seemed aware of their own limitations in responding to emotional or physical distress, alerting staff to the situation when they recognised that professional involvement was needed:

> *"There was one time when I was really upset... and [another service-user] was trying to calm me down... And then she went and got staff to help." (SU7)*

Talking about "personal stuff". Most service-users described instances of talking with another service-user about important personal issues, such as family/relationship difficulties or hearing voices. SU10 described how, on admission to the ward, he was *"...going through things I needed to talk to someone about but I had no-one to talk to"* and subsequently was able to talk to another service-user:

> "*I said I feel like Jesus Christ. I said I feel like a soul, something spiritual that affects me physical...In me, it gets heavy." (SU10)*

Being given the space to talk by someone who listened was highly valued:

> *"Just having someone you know that you've never talked to is help... she doesn't sit there and say 'oh I suggest you do this', but it's just*

> *being there and having someone to talk to...that's help in itself." (SU6)*

Service-users also showed sensitivity by *"pulling back"* (SU4) when a difficult topic of conversation was raised. SU4, who was ashamed of his work record, described how others had respected his unease about talking about work:

> *"[They] didn't probe any deeper...I think I've mentioned before that I haven't worked all the time... They won't press the issue...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." (SU4)*

"We're stronger if we work together". Peer relationships provided opportunities for cooperation, encouragement and mutual learning. As SU7 put it:

> *"... just knowing that someone else is trying their hardest to overcome [their difficulties], you have to try your hardest as well. And we're stronger if we work together." (SU7)*

In providing encouragement, service-users often thought carefully about what to say and how to say it. SU5 described how he calibrated his response to another service-user who had finally showered after weeks without washing:

> *"...anyone would be dancing for joy and giving him a high five... I had to refrain myself from being so chirpy... and just give him a 'well done'...because if I was to go over the top, then I know he probably wouldn't then have another shower..." (SU5)*

Service-users described helping one another to consider the consequences of their behaviour and think about alternative options.

> *"There's been times when I've said to other patients, 'What do you do this for?'...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..." (SU2)*

Having someone to plan the future with also inspired hope in moving on from the ward:

> *"We talk about opportunity, if it's possible to rent a room together... We try to help one another out when we go out from here." (SU8)*

2. Challenges and barriers to peer support

Ward context. All service-users commented on how the ward environment placed constraints on their desire to interact with others. Aggression, unpredictability, and a lack of personal space meant it could be an intimidating and frustrating place, which was not always conducive to supportive peer interactions.

> *"When manic patients come in its hard 'cause it means you have to hide in your room or feel scared, which isn't what you want to feel in hospital." (SU7)*

Some service-users felt that staff discouraged them from supporting others and did not understand its importance.

> *"...a staff member says go to my room, don't get involved... It blocks opportunity to talk over a problem with someone." (SU2)*

However, one service-user found it helpful when staff discouraged peer interactions because it *"protects us"* (SU9).

Treading carefully. Not knowing others well, and others not knowing them, meant that some service-users felt they needed to tread carefully when talking about their own or other individuals' lives. They worried about activating sensitive issues for others, sometimes leaving them feeling that it was safer not to say too much.

> *"...you don't know the risk assessments for others…You don't know if you're treading on painful ground if you mention something …it's always good to give someone a lift…but sometimes you don't want to aggravate things that you don't know about...it's always a bit dangerous to go and poke too deeply." (SU4)*

Worry about what others might think or say (and sometimes receiving unhelpful responses from others) also made some service-users reluctant to talk about their own issues, thereby making it difficult to receive peer support.

> *"[I don't say what is on my mind because] 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." (SU3)*

Personal difficulties. Giving and receiving support was sometimes challenging because of one's own personal difficulties: symptoms of mental ill health, side effects of medication, feelings of anger and frustration, or previous experiences that made it hard to trust others. This could make it difficult to connect with others, engage in helpful interactions and be helped in return. For example, SU3 described how "my brain gets in the way" of receiving encouragement or reassurance:

> *"I would ask a lot of people in here if they liked me or if they thought I was a nice person… [another service-user] 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." (SU3)*

Helping others can be distressing. There were occasions when service-users felt it was not possible, or appropriate, to support others. Witnessing other service-users' high levels of distress, including mood swings and aggressive behaviour, often left them feeling distressed themselves and unable to help.

> *"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... I didn't go and give her a hug then. Because sometimes when you[are] like that, you need somebody to... the nurses are very good with them. They have one-to-one..." (SU9)*

With this in mind, some service-users spoke of the importance of balancing supporting others with looking after themselves.

> *"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" (SU7)*

Staff accounts

The themes in service-users' accounts were (with one exception, 'Treading carefully') also present in staff members' accounts (Table 3). However, their descriptions tended to be less detailed, particularly regarding the ways in which service-users talked with each other about personal issues.

Two additional themes (Table 4) were prominent in the staff accounts: (1) peer support interactions that facilitated service-users' engagement with treatment, and (2) the dangers of peer support.

Facilitating engagement with treatment. Nearly all staff participants described how peer support could facilitate their own interactions with service-users and encourage treatment engagement. Difficulties in establishing a therapeutic relationship often arose because staff responsibilities (e.g., administering medication, enforcing service-users' stay on the ward) conflicted with service-users' wishes, resulting in staff being viewed as the "*enemy"* (S2). Such conflicts were sometimes resolved by conversations between the service-user and a peer, who provided another perspective or encouraged the service-user to evaluate their options. Staff also noted that service-users who had been reluctant to speak to them about their problems began to open up after talking to a peer.

Dangers. All staff expressed concerns about potential dangers or risks of peer support. These were often described in general terms, e.g. "it could go wrong" (S3), sometimes based on speculation and sometimes on observations of negative peer interactions. Staff's fears centred on service-users' behaviour being unpredictable and their relationships quickly moving from being supportive to unhelpful. Encouraging or reinforcing problematic behaviours (e.g. substance use, self-harm) in each other was perceived as a major risk. Staff also worried about the high level of support needed by service-users, which could potentially interfere with the "supporter's" own recovery.

Opinions varied regarding how these risks could or should be minimised. Some felt that peer support should be encouraged but closely *"observed and monitored"* (S3). Others described actively discouraging peer support interactions.

Discussion

Service-users in the current study described a range of naturally occurring peer support interactions, as well as challenges and barriers to both giving and receiving support. Staff accounts were broadly consistent with those of service-users, but they showed less understanding of the nature of peer support and placed greater emphasis on its risks.

A striking aspect of service-users' accounts was their thoughtfulness about their interactions and their responsiveness to each other's emotional needs. They described situations in which they or other service-users provided the space to be upset without offering solutions; talked openly about personal issues; actively listened to one another; pulled back when a difficult issue was raised; calibrated their responses to others' needs; and encouraged each other to think about their behaviour. These accounts are consistent with descriptions of formal one-to-one peer support programmes, in which an 'experienced' survivor provides support to someone at an earlier stage of recovery (e.g., Pistrang et al., 2012). However, the interactions described in the current study involved mutual support between service-users experiencing crisis and high levels of distress; despite being 'unwell' themselves, they were able to tune into the needs of others and respond sensitively.

Service-users were also very aware of – and thoughtful about – the challenges and obstacles to peer support. In addition to the constraints of the ward environment, they recognised their own limitations and potential risks to themselves. They were aware of their own and others' vulnerabilities, which sometimes led to engaging cautiously, or deciding not to engage at all, in emotionally-laden conversations.

Embedded in service-users' accounts was the intrinsic value of supportive social interactions with peers. From small acts of kindness to more emotional conversations about personal difficulties, such interactions were experienced as making the inpatient environment more tolerable as well as promoting recovery more broadly. The process of providing – not just receiving – support seemed particularly important: service-users often described their

efforts to help with a degree of thoughtfulness and elaboration that suggested these interactions were meaningful and satisfying. Although the benefits of helping others are oft-noted (e.g., Bracke et al., 2008; Faulkner & Basset, 2012), research on one-to-one peer support has tended to focus on the benefits for recipients. In the context of the inpatient setting, opportunities to help others may be especially valuable in promoting a sense of agency and a more positive identity, in contrast to that of a passive recipient of care.

Staff accounts showed less depth of understanding of the process and benefits of peer support, instead emphasising how peer support could encourage treatment engagement. They noted that service-users often perceived staff as coercive or untrustworthy, particularly when treatment decisions conflicted with service-users' wishes (Seed et al., 2016), and that peers could be a more trusted source of information about treatment options. However, peer support being valued because it promotes treatment compliance raises issues of 'co-optation', i.e., of peer support being absorbed into, or taken over by, the organisational culture (Alberta & Ploski, 2014; Alberta, Ploski & Carlson, 2012; Stratford, 2017).

Staff also did not seem to be aware of service-users' recognition of the challenges of peer support, or of their thoughtful attempts to manage them. Rather, they were highly concerned about deteriorations in mental health resulting from peer interactions, and focused on their professional responsibility to minimise such risks, by monitoring or discouraging peer interactions. It is likely that the current UK inpatient context heightened staff concerns: recent years have seen an increase in compulsory admissions and a focus on risk-management (Briner & Manser, 2013; Care Quality Commission, 2018). This risk orientation of services may, unfortunately, impede any consideration of peer support (Shaw, 2014).

Limitations

The study's sample size was small but not atypical of interview-based qualitative studies (Braun & Clarke, 2013). Although purposive sampling was used to achieve a diverse

sample of service-users, the transferability of the findings may be limited by several factors. Service-users were selected on the basis of being judged well enough to engage in a research interview; they therefore may have been further along in their recovery and more able to engage in, and reflect on, peer support interactions. Participants' average stay on the unit was also longer than was typical of the setting; longer stays may have provided more opportunities for peer support. Because service-users were recruited from one hospital site, caution must be exerted in generalising the findings to other acute units or to other types of inpatient settings. The staff sample was also small and limited to three professional groups. Staff attitudes to naturally occurring peer support need further investigation, particularly whether staff from different professional backgrounds or with different levels of experience hold different views.

Implications

The inpatient setting, by its very nature, provides opportunities for social engagement. Arguably, naturally occurring peer support should be a recognised aspect of an inpatient stay, and policies should focus on creating environments for it to flourish. The present study suggests, however, that staff may not be fully aware of the nature of peer support interactions and their potential value; staff descriptions of emotionally supportive peer interactions were notably less detailed than those of service-users, perhaps because such interactions usually occurred without them. Research findings, such as those of the present study, could be used to develop staff knowledge and engage staff in thinking about peer support.

Naturally occurring peer support is, of course, not always smooth sailing. The challenges experienced by service-users and the concerns of staff therefore need to be addressed in staff education. However, the individuality of service-users – and the particular context of any peer support interaction – must be kept in mind: accounts in the present study point to variations in peer support that depend on many factors, such as the psychological

state of the provider or recipient, and personal preferences about how much to disclose. Staff may be able to help service-users think through the challenges of giving and receiving support, but it is crucial that they recognise service-users' independent capacity to engage with each other in mutually supportive ways and the benefits such interactions bring to their inpatient stay.

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Table 1. *Characteristics of participants*

Service-users (N=12)	
Gender	
Men	7
Women	5
Age	M=34; range: 20-58
Ethnicity	
White British	7
White European	2
Black British	2
Asian British	1
Primary diagnosis	
Mood disorder	6
Psychosis	5
Personality disorder	1
Weeks on ward	M=12; range: 4-24
Detained under Mental Health Act	7
Staff (N=7)	
Gender	
Men	3
Women	4
Age	M=42; range: 25-55
Ethnicity	
White British	3
Black British	2
Black African	1
Asian British	1
Profession	
Mental health nurse	4
Support worker	2
Occupational therapist	1
Years since qualification	M=13.7; range: 1-29
Years working on ward	M=4.7; range: 1-10

Table 2. *Service-user themes: peer support interactions and challenges/barriers to peer support*

Theme[a]	**Subtheme**[a]	**Illustrative quotations**
Peer support interactions		
Companionship and friendship (12)	Connecting with others (12)	*"It is a good friendship between us... It's very good [to have a friend]. It's more than important, it's vital like water." (SU8)*
	"Little things" promoting social engagement (12)	*"I remember seeing him... reading a book by himself and I think I might have asked him about it, asked him for a book... He said, 'Yeah, I've got loads of books in my room', and we went to his room and he gave me a book." (SU3)*
	Family-like relationships (8)	*"...he treats me like a son sort of thing... he's like a father figure sort of thing to look up to. (SU1)*
"Stepping in" (7)	Providing protection (5)	*"He had the pool cue in his hand and he went to go for me…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 [backed down]..." (SU5)*
	Navigating the ward (2)	*"He helped me find my way and brought me a packet of cigarettes the first week I come in." (SU2)*
	Attending to physical needs (3)	*"…he was very ill and people were feeding him. He was sitting down once and there was no-one feeding him…So I stepped in and sat down with him and I started feeding him… It made me feel good, feeding him...it makes me a more mature person, instead of being like a kid." (SU1)*
Responding to distress (8)	"Just being there" (7)	*"There was one time when I was really upset... she was just hugging me and comforting me..." (SU7)*
	Providing another perspective (5)	*She was worried they were going to take her leave away from her, but 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."...[after we talked] she put the smile back on her face so she's alright so." (SU6)*

Theme[a]	Subtheme[a]	Illustrative quotations
	Getting staff to help (5)	*"I said, 'I'm going to get a nurse'. And I quickly told the nurse, and the nurse said 'Thank you', and...they went to her assistance." (SU9)*
Talking about "personal stuff" (10)	Talking about problems (9)	*"When I can't sleep I start sharing a problem with another patient, explaining the issue that I'm going through, and it helps me to relax and sleep afterwards, I think." (SU2)*
	Listening not doing (6)	*"Well, I've learnt that when someone is speaking, I have to be quiet…and be active in listening to what they're saying...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." (SU11)*
	Recognising sensitive issues: knowing when to back off (6)	*"...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. It sound[ed] like .she just didn't want to talk about anything heavy..." (SU6)*
"We're stronger if we work together" (11)	Encouragement (6)	*"...you could praise each other on what you do. Give each other motivation. That's what it's all about. Building each other." (SU1)*
	Promoting helpful choices (7)	*"[Another service-user said to me] 'Don't get involved' when someone is misbehaving...let staff deal with them...It prevented me from attacking people that misbehave again." (SU2)*
	Learning from each other (5)	*"...he's more mellow than me, so I learn, you know... I've learnt a lot to be a more mellow person by his vibe." (SU5)*
	Planning for the future (5)	*"...he wanted to find some place to move into and I suggested he try [service name]...I had just seen that [place], had got a lot of leads on flats... so I mentioned that to him."(SU4)*
Challenges and barriers		

Theme[a]	Subtheme[a]	Illustrative quotations
Ward context (12)	An intimidating and frustrating place (9)	*"....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." (SU10)*
	Staff discourage "getting involved" (3)	*"They [staff] 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[helping others] as well." (SU1)*
Treading carefully (8)	Safer not to say too much (8)	*"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." (SU9)*
	Fear of others' reactions (3)	*"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." (SU12)*
Personal difficulties (8)	Feeling unwell oneself (4)	*"[the medication] sedates me to the point where I can't even open my eyes and look at you..." (SU10)*
	Thoughts and feelings get in the way (7)	*"When I'm angry or shouting at other patients, if I'm not in a good mood…Thinking short-mindedly and selfishly…I want to be on my own really and I don't want to give time to others." (SU2)*
	Hard to trust others	*"Long of my life when I think I have a friend, real friend, betrayed me…And believe me, now I so precautious..." (SU8)*
Helping others can be distressing (7)	Hard to witness others' distress (7)	*"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… I don't know how to help her when she doesn't want to help herself." (SU7)*

Theme[a]	Subtheme[a]	Illustrative quotations
	Need to look after oneself (4)	*"I know that I'm like a mummy…that's what I'm like…But we're not here for that are we, we're here to get better." (SU6)*

[a] Numbers in brackets refer to the prevalence of themes/subthemes, i.e., the number of participants (out of a total of 12) in whose transcript a theme/subtheme occurred.

Table 3. *Quotations from staff accounts corresponding to service-user themes*

Theme[a]	Illustrative quotations
Peer support interactions	
Companionship and friendship (6)	*"We have seen patients helping each other with clothes, shoes, they have done that. Some of them, birthdays, buying cakes and what have you." (S2)*
"Stepping in" (4)	*"If we have a new patient, they notice. Even if their behaviour is bizarre they will go to him and say, 'Oh let me show you, this is food time'…to kind of orientate [them]. They do that a lot." (S6)*
Responding to distress (3)	*"Well, if they're upset about something and another patient gives you comfort…it happens, daily. Putting their arms round people, 'Don't worry it'll be alright', you know little things like that. It's genuine you know... and it brings genuine comfort, so that's good" (S7)*
Talking about "personal stuff" (5)	*"Sometimes when they are sitting in the sitting room, the TV lounge, they do talk, they share their experiences…two of them were watching telly and one of them was making comments and then the other one started talking about when he went through, that kind of a thing…they talk about life experiences, like what jobs they do, like I would really like to get back to working as a [job]…It's kind of reassuring one another" (S6)*
"We're stronger if we work together" (6)	*"...you kind of see it in subtle little ways all the time, really. Just encouraging each other, sometimes, like little things, which you wouldn't even necessarily really think about because they occur all the time. Like just encouraging somebody to come and sit in the dining room for a meal or encouraging somebody to come into an activity." (S3)*
Challenges and barriers	
Ward context (6)	*"Especially for those who are maybe new to services, it's a very frightening experience. You come onto the hospital, everyone or almost everyone is disturbed and some are very loud... [a timid service-user] gets very frightened when people start shouting and speaking at the top of their voices...he withdraws in to his room, he doesn't want to engage because he's kind of scared." (S1)*
Treading carefully (0)	-----

Theme[a]	Illustrative quotations
Personal difficulties (6)	*"There've been examples on occasions when somebody's quite aroused and then other service-users have tried to come in and help. And sometimes, that works really well. But sometimes, if it's somebody who's equally unwell and ends up sort of getting over involved and also shouting at staff, and then can become unhelpful." (S3)*
Helping others can be distressing (1)	*"And there are times, as well, where the patient is being so helpful they may not actually want to have to be so helpful. But then they've taken on a bit of a role, and it's difficult for them to remove themselves from that role without feeling bad, or being made to feel bad by the other person... we don't want them taking on all the problems of every other patient and not recovering themselves."(S5)*

[a] Numbers in brackets refer to the prevalence of themes, i.e., the number of participants (out of a total of 7) in whose transcript a theme occurred.

Table 4. *Unique staff themes*

Theme[a]	**Illustrative quotations**
Peer support facilitates engagement with treatment (6)	*"When somebody's feeling...quite negative, not wanting to be on the ward, feeling that the staff aren't listening to them... somebody else who's been in that position is able to say 'Well, look, I wasn't able to have that immediately. But they do want you to go home. They don't want you to stay here forever"... And maybe it's easier to see that another patient might be on their side... they will actually stop and listen and think for a little while if [another service-user is]giving something from a different perspective...." (S3)* *"If [a service-user] has been able to start talking about issues with another client it makes it a lot easier for them to talk about the same issues with you... Some [service-users are] embarrassed because what the voices are saying... [when they talk to other service-users] they find that 'No, actually you're not alone, I have experienced voices myself' and 'Just talk to the nurses if you're feeling distressed'...So next time the person experiences voices they come to you and you find out what is going on and you try and explore solutions together." (S1)*
Dangers of peer support (7)	*"...one minute they will hate each other, then next minute will be like this (crosses his fingers)... The thing is, they're so unpredictable....." (S4)* *"... if one of them had a para-suicide attempt, then more often than not the other one will try and do something as well...I would rather they stayed away from each other...it increases the risks for both of them if they become friends." (S7)* *"It's when they start to neglect their own needs, or be pulled from their own needs, because a patient is so demanding. We don't want another patient's levels of needs to impact negatively on a patient who's maybe very giving..." (S5)* *"We would tell them 'please don't discuss your personal details, don't discuss your illness..' if there is anything that a client wants to discuss, the best thing is to discuss it with staff so that it can be put on record if it is a matter of interest." (S1)*

[a] Numbers in brackets refer to the prevalence of themes, i.e., the number of participants (out of a total of 7) in whose transcript a theme occurred.