Peer Support Work

An International Scoping Review

November 2023

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GLOSSARY OF TERMS

BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Services
DBT	Dialectic Behaviour Therapy
DDA	Dual Diagnosis Anonymous
ED	Eating Disorders
FSW	Family Support Workers
HSE	Health Service Executive
MHER	Mental Health Engagement and Recovery
PSS	Peer Support Specialists
PTSD	Post-Traumatic Stress Disorder
PSW	Peer Support Worker
RCT	Randomised Controlled Trial
SMI	Serious Mental Illness
TAU	Treatment As Usual
WHO	World Health Organisation
YPSW	Youth Peer Support Workers

INTRODUCTION

This scoping review of the international literature was commissioned by the Peer Support Five Year Strategy Working Group established by the Health Service Executive (HSE) Mental Health Engagement and Recovery (MHER) Office (to create a five-year strategic plan for mental health peer support in Ireland. The aims of this scoping review were to:

1. To undertake a comprehensive review of the literature on peer support work; and
2. Identify how such work may be best implemented in specified, specialist areas.

The research questions, in line with the above, are:

1. What are the key messages from the international literature on peer support work? and
2. How should peer support work be most effectively implemented in specific aspects of mental health services including Child and Adolescent Mental Health Services, forensic services and other specialist mental health services?

The scoping review was conducted between July and November 2023 with the main database searches completed in August 2023. The scoping review research team worked closely with the Peer Support Five Year Strategy Working Group on all stages of the review process and so the report is co-authored by the Research Team and the Working Group. The members of both the Working Group and Research Team are listed below:

Peer Support Five Year Strategy Working Group

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CONTEXT

There has already been considerable work completed on developing and implementing peer support work in Ireland. In 2006, the mental health policy, *A Vision for Change* (Department of Health and Children), highlighted a need for the further development of peer-provided services and peer support work roles across sectors and levels. Recommendation 3.3 of *A Vision for* Change stated that "Innovative methods of involving service users and carers should be developed by local services, including the mainstream funding and integration of services organised and run by service users and carers of service users." (p. 27). Peer support for mental health in Ireland had initially developed though community peer-led initiatives and, beginning in 2012, was further promoted by the work of Advancing Recovery in Ireland, a Health Service Executive (HSE) initiative to support more recovery-orientated services. In 2015, Advancing Recovery in Ireland produced *Peer Support Workers – A Guidance paper* (Naughton et al., 2015) and a specific programme was launched to support the appointment of peer support workers in HSE mental health services with the first employed by the HSE in February 2017. Prior to their employment, the peer support workers completed the specially designed *Certificate in Peer Support Working in Mental Health* at Dublin City University (a Level 8 Undergraduate qualification). Since 2020, this course is also delivered by the Atlantic Technological University's Mayo campus.

In 2017, the HSE's *National Framework for Recovery in Mental Health* reinforced the recovery approach to providing mental health care and support, including the centrality of lived experience and coproduction at all levels of the design, delivery and evaluation of services.

In 2019, the findings of an evaluation of the impact of peer support workers in mental health services (Hunt & Byrne, 2019) showed that "Overall, Peer Support Workers have had a positive impact on service users, service providers and Mental Health Services. They had a key role in supporting service users with their recovery and in promoting recovery orientation of services." (p. 9). However, the evaluation also highlighted that "service readiness is an important factor in the success of peer support. A lack of understanding and acceptance of Peer Support Workers and the recovery practices they embody was one of the primary barriers to the positive impact of Peer Support Workers. Training on peer support and recovery principles is helpful and necessary for teams prior to the implementation of Peer Support Workers to the team. Additionally, the provision of appropriate support and supervision structures must be ensured to maximise the impact of peer support." (p. 10).

More recently, in 2020, the Department of Health's *Sharing the Vision: A Mental Health Policy for Everyone,* continued the strategic direction to further develop peer roles. Definitions of peer support and peer support work will be explored as part of this scoping review, but *Sharing the Vision* provided a helpful definition of peer support stating that:

"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement as to what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain." (Department of Health, 2020, p. 7).

In the wider context, the Sláintecare Action Plan for 2021-2023 (Department of Health, 2021), which sets out the actions needed to implement a universal health and social care system in Ireland, includes a number of developments that are potentially relevant to peer support work. Under Sláintecare, significant and relevant areas for development over the next few years include: the Healthy Communities Programme; workforce planning and reform; expansion of primary and community care and integration with acute services; and redevelopment of regional health areas. As the current action plan ends in 2023, revision of the plan will follow, and opportunities will arise to integrate and establish new posts such as peer support workers in mental health teams. This scoping review will hopefully support efforts to develop peer support in line with Sláintecare reforms and implementation, for example, by further informing how the role of new peer support workers may be defined and considering where, when and how they can be most effectively established.

In 2021, the HSE published a toolkit to support the further roll-out of peer support workers in the HSE and to address some of the issues identified by Hunt and Byrne (2019). The Toolkit defined a peer support worker as "Someone who identifies as having personal lived experience of mental health difficulties and intentionally shares their lived experience as a means of providing support and connecting with others experiencing similar challenges. [It also clarified that] Other countries use the acronym PSW for PrSWs- however as that is used for Principal Social Worker in the Irish context, the HSE has adopted the acronym PrSW." (p. 7). The toolkit provides guidance on a number of key areas:

- "TOOL 1: The Role of the Peer Support Workers in the HSE Mental Health Services Multidisciplinary Teams
- TOOL 2: Examples of Tasks that use Peer Support Workers Lived Experience
- TOOL 3: Guidelines for Defining Tasks of Peer Support Workers within the HSE Mental Health Services
- TOOL 4: Service Readiness Checklist
- TOOL 5: Role Of The Supervisor And Supervisee
- TOOL 6: Peer Support Workers Interaction With Service User
- TOOL 7: Example of a Protocol for Peer Support Work
- TOOL 8: Getting To Role Clarity" (p. 10)

The MHER Office, which is part of the HSE, was established in 2019 by bringing together the Advancing Recovery Ireland project and the Mental Health Engagement Office. In its *Strategic Plan 2023-2026* (Mental Health Engagement and Recovery Office, 2023), one of its strategic objectives "to support and enhance the role of peer and family peer support working in mental health services." (p. 7). It specified that "Peer and Family Peer Support refers to an intentional support where those who have lived experiences use their experiences in a mutual and reciprocal manner to support others in their own recovery journey." (p. 16). It also reported:

- "Since 2017, a total of 30 Peer Support Workers and 11 Family Peer Support Workers have been employed.
- In 2022, MHER secured a specific grade code for Peer Support Workers and Peer Support Team Leaders.
- Working groups have been established to further develop peer support, they are working on a 5-year strategy, guidance to protect lived experience as a knowledge set and a toolkit for Family Peer Support Workers." (p. 13)

The MHER Office's priority actions, as part of its *Strategic Plan 2023-2026* suggests that by the end of 2026 the MHER Office will have:

- “Secured the funding to bring the number of peer and family peer support workers up to 60 posts
- Worked with the regional management to identify teams who are ready to embed peer support in their team
- Developed new peer support team leader and principal peer support worker grades
- Agreed a new governance structure for peer and family peer support work
- Educated service provider teams about the evidence for peer support
- Advanced plans for peer support in other populations e.g., CAMHS
- Provided advice and recommendations with educational institutions to ensure that quality peer education is standardised across the country” (p. 23).

The Peer Support Five Year Strategy Working Group established as part of the Mental Health Engagement and Recovery Office commissioned this scoping review to support the achievement of Milestones 1 and 2 of its terms of reference which align with the aims of this review which are:

- “To review the peer reviewed and grey literature on peer support work in order to identify strategic priorities for the continuous implementation and expansion of the role”; and
- “To review the peer reviewed and grey literature to examine how to implement peer support work in specialised areas such as CAMHS, National Forensic Mental Health Services and Clinical Programmes.”

OVERVIEW OF THE REPORT

It is important to clarify the scope of this review of the literature. As mentioned above (and definitions will also be further explored in the review), peer support is a relatively broad concept which is used to refer to many various forms of support across different types of shared experience. Peer support, in its broadest sense, can refer to: informal support by families and friends; informal mutual support, for example through groups and/or online fora; and formal peer support work which tends to refer to more clearly defined roles. However, all have the common characteristic that the person is using their own experience to help inform and facilitate supporting others. Peer support and peer support work also refer to approaches across a wide range of shared experiences, from professional groups (such as fire fighters, police and health care workers) to the whole range of health and social care issues, as well as to the experience of mental health problems and caring for people with mental health problems.

This scoping review focuses specifically on the literature on mental health peer support work (where the peer support worker has their own experience of mental health problems and is supporting people with mental health problems) and family peer support work (where the family peer support worker has their own experience of caring for someone with mental health problems and is providing support to people who are caring for someone with mental health problems).

Although the immediate focus of the MHER Office's priority actions and the terms of reference of the Peer Support Five Year Strategy Working Group focus on developments in the HSE, this review includes literature from across sectors.

The report is structured into a number of sections following this Introduction. The next section is the methodology which describes how the scoping review was conducted. The findings of the scoping review are then presented. These are organised into a number of key topics including: definitions, the role, guidance, implementation and the research on effectiveness. The concluding section highlights some of the possible implications of the findings of the scoping review for the further development of peer support work and family peer support work in Ireland.

METHODOLOGY

RESEARCH AIMS AND QUESTIONS

As mentioned in the Introduction, the aims of this scoping review were:

1. To undertake a comprehensive review of the literature on peer support work; and
2. Identify how such work may be best implemented in specified, specialist areas.

The research questions are therefore aligned with these aims:

1. What are the key messages from the international literature on peer support work? and
2. How should peer support work be most effectively implemented in specific aspects of mental health services including Child and Adolescent Mental Health Services, forensic services and other specialist mental health services?

RATIONALE FOR USING THE SCOPING REVIEW APPROACH

A scoping review was identified as the most appropriate approach to reviewing the literature mainly because the aims of this review were relatively broad. A scoping review has been defined by Munn et al. (2022, p. 950) as "a type of evidence synthesis that aims to systematically identify and map the breadth of evidence available on a particular topic, field, concept, or issue, often irrespective of source (i.e., primary research, reviews, non-empirical evidence) within or across particular contexts. Scoping reviews can clarify key concepts/definitions in the literature and identify key characteristics or factors related to a concept, including those related to methodological research."

As Munn et al. (2018) have explained, scoping reviews are more appropriate than systematic reviews when the purpose of the review is relatively broad and aims to, for example, clarify concepts, scope a body of literature across different types of evidence, and identify knowledge gaps. A scoping review may therefore identify the need for a systematic review on a specific aspect or intervention related to the broad area being investigated.

The methodology for scoping reviews has been refined over recent years. Arksey and O'Malley (2005) developed an early structure for conducting scoping reviews, which was further developed by Levac et al. (2010) and, most recently, Peters et al. (2021). The Peters et al. (2021) framework, used here, involves the following steps: defining and aligning the objectives and questions; developing and aligning the inclusion criteria with the objectives and questions; describing the planned approach to evidence searching, selection, data extraction and presentation of the evidence; searching for the evidence; selecting the evidence; extracting the evidence; analysis of the evidence; presentation of the results; summarising the

evidence in relation to the purpose of the review, making conclusions and noting any implications of the findings.

INCLUSION CRITERIA

The inclusion and exclusion criteria were decided in line with the population, concept and context model as recommended by the Joanna Briggs Institute's Manual for Evidence Synthesis.

POPULATION INCLUSION CRITERIA

- Peer support workers (with experience of mental health problems) supporting people with mental health problems
- Family peer support workers (with experience of caring for someone with mental health problems) supporting carers of people with mental health problems
- Those responsible for the development and implementation of these peer support worker roles
- Those working with peer support workers within mental health services.

POPULATION EXCLUSION CRITERIA

- Peer support workers in other related areas (dementia, addictions, physical health and so on)
- Informal peer supporters (for example, online discussion fora - unless facilitated by peer support workers)

CONCEPT INCLUSION CRITERIA

- Definition, role, implementation and/or development of mental health peer support work
- Definition, role, implementation and/or development of family peer support work in mental health

CONCEPT EXCLUSION CRITERIA

- Generic involvement of those with lived experience in mental health services
- Wider overviews of recovery approaches
- Involvement in professional education (unless as part of peer support worker role)

CONTEXT INCLUSION CRITERIA

- Mental health peer support work and mental health family peer support work across all sectors, all settings (community, inpatient, specialist) and all countries

TYPES OF SOURCES OF EVIDENCE

- Sources of evidence included primary research studies, systematic reviews, guidelines, and policy documents. Protocols, book reviews, opinion papers and letters were excluded.

SEARCH STRATEGY

For this scoping review, four databases were identified as the most relevant to peer support work, recovery and mental health and so most likely to provide the breadth and depth of the literature needed for the review. These databases were: Social Sciences Citation Index, PsycINFO, MEDLINE and Social Policy and Practice. Hand searches of grey literature and relevant website searches were also conducted to identify other relevant policies, guidelines, reports and evaluations.

The search terms used included:

"peer support" or "peer worker*" or "consumer worker*" or "lived experience worker*" or "expert by experience" or "family peer support" or "peer led support"

AND

"mental health" or psychiatric or "mental illness*" or CAMHS or "child and adolescent mental health service*" or "forensic psych*" or "specialist mental health service*".

Searches were restricted to literature from 1990 onwards, when developments in peer support really started to accelerate. They were also restricted to literature in English as the Research Team did not have the capacity to translate from other languages within the timeframe of the review.

SELECTING THE EVIDENCE

Screening was conducted independently by two members of the Research Team, to determine which of the identified studies/sources were directly relevant to the review. This initially involved screening by titles and abstracts and then full texts. Any differences between the two perspectives were resolved by a third member of the Team.

DATA EXTRACTION

The database searches identified a high number of sources which met the criteria for inclusion. In extracting, analysing and presenting the data, the most relevant and representative sources have been selected. All of the included studies are not directly cited in the report, but a list of all the sources which meet the inclusion criteria is included in this report and all of the full texts are available to the Peer Support Five Year Strategy Working Group.

ANALYSIS OF THE EVIDENCE

The key themes from across the included sources were identified by an inclusive process which involved the whole research team and which were also considered by the Peer Support Five Year Strategy Working Group.

INTERVIEWS TO INFORM THE SCOPING REVIEW

In addition to the literature searches, a series of interviews was arranged with key people involved in the development, implementation and evaluation of peer support work. This was to provide informed and international perspectives on the themes being identified in the literature. In order to faciliate open discussion it was agreed that the interviewees would not be directly quoted in this report but that their perspectives would be used to help inform the analysis. The interviewees included:

- Professor Lisa Brophy, Professor of Social Work, La Trobe University, Melbourne, Victoria, Australia
- Elaine Browne, Peer Specialist, Perspective Ireland
- Louise Christie, Director of the Scottish Recovery Network
- Naoise Cunnigham, Community Living Mental Health Recovery Coordinator, HAIL Housing, Dublin
- Marty Daly, Service User Consultant and Tory Cunningham, Peer Support Worker Project Development Lead, Belfast Trust
- Sharon Ferguson, Mental Health & Wellbeing Project Officer ATU Donegal/Founder Donegal Wellness Cafe Model and Craig Jennings, Donegal Wellness Cafes Development Group
- Ciara Glynn, Peer Support Worker, North Dublin and Lecturer, Dublin North and North East Recovery College.
- Martha Griffin, Chair of the Peer Support in Mental Health Programme, Dublin City University
- Moira Harper, Carer Advocate, Cause and Catherine Harper, Barrister and former Peer Worker, Belfast Trust

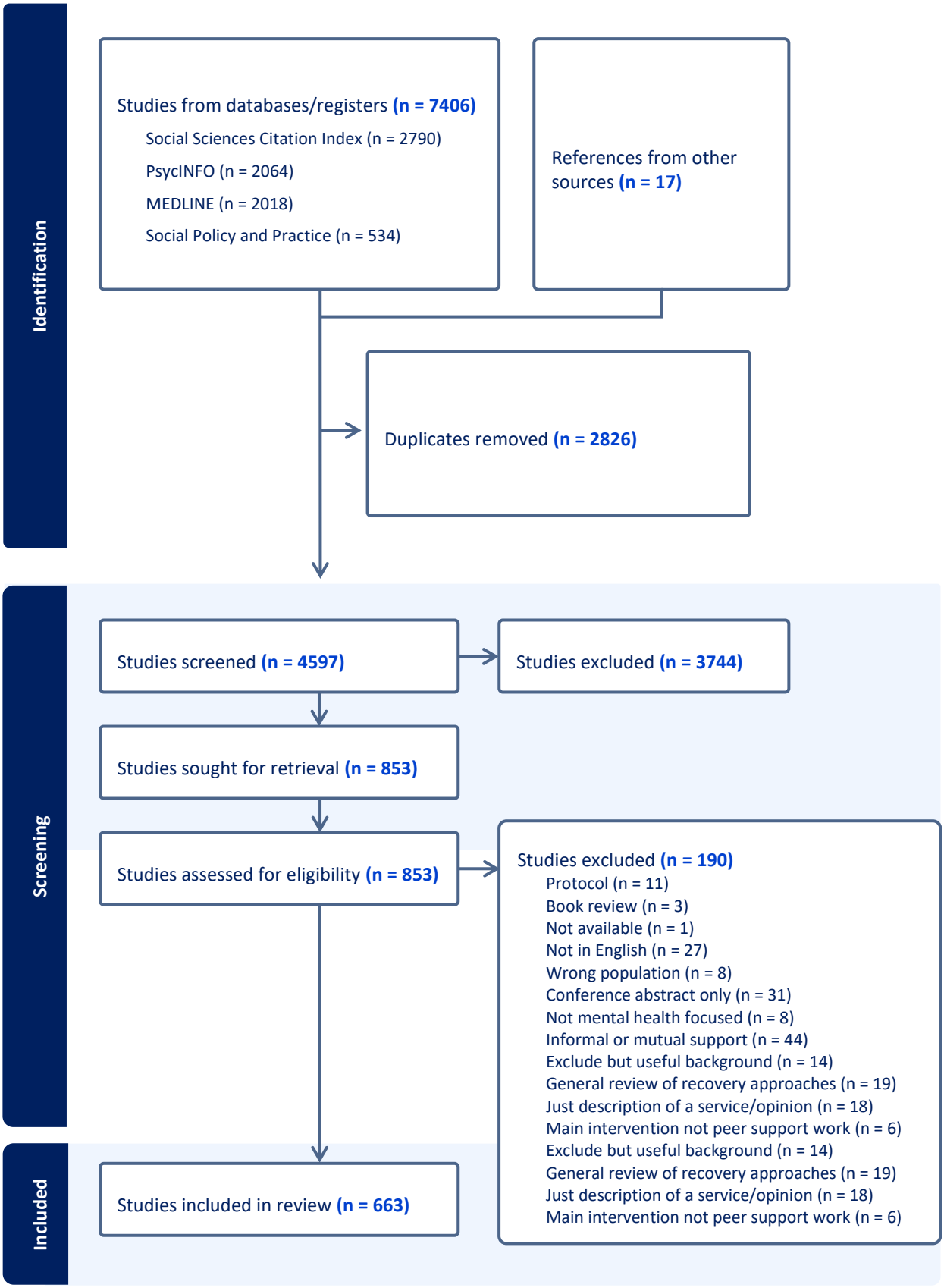
- Dori Hutchinson, Executive Director/Director of Services, Center for Psychiatric Rehabilitation, Boston University
- Emilia Marchelewska, Rawan Alzawadi and Karolina Schlagner, Cairde (community health development organisation working across Ireland, challenging ethnic minority health inequalities)
- Associate Professor Giles Newton-Howes, University of Otago, Wellington, New Zealand
- Professor Bernd Puschner, Psychologist and Senior Researcher, Head of Section Process-Outcome Research, Department of Psychiatry, Ulm University, Günzburg, Germany
- Callum Ross, Habitus Collective partner and International Peer Leadership facilitator with the International Peer Leadership Network
- Dr Aurélie Tinland, Health Service Research and Quality of Life Center, Aix-Marseille University, France and Department of Psychiatry, Hôpitaux de Marseille, Marseille, France; and Virgine Belle, Peer Researcher, Aix-Marseille University, France
- Emma Watson, Peer Support Development Lead, Nottinghamshire Healthcare NHS Trust and ImROC Consultant
- Mike Watts, Recovery Activist, Grow and Professor Agnes Higgins, Trinity College Dublin

FINDINGS

SEARCH RESULTS

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram (Figure 1) presents the main stages of the scoping review.

Figure 1. PRISMA Flow Diagram



DESCRIPTION OF INCLUDED STUDIES

Each of the included studies were labelled as providing potentially useful data on one or two aspects of the scoping review. The list below presents the number of sources identified for each topic:

- Findings:
    - Definitions, values and the role (65)
    - Guidance and toolkits (17)
    - Development and implementation of peer support work including complexities and enablers (85)
    - Experiences of peer support workers (91)
    - Perceptions of others about peer support work (33)
    - Recruitment of peer support workers (9)
    - Training (33)
    - Supervision and support (18)
- Research on effectiveness (142)
- Specific interventions:
    - Inpatient (including alternatives and facilitating discharge) (51)
    - Online/digital (50)
    - Physical health (19)
    - Activity/employment (11)
    - Decision-making (11) and Advance care planning (5)
    - Examples of Other Specific interventions – such as Open Dialogue (12), suicide prevention (5) and Medication (2)
- Specific services:
    - Family peer support (45)
    - Forensic (18)
    - Early Intervention (8)
    - CAMHS/Children's services (30)
    - Perinatal and parental (18)
    - Examples of other specific services – Trauma/PTSD (7), Personality Disorder (5), Mental health problems and Substance use (3), Eating Disorders (2), LGBTQ+ (2) and Migrants (1).

DEFINITIONS, VALUES AND THE ROLE

DEFINITIONS

As mentioned in the Introduction, there is a range of relevant terms used in the literature on peer support and it is important to distinguish between the various concepts. There are already definitions available from Sharing the Vision: A Mental Health Policy for Everyone (Department of Health, 2020), the HSE's (2020) Toolkit to support peer support workers and the Mental Health Engagement and Recovery Office's (2023) Strategic Plan 2023-2026. This section will therefore focus on examples of other perspectives on definitions and the role of the peer support worker.

Mind (2019) have suggested that, although there are different forms of peer support, they do share some characteristics: "Peer support is when people use their own experiences to help each other. There are different types of peer support, but they all aim to:

- bring together people with shared experiences to support each other;
- provide a space where you feel accepted and understood;
- treat everyone's experiences as being equally important; and
- involve both giving and receiving support." (p. 2).

The Mental Health Commission of Canada (2016) also provides a very broad definition of mental health peer support which is "any organised support provided by and for people with mental health problems or illnesses. The families of people with mental health problems or illnesses also provide peer support to each other….Peer support is sometimes known as self-help, mutual aid, co-counselling or mutual support. These terms are all used for processes that bring people with shared experiences together in a wide variety of structures; in groups, in organizations, online and one-to-one." (p. 45). While it is important to be aware of this wider context of peer support, this report focused specifically on peer support work which is further explored below.

An early articulation of the different forms of peer support was provided by Davidson et al. (2006) who traced some of the origins of peer support work in mental health services to an American Psychiatrist, Harry Stack Sullivan who, possibly influenced by his own experience of psychosis, employed people who had recovered from their own mental health problems to work in an inpatient service in Baltimore in the 1920s. Davidson et al. (2006) identify three main forms of peer support: "(1) naturally occurring mutual support groups, (2) consumer-run services, and (3) the employment of consumers as providers within clinical and rehabilitative settings" (p. 165). The focus in this report is on the third form of peer support work, which

involves defined roles and some form of part-time or full-time employment although this can vary due to people's circumstances. Even within this focus there are various potential forms of how peer support work can be provided. A mapping of peer support workers in England reported three main approaches to employing peer support workers:

- "Peer workers could be employed by the Mental Health Trust, to work in the Mental Health Trust;
- Peer workers could be employed in partnership by an agency outside of the Mental Health Trust (often in a peer-led organisation, but this could be a social care provider or a non-peer-led third sector organisation) to provide a service either in the Mental Health Trust or for people who used Trust services;
- Peer workers could be employed by a peer-led organisation to work independently of the Mental Health Trust" (Peer Worker Research Team, 2015, p. 4).

An influential perspective on peer support, referred to as Intentional Peer Support, was developed in the 1990s by Shery Mead in the US and others. It states that "'As peer support in mental health proliferates, we must be mindful of our intention: social change. It is not about developing more effective services, but rather about creating dialogues that have influence on all of our understandings, conversations, and relationships' Shery Mead, Founder of IPS. Intentional Peer Support is a way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things." (Mead, 2023, p. 1). Intentional refers to having the specific purpose of communicating "in ways that helps both people step outside their story…It means that in real dialogue, we are able to step back from our truth and be very deeply open to the truth of the other person while also holding onto our own. When this type of dialogue occurs, both of us have the potential to see, hear, and know things in ways that neither of us could have come to alone." (Mead, 2014, pp. 7-8).

In the UK, Implementing Recovery through Organisational Change (ImROC) was initially an NHS and Sainsbury's Centre for Mental Health initiative, but is now an independent consultancy and training organisation. In a recent reflection on where are we now, Watson and Repper (2022) reported that "The past 15 years have seen phenomenal change in the employment of people with personal experience of mental health challenges in services. This has built on the benefits of mutual support developed in self-help, user led community groups and natural relationships to become a role within mental health services across the world. From a largely informal approach between people who share similar struggles, peer support has been formalised, and the presence of Peer Support Workers, who are employed within

mental health services to use their lived experience of mental distress to support others, is now commonplace." (p. 2).

The Scottish Recovery Network (2015) has also been an important provider of guidance on defining and explaining peer support. They suggest that "Peer support is generally understood to be a relationship of mutual support where people with similar life experiences offer each other support especially as they move through difficult or challenging experiences."(p. 53). They have also clarified that "Peer support exists in many different forms in mental health… While these different forms of peer support have common foundations, they differ in the extent to which the roles are formalised. The process of formalising the naturally occurring peer relationships brings opportunities and challenges. These challenges can be addressed and opportunities enhanced by care planning and by remaining true to the underlying principles and values of peer support." (p. 54). We will explore the relevant values in more depth in the next section.

The National Association of Peer Supporters (NAPS) in the US has an interesting perspective as it is providing definitions and guidance in the context of a funding system which sometimes requires specific roles and tasks to be recognised by insurers for payment and most obviously through Medicaid. Its National *Practice Guidelines for Peer Specialists and Supervisors* (2019) set out some of the relevant issues by stating, for example, that: "Many states funded peer support worker positions through Medicaid reimbursement…which required supervision by a licensed (qualified) mental health professional as defined by each state. While this led to substantial growth in the peer support specialist workforce, it also resulted in peer support worker supervisors with no direct knowledge of peer support values; the supervisors' ethical codes often prevented practice of essential aspects of peer support such as self-disclosure (sharing relevant elements of one's own personal story to connect with someone else)…The purpose of the added guidelines for supervisors is to educate them about the core peer support values as applied in supervisory relationships. The NPG-S [National Practice Guidelines for Peer Specialists and Supervisors] describe the supervisor's role and offer practical tips about how supervisors can help peer support specialists remain true to the values outlined in the original NPG." (NAPS, 2019, pp. 1-2). These guidelines may therefore be very relevant to the further development of peer supervisors in Ireland.

Stratford et al. (2019) used an international consortium of peer leaders to develop an international charter on mental health peer support. It defined peer supporters as "people who have experienced mental ill health and are either in or have achieved recovery. In their role as peer supporters, they use these personal experiences, along with relevant training and supervision, to facilitate, guide, and mentor another person's recovery journey by instilling

hope, modelling recovery, and supporting people in their own efforts to reclaim meaningful and gratifying lives in the communities of their choice." (p. 630).

The World Health Organisation, as part of its WHO QualityRights Initiative, has developed guidance and two modules on peer support, one of which focuses on *One-to-one peer support by and for people with lived experience* (WHO, 2019a) and the other which focuses on *Peer support groups by and for people with lived experience* (WHO, 2019b). It provides definitions of both approaches as follows: "Individualized peer support in the context of this module is one-to-one support provided by a peer who has personal experience of issues and challenges similar to those of another peer who would like to benefit from this experience and support. Individualized peer support can be provided by people hired by mental health or social services, people working in an autonomous and independent peer support role or by people engaged in non-hierarchical and unpaid peer support. The aim is to support people on the issues they consider important for their recovery in a way that is free from assumptions and judgement. In doing so, the peer supporter becomes an empathetic listener, coach, advocate and partner." (WHO, 2023, p.1).

The WHO defines peer support groups as groups which "bring together people who have similar concerns so they can explore solutions to overcome shared challenges and feel supported by others who have had similar experiences and who may better understand each other's situation. Peer support groups may be considered by group members as alternatives to, or complementary to, traditional mental health services. They are run by members for members so the priorities are directly based on their needs and preferences. Peer support groups should ideally be independent from mental health and social services, although some services may facilitate and encourage the creation of peer support groups." (WHO, 2019b, p. 1). These definitions raise an important point about the overlaps between the different forms of peer support. For the purposes of this scoping review most forms of informal individual peer support and mutual support groups are not considered but there are grey areas, for example, when peer support workers facilitate support groups as part of their role.

The language used is slightly different in Australia although the National Mental Health Commission has developed an excellent set of guidance documents which we will return to in the guidance section. The guidance on planning the future mental health workforce states that: "Lived experience is central to mental health reform. It is the responsibility of every agency in the mental health system to take steps to bring lived experience into the design and delivery of services.

Organisations that provide mental health services have an important role to play in building the foundations for an effective Lived Experience workforce. They are at the frontline in

creating employment opportunities, supporting the ongoing development of individual workers, and demonstrating the impact of this employment strategy. The Lived Experience workforce is not an optional addition to service delivery. Investment in developing this workforce is essential to improve outcomes for people who use mental health services and their families. Lived Experience work needs to be supported and embedded as an integral part of the way all mental health services are delivered. The challenge is not simply to create new jobs or recruit new workers, but to embed a new source of knowledge and new ways of thinking about mental health, into an established service system." (National Mental Health Commission, 2023, p. 1).

Another way to help define peer support work is to identify what it is not. This will be explored further in the next section on the role of the peer support worker, but one example is from Norton (2022) who stated that although there may be overlaps in what health care assistants (or in other services, support workers and other mental health workers) do, there are differences in the nature and purpose of this work. "In my opinion, PrSWs [Peer Support Workers] do carry out a lot of practical support which is inclusive of bringing service users shopping and supporting them with their own money management. However, I argue that this is purposeful. This is particularly purposeful in rehabilitation and recovery as one needs to find unique mechanisms to connect with this target population. The central tenet to achieving a trusting, reliable and safe relationship is through the creation of informality." (p. 1). A key goal of Peer Support working, therefore, is building an authentic relationship. This may involve jointly partaking in a social activity. However, the activity itself is a means to an end that is, creating an authentic interaction – e.g. chatting about mental health experiences in a café normalises the interaction.

A helpful guide and definition of both peer support work and family peer support has been developed by the Peer Support Development Team (2023) in Nottinghamshire Healthcare NHS Foundation Trust. It states that: "Peer support workers are employed to draw on their lived experience of recovery, as well as the skills they build in peer support training, to develop mutual supportive relationships with people using services. Carer peer workers draw on their experience of being a carer to someone using a particular service to support other carers, family members and loved ones." (p. 2). This definition highlights the important point that, although the person's lived experience is a central aspect of the role, on its own it may be insufficient for peer support work which requires specialist peer support work training, knowledge, skills and values or 'peer-plus' as Nicholson and Valentine (2018) have suggested.

In the next section, we will consider further literature about the values relevant to peer support work.

VALUES

There are a number of statements on the values or principles of peer support and peer support work that provide the context for the role of the peer support worker. For example, Watson and Repper (2022) highlight the considerable progress that has been made in defining peer support and its values, but there may also be a "Risk of mandating the values of peer support rather than allowing them to be articulated differently in different contexts. [And also that] Values could become lost in the momentum, with peer workers being employed at such scale, and working in very challenging cultures where other (expert-patient) values are predominant" (p. 4). Nonetheless, it is important to explore the relevant values and principles to identify common themes and consider their relevance to the context in Ireland.

In Ireland, the *National Framework for Recovery in Mental Health* (Health Service Executive, 2017) identified four principles for all recovery and recovery-oriented services. These apply more generally than just to peer support work, but are still directly relevant and also important for the organisational context:

- "Principle 1: The centrality of the service user lived experience.
- Principle 2: The co-production of recovery-promoting services, between all stakeholders.
- Principle 3: An organisational commitment to the development of recovery-oriented mental health services.
- Principle 4: Supporting recovery-oriented learning and recovery oriented practice across all stakeholder groups." (p.8).

Repper et al. (2013, pp. 8-9) identified eight core principles of peer support as mutuality, reciprocity, a non-directive approach, being recovery-focused, strengths-based, inclusive, progressive and safe. They also provided an explanation of each principle as outlined below.

"1. Mutual - The experience of peers who give and gain support is never identical. However, peer workers in mental health settings share some of the experiences of the people they work with. They have an understanding of common mental health challenges, the meaning of being defined as a 'mental patient' in our society and the confusion, loneliness, fear and hopelessness that can ensue.
2. Reciprocal - Traditional relationships between mental health professionals and the people they support are founded on the assumption of an expert (professional) and a non-expert (patient/client). Peer relationships involve no claims to such special expertise, but a sharing and exploration of different world views and the generation of solutions together.

3. Non-directive - Because of their claims to special knowledge, mental health professionals often prescribe the 'best' course of action for those whom they serve. Peer support is not about introducing another set of experts to offer prescriptions based on their experience, e.g. 'You should try this because it worked for me'. Instead, they help people to recognise their own resources and seek their own solutions. 'Peer support is about being an expert in not being an expert and that takes a lot of expertise.'

4. Recovery-focused - Peer support engages in recovery focused relationships by:

- inspiring HOPE: they are in a position to say 'I know you can do it' and to help generate personal belief, energy and commitment with the person they are supporting
- supporting people to take back CONTROL of their personal challenges and define their own destiny
- facilitating access to OPPORTUNITIES that the person values, enabling them to participate in roles, relationships and activities in the communities of their choice.

5. Strengths-based - Peer support involves a relationship where the person providing support is not afraid of being with someone in their distress. But it is also about seeing within that distress the seeds of possibility and creating a fertile ground for those seeds to grow. It explores what a person has gained from their experience, seeks out their qualities and assets, identifies hidden achievements and celebrates what may seem like the smallest steps forward.

6. Inclusive - Being a 'peer' is not just about having experienced mental health challenges, it is also about understanding the meaning of such experiences within the communities of which the person is a part. This can be critical among those who feel marginalised and misunderstood by traditional services. Someone who knows the language, values and nuances of those communities obviously has a better understanding of the resources and the possibilities. This equips them to be more effective in helping others become a valued member of their community.

7. Progressive - Peer support is not a static friendship, but progressive mutual support in a shared journey of discovery. The peer is not just a 'buddy', but a travelling companion, with both travellers learning new skills, developing new resources and reframing challenges as opportunities for finding new solutions.

8. Safe - Supportive peer relationships involve the negotiation of what emotional safety means to both parties. This can be achieved by discovering what makes each other feel unsafe, sharing rules of confidentiality, demonstrating compassion, authenticity and a non-judgemental attitude and acknowledging that neither has all the answers."

The Scottish Recovery Network (2013) developed a values framework for peer working. It reinforced the importance of clarifying the values underpinning peer support work to: ensure the role remains faithful to the aims and ethos of peer work; clarify the role of peer support workers; provide the basis for further development; and improve understanding of the role. It identified six core values:

- Hope – about recovery and learning and the role of the peer support work in that process
- Experience – valuing everyone's experience and the potential benefits of sharing experiences
- Authenticity – emphasising openness, honesty, empathy and compassion
- Responsibility – people taking responsibility for their recovery and peer support workers taking responsibility for their own learning, development and role
- Mutuality – we are interdependent and everyone peer support work can benefit all involved
- Empowerment – a strengths-based approach, with positive risk taking and people taking more control of their own care and lives

The Intentional Peer Support approach includes three main principles which are then connected to tasks, skills and practices:

- principles - learning vs helping relationship vs individual, hope and possibility vs fear;
- tasks – connection, language/listening/worldview, mutuality, moving towards vs away from;
- skills – relational self-awareness, giving reflective feedback, receiving reflective feedback; and
- integrative practices – co-reflection, personal and social change (Penney et al., 2021).

Gillard et al. (2017) developed a principles framework for peer support work based on a systematic review of the literature and consultation with a UK National Expert Panel of people involved in peer support. This work was part of the ENRICH research programme which developed and tested peer support workers supporting discharge from hospital. They identified five main peer support principles:

"1. Support the building of safe and trusting relationships based on shared lived experience as fundamental to peer support:

- Where that lived experience is appropriate to the service or community context in which peer support is given and received, reflecting and respecting the full diversity of lived experience that people bring.
- Through the offer of human kindness, compassion, time and space to share experiences of mental distress & difficulty and to build connections through shared language, learning and understanding.

2. Ensure that the values of mutuality and reciprocity underpin peer support relationships:

- Mutuality in this context includes the qualities of empathy and mutual respect, a fundamental sense of equal value, and a connection to communities defined by the diversity of culture and experience.
- Reciprocity in this context includes willingness to both give and receive support, of listening and sharing, and of learning from difference.

3. Promote the validation and application of experiential knowledge in the provision of peer support:

- Where validation means recognising, acknowledging and placing value on peers' personal lived experience as useful and powerful sources of knowledge and strength.
- Especially where that knowledge provides an alternative to, or complements other forms of knowledge about mental health (e.g. medical or psychological knowledge, recovery models etc.).
- Paying attention to the diversity of peers' lived experience as grounded in particular cultural contexts and ways of making sense and meaning.

4. Enable peers to exercise leadership, choice and control over the way in which peer support is given and received:

- To exercise leadership in peer support at an organisational level (especially where there are organisational constraints and control over how peer support is put into practice).
- To bring power to peer support roles within teams (enabling peers to use their lived experience in a safe and supported way).
- To retain choice and control over how lived experience is shared at an individual level and within relationships (including self-determination and negotiation in the sharing of lived experience).

5. Empower peers to discover and make use of their own strengths, and to build and strengthen connections to their peers and wider communities:

- To enable peers, in a non-directive, non-prescriptive way, to discover, develop and make use of their own strengths, skills and strategies, and to build and strengthen positive connections with their peers, networks and wider communities." (pp. 137-139).

Points 4 and 5 above reinforce the importance of having regular regional and national reflective practice sessions and similar supportive opportunities for peer support workers. Stratford et al. (2019) as part of the international charter identified the guiding values of mental health peer support as:

- "Equity. Peer supporters view the people they support as their equals in terms of human worth, dignity and membership in society.
- Hope. Peer supporters communicate, embody, and instil hope in others by offering tangible proof that recovery and membership in society remain possible for persons with mental health concerns.
- Trust. Peer supporters work hard to earn and preserve the trust of the people they support. In turn, they also demonstrate trust in the people they support, believing that people are doing their best to live their lives with dignity on a daily basis.
- Respect. Peer supporters demonstrate a deep respect for the people they support, believing in their worth as fellow human beings.
- Acceptance and Understanding. Peer supporters strive to accept and understand the people they support in a non-judgmental, non-critical way.
- Shared Experiences and Shared Responsibility. Peer support is based on the belief that overcoming adversity becomes possible through the combination of personal effort with the support of caring and compassionate others. Coming out of a history of shared experience, peer supporters share the responsibility for recovery with those they support, working collaboratively together to fashion lives they have reason to value." (p. 630-631).

Mackay et al. (2022) used data from two mental health evaluations and one development project, which included aspects of peer support work and more general peer support to identify six peer support values:

- "Safety – peer support has structures in place to create physical and emotional safety
- Experiences in common – peers share backgrounds, experiences, interests or goals

- Choice and control – peers have choice and control in how they are involved in their peer support
- Freedom to be yourself – peers feel able to express themselves and be themselves in peer support
- Two-way interactions – peers have opportunities to give and receive support
- Human connections – peers develop meaningful connections with each other" (p. 4).

The above authors also cautioned that values frameworks should be flexible: "We held concerns that describing values or creating a toolkit might contribute to commercialising peer support. Further, we felt that if the values were applied as a standardised model, it may foster something more akin to a professional worker-client structure with power imbalances, hindering the development of reciprocal peer relationships. It could also suggest to commissioners that there is one model with specific outcomes, when new peer support groups need adaptability and organic development. There were concerns that user-led community groups may be overlooked in commissioning decisions that favour larger providers with more formalised approaches to peer support. This trend could change the culture of provision to homogenic, outcome-driven approaches, marginalising the unique culture of peer support." (p. 8).

ImROC (2023) have identified eight core principles for all forms of peer work – equity, mutuality, reciprocity, non-directive, recovery-focused, strengths-based, community-facing, progressive and safe (imroc.org/peer-support-old/the-values-that-underpin-peer-support-work).

THE ROLE OF THE PEER SUPPORT WORKER

Watson (2019) provides an overview of the various ways peer support can be provided across settings. She highlights that, "The variety of peer support approaches indicates the widespread popularity for peer support but might also mean that peer workers and the people they work alongside might benefit from more clarity about the specific tasks and responsibilities of their role" (p. 39). Watson also cautions that in more formalised roles, such as peer support workers in mental health services, the key peer support values of mutuality and reciprocity may be compromised. She concludes that "While there should be room for peer support to flourish in as many contexts as possible, there is work to be done in each of these settings to ensure that values and specific activities of peer support are defined sufficiently to ensure its success" (p. 51). The importance of the peer support values of mutuality and reciprocity is repeatedly reinforced in the guidance and literature and these are key aspects of the distinctive

contribution of peer support work but also, possibly, aspects of peer support work that can help inform and change more traditional approaches to mental health support across professions. Being involved in this type of work (e.g. recovery training for staff) may help bolster the role of peer support workers by making positive connections with staff and help clarify the benefits of peer support in recovery.

Jacobson et al. (2012) used a grounded theory approach, using interviews, focus groups and activity logs, in Toronto, to help develop job descriptions for peer support workers. They found that "Peers engage in direct work with clients and in indirect work that supports their work with clients. The main types of direct work are advocacy, connecting to resources, experiential sharing, building community, relationship building, group facilitation, skill building/mentoring/goal setting, and socialization/self-esteem building. The main types of indirect work are group planning and development, administration, team communication, supervision/training, receiving support, education/awareness building, and information gathering and verification. In addition, peers also do work aimed at building relationships with staff and work aimed at legitimizing the peer role. Experience, approach, presence, role modelling, collaboration, challenge, and compromise can be seen as the tangible enactments of peers' philosophy of work." (p. 205).

The Scottish Recovery Network (2013) produced a long list of the behaviours of peer support workers that would demonstrate the value base of peer support in practice. These included:

- "Intentionally sharing experiences and stories of hope and recovery.
- Help peers explore and broaden personal identity and worldview.
- Accepting peers where they are at, avoiding judgement and interpretation.
- Encourage responsibility for self-care, wellness and recovery.
- Demonstrating and modelling relationship skills through our attitudes, interactions, behaviours and use of language.
- Take a strengths based approach focusing on hopes, aspirations and self-defined goals.
- Being alongside and partnering peers – not doing to or for.
- Encourage peers to challenge themselves and to mitigate for potential risks.
- Encourage the reframing of setbacks and help identify ways to learn from them.
- Acknowledge and discuss issues relating to power.
- Encourage peers to make informed choices and seek out relevant information to enable this.
- Respect rights, dignity, privacy and confidentiality.
- Support peers to explore meaning and purpose in their lives.

- Respect diversity and have cultural awareness.
- Help people build social supports and make community connections.
- Maintaining and building on skills and learning whilst keeping current with emerging knowledge on peer support and recovery.
- Work with boundaries that are responsive and flexible being mindful of organisational policies.
- Be a reflective practitioner and learn from experience.
- Use supervision to support and enable you to develop your understanding and practice.
- Ensure the values of peer working are at the centre of all our interactions.
- Seek out opportunities to meet with other peer workers to share learning.
- Advocate for peers to make their own decisions in matters affecting their lives.
- Take personal responsibility for your own self development, self-care, wellness and recovery.
- Be an active member of the team and contribute in a positive and solution focused manner.
- See and use the community as a resource.
- Constructively challenge non-recovery focused, stigmatising and discriminatory practices.
- To be a role model and champion recovery." (pp. 14-16).

Christie (2016) in a summary of the evidence on peer support roles in mental health services also reported that there were various potential components: "The roles and activities of peer supporters in services vary, depending on their particular setting. These include:

- Working one-to-one with people
- Supporting people through transitions such as from hospital to home; and from secondary mental health services to community based supports and into employment
- Being part of social prescribing or community links-type initiatives that help people to access local opportunities and activities they feel will improve their wellbeing
- Facilitating recovery education, mutual support and self-help groups
- Supporting people to use self-management tools including Wellness Recovery Action Plans (WRAP)" (p. 6).

Stratford et al. (2019) as part of the International Charter on mental health peer support also identified some of the core practices of peer support workers across settings:

- "Peers elicit and promote each person's own resilience, gifts, and talents.
- Peers support people in taking ownership of their own lives and decisions, even if these decisions involve affording other people (e.g. family members, elders) important roles in making decisions about their lives.
- Peers focus on those health and quality of life outcomes most important to the people they support.
- Peers advocate for changes, both in systems of care and in the broader society, to eliminate discrimination; expand opportunities, resources and supports; and improve the quality of care offered to persons with mental health concerns." (p. 631).

This advocacy role, across levels, is an important aspect of the peer support role although it is important to distinguish it from more formal and independent Advocacy. The Scottish Recovery Network (2013) describes the peer support worker being an "Advocate for peers to make their own decisions in matters affecting their lives"; to "Constructively challenge non-recovery focused, stigmatising and discriminatory practices." (pp. 14-16). Similarly, Stratford et al., (2019, p. 631) assert that "Peers advocate for changes, both in systems of care and in the broader society, to eliminate discrimination; expand opportunities, resources and supports"; and improve the quality of care offered to persons with mental health concerns.". The HSE Tool Kit clarifies that the peer support worker has an important role in supporting people to access professional services, for example from lawyers, doctors, psychologists and financial advisers but the emphasis remains on 'doing with' and not 'doing for'. Further, Watson et al. (2023) describe peer support workers "Attending ward rounds or reviews to advocate for the person they are supporting." (p. 9).

Gaiser et al. (2021) conducted a systematic review of the roles and contributions of peer support workers in mental health and substance use services in the US. They included 23 articles and reported that the findings did suggest that peer providers can be effective, they also highlighted the variations in delivery which they suggested could be related to a lack of defined roles and/or a lack of standardisation of training and accreditation.

More recently Matthews et al. (2023) completed a scoping review of the roles and responsibilities of peer support workers in mental health and substance use services in the US. They included 44 studies and reported a range of roles including: informal support or mentorship; service linkage and initiation (mainly health and therapeutic); instrumental (such as transport, housing and employment) and affiliative support (social inclusion).

The HSE's (2021) toolkit to support peer support workers in the HSE has a very clear outline of the role of a peer support worker in that context. It highlights that "PrSWs work from a lived experience perspective. The intentional sharing of personal lived experiences of mental health challenges are the cornerstone of peer support work. Through sharing lived experiences an authentic, empathetic relationship based on mutuality and professional companionship is created between the PrSW and the service user. This role is unique within the Mental Health Services." (p. 12). The Toolkit also sets out a table (p. 13) presented below, of some of the key aspects and tasks of peer support work:

Table 1. Key aspects and tasks of peer support work

"A PrSW is/Does	**A PrSW is Not/Does Not**
A person in recovery	A clinical role
Shares lived experience	Does not give advice
Works to best practice in peer support & recovery	Does not just support one intervention
Encourages informed decision making	Does not enforce treatment or activity
Sees the person as a whole person in the context of the person's roles, family, community	Sees the person as a case or diagnosis
Motivates through hope and inspiration	Motivates through fear of negative consequences
Teaches the person how to accomplish daily tasks	Does tasks for the person
Helps the person find basic necessities	Provides basic necessities such as a place to live
Uses language based on common experiences	Uses clinical language
Helps the person find professional services from lawyers, doctors, psychologists, financial advisers	Provides professional services
Encourages, supports, praises	Diagnoses, assesses, treats
Helps to set personal goals	Mandates tasks and behaviours
A role model for positive recovery behaviours	Is prescriptive on how someone should lead his/her life in recovery"

The Toolkit also sets out the principal duties and responsibilities of peer support workers in the HSE. These include: working as part of the multidisciplinary team, working with service users through their recovery process, facilitating support and connecting service users to the community.

Watson (Peer Support Development Team, 2023) in guidance which is currently being developed on recruiting and supporting peer support workers at Nottinghamshire Healthcare NHS Foundation Trust has included a very clear and helpful outline of the role:

"In terms of the peer worker role, this will vary depending on the team that they work within but there are some common elements across all peer support worker roles. All peer workers:

- Are able to lone work or offer one to one support. In the community, peer workers hold a caseload of their own. Peer workers should plan their own time with the support of supervision and manage it appropriately.
- Should support people to work toward goals that they have defined for themselves in their own recovery
- Should maintain up to date clinical records using the same reporting systems as the rest of the team
- Be conscious of issues surrounding risk and know who to go to if they have concerns
- Follow the peer worker and bands 2-4 Code of Conduct
- Should have access to the IT systems used by the team, including a mobile phone and laptop where needed

While we expect all peer workers to work as part of a team and help out where necessary, their role should not be taken up exclusively with medication drops, covering duty rotas, patient escorts or activities which don't require them to use their peer worker skill set. Peer workers do not diagnose or formally assess people using services and should not be expected to lead on these elements of support.

Examples of activities which a peer worker might do are:

- One to one support with people who would benefit from a relationship with a person who can be open about their own recovery and lived experience
- Practical support where this can be done in a way that empowers the person using services, for example supporting someone to de-clutter or access PIP, rather than doing these things on their behalf
- Facilitating peer support groups or co-facilitating groups with other colleagues around recovery related topics
- Supporting assessments – but not leading on these or completing the necessary paperwork
- Attending ward rounds or reviews to advocate for the person they are supporting." (p. 9).

A recent international review (Kotera et al., 2023) and consultation process aimed to identify a typology or classification of the components that are involved in one-to-one peer support work with adults in mental health services. The rationale was that the key components of peer support work, and their relative effectiveness in supporting people, are not always clear so an important aspect of developing the evidence base is to define these components. It included 42 publications in the review. It identified four themes with 16 components and eight sub-components which are summarised in the table below.

Table 2. Components of one-to-one peer support

Theme	Component	Sub-component
Recruitment	Mental health lived experience	
	Experience of mental health recovery	
Preparation	Peer Support Work training	Knowledge of mental health
		Knowledge of the Peer Support Worker role
		Knowledge of ethics
		Knowledge of own wellbeing
	Staff training	Staff knowledge of the Peer Support Worker role
		Knowledge of how to make appropriate referrals
Practice	Service user match	
	Relationship building	
	Sharing lived experience	
	Cultural adaptation	
	Goal setting	
	Practical support	
	Social Support	
	Emotional support	
	Record keeping	
Peer Support Worker wellbeing	Peer Support Worker supervision	Peer Support Worker supervision from peer
		Peer Support Worker supervision from non-peer
	Peer Support Worker meetings	
	Self-care	

It's important to note that Kotera et al. (2023) identify "service user match" as an important component of practice. This may be significant when developing a referral system when personal experience and identity are to be considered/facilitated, for example in relation to gender preferences and cultural backgrounds.

GUIDANCE AND TOOLKITS

In addition to the HSE's (2021) toolkit, other guidance and toolkits for the development and implementation of peer support work have been developed across a range of organisations and countries. For the purposes of the scoping review, 15 documents have been selected to provide an overview of the types of guidance available. They are presented in chronological order and a brief summary of their contents included. Key aspects of these guidance documents and toolkits are also referred to in other sections of this report.

1. An early and influential guidance document was developed by Repper et al. (Repper, 2013) as part of the Implementing Recovery through Organisational Change initiative. *Peer Support Workers: a practical guide to implementation* included four key phases of developing peer support worker posts: preparation (including the organisations, teams and peer workers); recruitment; employing peer workers; and ongoing development of the role (including career pathways, training opportunities and wider system change). It is available online at: www.centreformentalhealth.org.uk/publications/peer-support-workers-practical-guide-implementation

2. In 2015, the Peer Worker research team at St. George's, University of London, published an organisation toolkit for *Introducing peer workers into mental health services*. It included a number of organisational learning tools including: a peer worker mapping and decision-support tool; the peer worker role star; and the peer worker role inventory. It is available online at: www.scie-socialcareonline.org.uk/introducing-peer-workers-into-mental-health-services-an-organisational-toolkit

3. The Mental Health Commission in Canada produced a helpful document in 2010, updated in 2016, on *Making the Case for Peer Support*. It contains a literature review and a map of peer support in Canada. It also outlines the challenges for peer support, the benefits and successes, the international context and the evidence base for making the case. It is available online at: mentalhealthcommission.ca/wp-

content/uploads/drupal/2016-07/MHCC_Making_the_Case_for_Peer_Support_2016_Eng.pdf

4. In 2017 The Side by Side Consortium (made up of the McPin Foundation, MIND and St. George's, University of London) produced *Developing peer support in the community: a toolkit*. It outlines: the different types of peer support; core values; key decisions including about leadership, decision-making, the focus and support; dealing with challenges; and how to evaluate and report impact. Interestingly it also includes advice for funders and commissioners. It is available online at www.mind.org.uk/media-a/4247/peer-support-toolkit-final.pdf

5. Kent's (2019) article reports the findings from a literature review to identify what should be considered in *Developing a Strategy to Embed Peer Support into Mental Health Systems*. It identifies the following key issues: the core components of peer support; the focus of what peer support workers are doing; their role and scope; team integration; boundaries; professionalism; training and support; and organisational factors. The article is not open access online, but is one of the included articles in the scoping review and so is available, along with all the other included articles, through the research team.

6. The WHO's (2019) QualityRights Initiative has provided a range of training and guidance documents for developing mental health services. This includes two guidance documents on *One-to-one peer support by and for people with lived experience* and *Peer support groups by and for people with lived experience*. As the target audience for these guidance documents is all countries, they are broad but do provide helpful definitions, summaries of the benefits and considerations for implementation. All of the QualityRights Initiative's resources can be accessed online at: www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

7. The National Association of Peer Supporters (NAPS) which is the professional association of peer support workers in the US produced *National Practice Guidelines for Peer Support Specialists and Supervisors* in 2017. These outline core values and their implications for peer support workers and their supervisors. The *Guidelines* are available online at: www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf. In a commentary on the *Guidelines*, Foglesong et al. (2019) highlighted that their main purpose is "to narrow the divide between supervisors and

peer support specialists as they embark together on a mutual learning process about peer support values and how best to put them into practice" (p. 217) which is an important recognition of this as an ongoing process.

8. Health Education England (2020) have produced a very comprehensive *Competence Framework for Mental Health Peer Support Workers*. It covers: values; knowledge; skills; providing support; working with teams; self-care and support; as well as some overarching meta-competences such as: balancing roles; and self-awareness. It presents the detail of each area of competence but also a very helpful summary in a competence map. The main document is available online at: www.hee.nhs.uk.

9. Most of the guidance in this section is for developing and implementing peer support work in mental health services in general. There are also some sources of guidance for more specialist services. An example is MIND's (2020) guidance on *Peer Workers in NHS perinatal mental health services: A values-based approach*. It focuses on the key principles for peer support workers in perinatal mental health services but these are also relevant more widely: *Safe and Nurturing; Accessible and Inclusive; Complementary; Informed; and Reciprocal*. The MIND guidance is available online at: www.mind.org.uk/media-a/6334/perinatal-mental-health-peer-support-thought-piece-final.pdf

10. ImROC has produced a series of briefing papers relevant to peer support work and an important one, when considering development and implementation focused on *Preparing Organisations for Peer Support: Creating a Culture and Context in which peer support workers thrive* (Repper et al. 2021). It also outlines the benefits for the people being supported, the peer workers themselves and for organisational culture. It then works through the need to prepare the organisation and how that should be done at all levels. It is available online at: imroc.org/resource/preparing-organisations-for-peer-support/

11. A further resource from ImROC (Watson and Repper, 2022) provides important reflections on developments so far and considerations for the future. It covers: defining peer support and its values; the evidence base; the role within statutory services; and some recommendations. These include: the need for organisation and national level strategy; peer leadership across all levels; maintaining the connections with the roots of peer support; focusing on diversity and inclusion in the development, delivery and reach of peer support; and the need to locally co-ordinate all services

that offer peer support. It is available online at: imroc.org/resource/22-peer-support-in-mental-health-and-social-care-services-where-are-we-now

12. In Australia, the National Mental Health Commission has produced a series of reports, between 2020 and 2023, as part of the process of developing a comprehensive set of *National Lived Experience (Peer) Workforce Development Guidelines*. The reports cover different aspects of the process, considerations and the *Guidelines* themselves. They are all available online at: www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines

13. Developments in other aspects of peer support may also help inform its development in the HSE. Ferguson (2023)'s *Toolkit to Support the Development of Peer Led Wellness Café Model* provides the background to the development of Wellness Cafes in Donegal which are peer-led community services. It also provides guidance on how these services can be developed and implemented in other settings. As the ImROC (Watson & Repper, 2022) guidance highlights it is important to consider how all the forms of peer support and peer support work can be coordinated in each area to work together, learn and support each other.

14. The Scottish Recovery Network (SRN) has been producing helpful and accessible guidance on promoting recovery since it was established in 2004. This has included a number of guidance documents on peer support work. Most recently this includes *Let's Develop Peer Roles* (SRN, 2023) which is a very helpful toolkit for organisations introducing or further developing peer support. It is available online, along with the other SRN resources, at www.scottishrecovery.net/resources

15. The final example of guidance included in this section is the Nottinghamshire Healthcare NHS Foundation Trust draft guidance on recruiting and supporting peer support workers (Watson, 2023). It provides guidance on recruitment, training, induction, the peer worker role, supervision and access to a peer community, wellbeing at work and service specific considerations. This guidance is still being developed but will hopefully be approved and publically available soon.

Although the definition, values and role of the peer support worker may be clearly set out in various guidance documents, there may still be misunderstandings about this in practice. Elswick et al. (2023), based on interviews with 21 peer support workers in the US, reported

that “the role of peer workers is not well understood, except by peers themselves, presenting a threat to the integrity of the peer support role…participants suggested the organizations which employed peers did not possess a working understanding of how peer support should be utilized. The results of this study suggest a lack of understanding that pervaded organizational structures from clinicians to supervisors to administrators. As a result, onboarding organizations lacked sufficient training, supervision, preparedness, and role definition for peers within the workplace” (pp. 4-5). Some of these complexities in the development and implementation of peer support will be explored in the next section.

DEVELOPMENT AND IMPLEMENTATION

The guidance and toolkits to inform the effective development and implementation of peer support work provide a useful overview of the key considerations and of the potential barriers and enablers. There is also now considerable available literature on experiences of these complex processes across different settings and countries. In this section, this literature will be explored. Given the amount of available literature, the findings of previous literature reviews are prioritised. This section begins with general accounts of the development and implementation processes and then focuses on some specific areas including: accounts of the experiences of peer support workers; studies which explored the perceptions of other staff about peer support workers; the recruitment process; training; and supervision and support.

DEVELOPMENT AND IMPLEMENTATION INCLUDING COMPLEXITIES AND ENABLERS

There are already a number of reviews of the literature on the development and implementation of peer support work in mental health services included in the scoping review.

Mutschler et al. (2022) conducted a systematic review focused on the implementation process and used the Consolidated Framework for Implementation Research (CFIR) to organise the findings from the 19 articles that were included. The CFIR framework organises the relevant information into a number of domains: innovation (in this case peer support work); the outer setting (the policy, population and wider context); the inner setting (the organisation and culture); the roles and characteristics of the individuals involved at all levels; and the implementation process.

They reported that, in terms of the innovation domain, the evidence base for peer support work was well established but needed to continue to be articulated as many non-peer staff still had misconceptions about the role. Within the outer setting, the need for clear, precise and accessible policy was highlighted. For the inner setting, a positive and accepting organisational culture, resources, leadership and support for implementation of recovery-

oriented approaches including peer support work. The individual domain include the peer support workers themselves but also the support, engagement and education of all staff and across levels. Finally, for the implementation process the importance of initial and ongoing training for all was reinforced.

An earlier review of the literature by Repper and Carter (2011) took a much broader approach and covered a range of issues including; the definition of peer support, the evidence of effectiveness; benefits for service users; empowerment; social support and social functioning; empathy and acceptance; reducing stigma; hope; and benefits for peer support workers. They did, however, also identify some of the challenges which included; boundaries; power issues; stress for the peer support workers; accountability and risk issues; and maintaining their distinct role.

Another review by Miyamoto and Sono (2012) included 51 studies and, in addition to the benefits of peer support, also identified a number of challenges including role conflict, boundaries, disclosure of peer status, role ambiguity, low compensation and limited hours of work.

Vandewalle et al.'s (2016) review concentrated on peer support workers' perceptions of barriers to implementation. They include 18 qualitative studies, and organised barriers into six categories:

- The nature of the innovation which included the characteristics of roles and peer workers: lack of role clarity; pressure to gain acceptance; residual and recurring health issues;
- Other professionals: misunderstanding and negative attitudes; tensions related to different perspectives and the nature of their respective work;
- Service user related issues: a lack of interest or engagement; challenging personal and interpersonal boundaries especially when there were existing relationships; and the potential adverse effects of self-disclosure;
- Social context: these barriers included: struggles with team integration and collaboration; conflicted sense of identity; and a lack of a recovery oriented culture;
- Organisation context: which related to training, supervision, working conditions, job structure, allocation of tasks and inflexible organisational structures;
- The wider economic and political context: mainly in relation to recruitment; contracting; funding; certification; and the impact on social welfare benefits.

The review discussed some tensions between providing clear descriptions of roles, substantial training and other aspects of professionalisation with maintaining a distinctive and flexible approach.

Shalaby and Agyapong (2020) also completed a broad literature review which covered: definitions; the origin and growth of peer support work; transformative concepts in peer support; the effects of peer support in different contexts; the conceptual framework for the effects of peer support; peer support workers' satisfaction and challenges; novel technology in peer support work; and the future of peer support services. In terms of challenges, they highlight peer support workers' experiences of diverse and unclear job roles, low pay, stigma, alienation, skills deficits/lack of training, emotional stress and the challenges of self-care. They also report that the potential benefits of peer support work are for service users, the peer support workers, the wider workforce and the whole mental health care system.

Ibrahim et al. (2020) conducted a systematic review of influences on implementation. They included 53 publications and identified both facilitators and barriers. These included: organisational culture; training; role definition; staff willingness to work with peer support workers; resource availability; financial arrangements; support for peer support workers' wellbeing; and peer support workers' access to a peer network. They also suggest that these eight influences can be mapped onto the domains in the Consolidated Framework for Implementation Research (CFIR) and form the basis of a measure of implementation of peer support work.

A further review of factors influencing the implementation of peer support work in mental health services was completed by Mirbahaeddin and Chreim (2022) who used a narrative approach and included 38 articles. They organised the factors into three, interacting levels:

- Macro level (socio-cultural factors including the medical mode, recovery values, professional power dynamics, training and certification; regulatory and political factors including policy, political commitment) and economic and financial factors (funding and affordability of services);
- Meso level which included organisational culture, organisation leadership, change management and human resource management policies; and
- Micro level which focused on relationships between peer support workers and other staff, and peer support workers' wellbeing.

They highlight the importance of attending to professional power dynamics including at the macro level. They also acknowledge that most of the literature they considered was from Western countries and there is a need for these issues to be explored further in non-Western countries.

Ong et al. (2023) also completed a scoping review on the implementation of peer support services in Asia. They included 16 studies, from six Asian countries, and suggested that the political and cultural contexts in Asia are important to consider. Examples included China and

that the focus on the family as the central means of support there, may inhibit implementation. Another example was from Singapore and Israel where, due to the dominance of the biomedical model, there may also be less openness to peer support services.

An important factor in implementation which is identified across reviews is leadership. Scholz et al. (2017) conducted a systematic review specifically of service users in mental health service leadership. They reported, based on 36 included articles, that it was important for service user leadership roles to be viewed as an important resource in themselves which provide benefits to the organisation and also its reputation. The need to consider and possibly restructure existing hierarchies was also identified. Personal factors were also considered such as peoples' educational and employment experience, as well as their training and interest in leadership.

In addition to the existing literature reviews, there were also a range of studies that included consideration of the development and implementation process. For example, Mancini (2018) conducted interviews with peer support workers and other community mental health staff. They found that peer support workers' job satisfaction was associated with role clarity, autonomy and acceptance by other staff. The other staff identified the need for organisational support for peer services and guidance for all staff to ensure organisational readiness.

Jones et al. (2020) surveyed 801 peer specialists in the US to explore organisational climate and support in peer-run, hybrid and conventional mental health settings. They identified a range of types of setting based on levels of climate and support. High climate/support groups tended to have career structures and supervisors with lived experiences. Peer run organisations and peer run programmes within non-peer services were overrepresented in the high climate/support groups.

EXPERIENCES OF PEER SUPPORT WORKERS

The experiences of peer support workers are important to the development, implementation and effectiveness of peer support work.

Edwards and Solomon (2023) explored job satisfaction among a sample of 645 mental health peer support workers in the US. They found that key factors were co-worker support, perceived organisational support, supervisor support and job empowerment. They highlighted that perceived organisational support and job empowerment seemed to be particularly important.

Lapidos et al. (2018) had also surveyed 319 peer support specialists in the US about their professional activities, self-rated skills, job satisfaction, and financial well-being. They reported that the most common activities were sharing recovery stories and health-related tasks. The highest rated self-reported skills also included sharing recovery stories and community visits with the lowest being financial education and vocational support. Most reported (more than 75%) satisfaction with their safety at work, working hours and supervisor supportiveness but fewer were satisfied with job security (67%) stress (52%) and chances for promotion (41%). They also found wages were low compared to other health workers.

Gillard et al. (2022) used a longitudinal mixed methods design to explore the impact of working as a peer worker in mental health services in the UK. There were 32 participants and the findings suggested that peer support workers have levels of wellbeing comparable to the general population. There were some decreases in wellbeing scores at four months but these were largely not maintained at 12 months. They reported that there were positive impacts of working in the peer support role which included feeling valued, empowered and connected. Positive pay and working conditions were also associated with satisfaction. Some did also report that the work could be emotionally and practically difficult.

In Australia, Scanlan et al. (2020) surveyed 67 peer support workers to explore job satisfaction, burnout and turnover intention. They found peer support workers' self-ratings of job satisfaction, turnover intention and burnout were not significantly different from other staff in the mental health workforce. In terms of motivation, they reported that peer support workers tended to want to use their lived experience to support others, improve mental health services and make a difference. It highlighted the positive impact of good team culture and relationships but also the negative impact when peer support workers didn't feel valued by other workers suggesting an ongoing need for education and training for non-peer staff.

Byrne et al. (2016), also in Australia, explored 16 peer support workers' experiences using a grounded theory approach. They highlighted the ongoing dominance of the medical model in mental health services which created tensions and limitations for the peer support work role. Byrne et al. (2019) also explored the role of stigma and discrimination and reported that peer support workers have a key role in reducing stigma, but also continue to face it themselves within services.

Bailie and Tickle (2015) reviewed the qualitative evidence from 10 articles about the effects of employment as a peer support worker on personal recovery. They identified a number of themes including: increased knowledge about own mental health; impact on sense of identity; and the impact of their position within a professional team, especially if there is a clear role,

support, acceptance, belonging and a sense of being valued. The general positive impacts of being employed were also mentioned.

PERCEPTIONS OF OTHERS ABOUT PEER SUPPORT WORK

A theme within the development and implementation literature is the importance of the readiness and response of other staff in mental health services. Some studies have specifically explored the perceptions of other staff about peer support work.

Chisholm and Petrakis (2022) surveyed 203 multidisciplinary mental health professionals prior to the introduction of peer support workers to their teams. Responses tended to be positive about the potential contribution and role of peer support workers. There was less clarity about equal status with over a third of respondents reporting that they did not feel peer support workers should have equal status. This may have been associated with issues such as level of qualification and experience but it does seem a concerning finding.

Parker et al. (2023) used a grounded theory approach to better understand the experiences of staff during the process of implementing peer support worker roles in a community-based rehabilitation service. They highlighted some of the positive impacts of this integrated staffing approach with peer and non-peer staff reporting that the peer support workers' role and experience was valued but also that it had been a steep learning curve for all involved.

Ehrlich et al. (2020) evaluated the implementation of a newly formed community-based mental health team in Australia which included peer support workers. They identified three themes relating to the inclusion of the peer support workers. The first was the process of all of the staff understanding, navigating and establishing the role and fit of the peer support workers in the team. The second was the process of that role, and team member, being or becoming valued. The final theme related to the impact on how the whole team worked which moved to a more individualised, person-centred and holistic approach to support in which the peer support worker played a key role in working with service users, other staff and other services.

Korsbek et al. (2021) explored the views and experiences of non-peer mental health providers on working together with peer support colleagues in Denmark. They also identified three main themes. The first was about the relationship between the peer and non-peer workers with the non-peer workers identifying and valuing the additional contribution of the peer workers – so an equal colleague but with a different and positive role in the service. The benefits of working with peers were also highlighted especially in relation to giving hope and bridging between service users and services. There were some concerns identified, especially early in implementing peer roles, about issues of confidentiality and information sharing, different working conditions and the nature of relationships between peer workers and service users

especially in relation to boundaries and self-care. Korsbek et al. highlighted that these concerns were, to some extent, aspects of the flexibility and benefits of peer support work.

Tse et al. (2017) explored the perspectives of peer support workers, support workers and services users over three time points during the training, work placements and employment of peer support workers in Hong Kong. They also reported some uncertainties about the role of peer support workers in the early stages but, as trust and relationships developed, more of the benefits, including the unique contribution of using lived experience, were highlighted.

RECRUITMENT

An important aspect of the available guidance and toolkits on peer support work tends to be the recruitment process and there are also some helpful accounts of the relevant issues in the research literature.

In the UK, Simpson et al. (2014) completed an evaluation of the selection, training, and support of peer support workers in a service to support people being discharged from inpatient care. The recruitment and selection process included a role description and person specification, advertising the opportunities, a two stage selection process which involved a telephone interview and an open day. The training was delivered one day a week over twelve weeks and was evaluated using the Nottingham Peer Support Training Evaluation Tool. In general the evaluation was positive about the training, including the content and role-plays, although some felt they could have been better prepared for the level of emotional impact involved in the work, for example for the process of ending peer support, and the need for more preparation to work with families. The individual supervision and group support provided were viewed very positively.

Oh and Solomon (2014), in the US, also explored the use of role-playing as a tool for recruiting, training and supervising peer support workers. They emphasise how useful role-plays can be but also highlight the importance of carefully considering the format and structure of the role-play, the need for preparation, the need to guide the role-play and for debriefing afterwards. They also highlight that role-plays may be a useful tool for these important aspects of peer support work but are only a potential aspect of the comprehensive approach needed to recruit, train, supervise and support peer support workers.

In Germany, Lammers et al. (2023) explored the motives of 23 peer support workers. In this service the peer support workers were volunteers. They identified a number of aspects of motivation including: to develop their own understanding, competence and skills; to express their values through helping people and reciprocating for some of the support they had received; there was also a social aspect to motivation as some had got involved through others

although two participants did also mention that some of their friends and families had expressed concerns about them becoming peer support workers. A further aspect of motivation was to develop their careers and improve their self-esteem and confidence. More specific to peer work, most of the participants identified the importance of their own experiences as providing expertise and potential benefit to others and to bring out wider change to services. Finally, although they were in voluntary positions, some peer support workers did mention the importance of their expenses allowance. Lammers et al. acknowledged the ongoing debate about the professionalisation of peer support work and this process may change some of the themes they identified.

In the US, Moran et al. (2014) also interviewed peer support workers (n = 31) about their motivations. Drawing on self-determination theory, they divided their findings into internal motivations (autonomy, relatedness and competence) and external motivations (occupation and negative experiences) with a number of sub-themes in each:

- Autonomy: work has personal meaning and value; work supports the use of self-disclosure; work brings a sense of personal freedom and integrity;
- Relatedness: experiencing mutual-equal relationships; learning from others' experiences; having a sense of community; breaking from social isolation;
- Competence: employing natural help-giving tendencies; using lived-experience as a resource to support others; using lived-experience to get back to work;
- Occupation: needing a job/additional income; wanting to acquire status and qualifications; to develop skills and competencies;
- Negative experiences: to get away from previous monotonous jobs, conflicts with supervisors and burnout.

Although developed specifically for student peer support worker selection, an interesting development is the Peer Edmonton Empathy Recruitment Scale (PEERS) (Dubue et al., 2018) which is an empathy scale to inform the recruitment process. It was developed with 1439 undergraduate students and includes 18 items which are rated on a 1-10 scale from Strongly Disagree to Strongly Agree.

TRAINING

The importance of training for peer support workers and all other staff about peer support work is repeatedly identified in the guidance and research literature.

Charles et al. (2021) completed a review to identify topics from across peer support worker training courses and then conducted a Delphi consultation to identify consensus on what was

most important to include. They included 32 training courses from 14 countries and initially identified a list of 20 topics:

- “Introduction to peer support and peer support worker (PSW): Presenting the local and international history of peer support, survivor or activist grassroots knowledge, and key information on the context of peer support, PSW, principles, and concept of expertise by experience is essential to formal PSWs
- PSW role focus on recovery: Teaching about the meaning, stages, and culture of recovery, allowing integration into the PSW’s own experiences and practice. Additionally, teaching leadership, supporting informed choice, and working with service users in difficult times
- Approaches, frameworks, and models used in PSWs: Familiarizing prospective PSWs with approaches and frameworks underlying which peer support could be practised. For example, the tree of life, coaching frameworks, strengths-based approach, Intentional Peer Support, and Wellness Recovery Action Planning
- Knowledge of mental health: Introducing prospective PSWs to different frames of understanding of mental health, including nonmedical models of understanding mental distress (eg, Hearing Voices, Alternatives to Suicide, or Mad Studies) and medical models (eg, diagnosis or interventions), the different types of service setting (eg, inpatient units), and the mental health needs of different populations (eg, age groups, dual diagnosis, or marginalized and minority groups)
- Human rights and disability legislation: Providing training about the meaning and implications of human rights legislation, including regional or national mental health laws and international legislation such as the Convention on the Rights of Persons with Disabilities, to inform values-based PSW practice and skills in working within systems to uphold and protect the rights and social justice for people they work with, for example, through advocacy
- Ethics: Teaching about PSW values, beliefs, and actions, supporting self-reflection and an understanding about mental health practice and accountability including the importance of boundaries, levels of disclosure, and confidentiality
- Cultural competency: Practising PSWs in a way compatible with the cultural needs, values, background, and context of people using services
- PSW skills and competencies: Providing prospective PSWs with essential competencies needed for formal PSWs through an overview of different PSWs’ job descriptions; teaching the importance of maintaining role integrity and reflecting on the essential qualities and values of PSWs

- Lived experience as an asset: Highlighting how the experience of mental health problems, alongside other peer experiences such as service use, is a central resource for the PSW role; exploring methods and strategies for using lived experience with service users, including the safe, purposeful, and appropriate use of one's story to benefit others
- PSW well-being: Supporting self-reflection and offering strategies for PSWs to promote wellness, recovery, and resilience (eg, teaching PSWs about their workplace rights, self-advocacy, stress management techniques, vicarious trauma, self-care, and how to use reflective practice)
- Communication: Ensuring prospective PSWs have the fundamental connecting skills (eg, listening skills, use of language, and awareness of verbal and nonverbal cues), which facilitate effective communication with service users in different settings and situations, and helping them develop these skills if necessary
- Trauma-informed peer support practice: Offering peer support to understand and respond to the trauma of people using services to help them regain or achieve wellness and healing
- Crisis management: Helping PSWs to understand how to respond collaboratively, supportively, respectfully, and empathically to someone in a crisis
- PSWs working with groups; Training prospective PSWs on the skills needed to start, facilitate, or co-facilitate a peer support group, in addition to understanding the group processes, dynamics, and coproduction practices and addressing any arising issues
- Workplace aspects of PSWs: Ensuring PSWs have the skills needed to deal with workplace challenges, including knowledge of support options and training in dealing with work-related pressures, such as working with other professionals with conflicting values, workplace culture, organizational structures, exposure to violence, discrimination, bullying, and managing power dynamics and conflict
- Referral and communication with other services: Ensuring prospective PSWs know about local services and community resources and about formal communication or referral processes to other services; ensuring PSWs are sensitive to the balance between helpful referrals and supporting self-management or being heard
- PSW supervision: Introducing PSWs to the purpose, types of, and importance of supervision
- Developing a career as a PSW; Involves teaching prospective peers about the professionalization of the PSW role, including motivational drivers, career development, training opportunities, and financial management

- Role-specific PSW skills and competencies: Equipping PSWs with role-specific skills (eg, motivational interviewing, solution-focused thinking, family therapy approach, intentional sharing, and understanding cognitive behavioral therapy and mindfulness), understanding of service settings (eg, inpatient units and community teams) and the mental health needs of different populations (eg, age groups, dual diagnosis, homelessness, and marginalized and minority groups)
- Work skills: Teaching the administrative skills of recording and documenting direct mental health care and incidents and other work-related skills, such as time management" (pp. 7-8).

In the Delphi consultation there was a strong consensus, across peer support workers, managers and researchers, about the high importance of five of these 20 topics:

- Lived experience as an asset;
- Ethics;
- PSW well-being;
- PSW role focus on recovery; and
- Communication.

Although all topics were identified as being possible to partly or completely deliver online, there wasn't consensus about the most effective balance between online and face-to-face training. Peer support workers were more consistent about identifying the need for face-to-face training.

Opie et al. (2023) conducted a rapid review of the content and outcomes of training for peer support workers. They included 36 studies, and identified 22 topics across the content of the courses: communication skills; counselling skills; cultural competence; employment opportunities; group facilitation; help-seeking pathways/referrals; illness/health behaviour management; information about mental health; intervention content/therapeutic approach; needs assessment; organisation and leadership skills; peer helping/peer advocacy principles; personal recovery; planning/goal setting; problem solving; professional behaviours; recovery concepts; resource provision; risk/crisis management; self-care, personal support/coping skills; self-disclosure; the care/treatment/service system. They also reported the combination of methods of teaching used which included: didactic; discussion; feedback on performance; group/peer support; observational learning; placement/practical training/site visits; post training implementation; reflection; role play/experiential practice; scenarios; and sharing personal experiences. In terms of the outcomes of training for peer support workers, Opie et

al. (2023) identified the most promising as increased professional knowledge and skills, and improved personal psychosocial wellbeing and trauma recovery.

Another scoping review was completed by Viking et al. (2022) who focused on inter-professional learning and included 23 studies. They identified four main themes:

- Key factors of the PSW role in inter-professional teams: ambiguity of role, disclosure of lived experience, professionalism and culture, stigma and hierarchy
- Challenges for the PSW role in inter-professional teams: being a pioneer and varying expectations, patient or staff, workload and tasks, and complementary, but threatening roles
- Legitimacy of the PSW role and expertise: becoming a legitimate member, the expertise, training and supervision/support, certification and remuneration
- Benefits of the PSW role: role model and guidance and support, PSWs' contributions, bridge, collaboration with PSWs, and peer programmes and inter-professional learning

These themes reinforce the need and potential benefits for training for all of the relevant staff working with peer support workers.

RESEARCH ON EFFECTIVENESS

The question of the effectiveness of peer support is an important one in terms of identifying what types of interventions, approaches and services work best for whom and under what circumstances. There are obvious challenges here because, as mentioned earlier in this report, peer support is not a single intervention, but instead, refers to a broad range of work and concepts. For example, Lloyd-Evans et al. (2014) usefully describe three main categories of peer support within the effectiveness literature including: (1) Mutual support groups (i.e. where relationships are reciprocal); (2) Peer-support services (i.e. where support is primarily uni-directional with clearly defined peer workers offering support); and (3) Peer mental health service providers (i.e. people who have used mental health services and are employed to provide all or a substantial part of standard mental health care). However, even within each of these categories, there is likely to be considerable variation.

Likewise, the roles, responsibilities and activities of peer support workers may also vary considerably. For instance, sometimes peer support workers deliver or co-deliver specific low-intensity or recovery-oriented interventions such as WRAP (Wellness Recovery Action Planning Program; Copeland, 2002). Occasionally, they may also be employed in para-clinical or para-professional roles to support mental health professionals (e.g. through case management). It is also clear from the literature that peer workers receive, or participate in, widely varying forms of both formal and informal training to support them in their role.

There has been an interest in the literature regarding how peer support might lead to improvements in mental health disorders and a number of speculations have been put forward. More than two decades ago, Dennis (2003) suggested that peer support may decrease isolation for people with mental health challenges and provide positive role models whilst around the same time, Rogers et al. (2007) proposed that peer support may encourage patients to play a more active role in their recovery. More recently, Yalom (2020) argues that peer support groups are similar to group psychotherapy and that both may be used to promote altruism and cohesiveness, whilst also modelling positive behaviours, instilling hope and facilitating catharsis. Kotera et al. (2022) suggest common humanity as a mechanism of effectiveness, in the sense that recognising there are other people living with suffering, helps us to regulate our emotions (Kim et al., 2020); this recognition is strongly encouraged in peer relationships (Stratford et al., 2019). Overall however, the specific mechanisms of action for peer support work have yet to be investigated and tested.

Research on the effectiveness of peer support work is in its relative infancy. Furthermore, it is often unclear as to the kinds of outcomes which services hope to achieve by implementing peer support. Arguably, peer support workers should not be expected to deliver similar outcomes to other interventions in mental health which typically, have a focus on symptoms, service usage and psychosocial functioning. In other words, peer support work is firmly rooted in the recovery model which tends to focus on other outcomes such as hope, empowerment, relationships and agency. A conceptual framework which identifies some of the key aspects of recovery is CHIME (Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment). This has been used to inform the development and use of standardised measures (Vogel et al., 2020) but challenges remain with regard to how researchers can appropriately measure and capture these kinds of constructs.

Despite the many challenges in a field of research that is currently in its infancy, a number of useful and informative reviews have been published, to date, that have examined the effectiveness of peer support both in the field of mental health more generally and also with regard to specific disorders such as schizophrenia, depression and anxiety as well as for specific client groups such as young people. Further information is provided below.

PEER SUPPORT IN GENERAL MENTAL HEALTH SERVICES

A recent 'umbrella' review of systematic reviews and meta-analyses (Yim et al., 2023) (or 'review of reviews'), based on a total of 13 reviews, concludes that peer support work is generally effective, particularly with regard to recovery-oriented, as opposed to clinical and psychosocial, outcomes. With regard to the first of these, increases in empowerment, self-efficacy and hope were the most frequently reported positive outcomes. For instance, 8 of the 13 reviews showed that peer support was important in increasing hope and empowerment.

A second review by White et al. (2020), based on an overall sample of 3000 participants, included 23 studies of one-to-one peer work. A meta-analysis based on 11 different outcome variables, showed no impact on clinical symptoms or service utilisation, but a modest impact on self-reported recovery and empowerment. Notably, the authors identified a broad range of individual one-to-one forms of peer support working. For example, some trials involved the peer worker adopting paraclinical or substitute roles such as a traditional case manager (e.g. Solomon & Draine ,1995), while others were delivering either low intensity psychological interventions (Seeley et al., 2017) or recovery-oriented approaches/interventions (Rogers et al., 2016). The authors suggest, on the basis of the findings, that one-to-one peer support should focus on providing interventions that are additional to what is already provided in

mental health services in order to avoid duplication and promote the most efficient use of resources.

Group-based peer support interventions have also grown in popularity in recent years. A recent review by Lyons, Cooper and Lloyd-Evans (2021) found that peer support groups may be particularly effective for supporting personal recovery, but have a limited impact on other outcomes such as symptom reduction or service usage. The most commonly used interventions were self-management interventions such as WRAP (as mentioned above) Copeland, 2002) and anti-stigma interventions such as 'Coming Out Proud'(Corrigan al., 2015). However, the authors do note the difficulty in drawing definitive conclusions due to the paucity of research and the heterogeneity of the group interventions under investigation.

Two other reviews, also included here, focused on the effectiveness of peer support for generic mental health problems. The first and most recent of these (Egmose et al.,2023) based on 49 Randomised Control Trials (RCTs) and a very large pooled sample of participants (*n* = 12,000), focused on the extent to which peer support influences both personal recovery variables and more traditional clinical outcomes (e.g. symptoms and social functioning). The results showed that peer support interventions led to modest improvements in measurable aspects of recovery such as self-efficacy, but had little or no effect on symptoms, functioning or service usage. The authors also note that the majority of studies took place within a hospital or mental health service environment. However, there were also some promising results from studies which focused on online peer support and services provided outside of a traditional service environment.

The second review (Burke et al., 2019) was based on 23 studies which reviewed the effectiveness literature specifically in relation to the outcomes of empowerment, self-efficacy and internalised stigma for those with mental health problems who were receiving support from peers. Three main categories of peer support were identified including: peer-led group interventions; one-to-one peer support; and peer-provided services. The findings indicated that peer-facilitated time-limited group interventions can result in small, but clinically important improvements in empowerment, and self-efficacy when compared to usual services. The vast majority of these interventions were grounded in the recovery model including the following:

- Wellness Recovery Action Planning Program (WRAP; Copeland, 2002)
- The Spaniol Recovery Workbook (Spaniol et al., 1994)
- Pathways to Recovery strength-based self-help workbook (Ridgway et al., 2002)

- Recovery Is Up To You (van Gestel-Timmermans, 2011)
- Building Recovery of Individual Dreams and Goals (Pickett et al., 2010)

Overall, however, the evidence was inconclusive with regard to the effectiveness of one-to-one and peer-run services and also for the outcome variable of internalised stigma, mainly due to the small number of high-quality studies. Nonetheless, it remains a hopeful area of investigation.

An important conclusion of this review is that the effectiveness and efficacy of peer support workers is likely to be driven by the type of interventions that they deliver. More specifically, they are ideally placed to deliver interventions grounded in the recovery model mainly because they lend the credibility of lived experience. Notably, the authors indicated that the quality of most of the included studies was weak to moderate. Overall, the literature on the effectiveness of peer support with regard to mental health problems more generally, provides some promising positive evidence, but a need for much more (high-quality) research is indicated in order to address important gaps in knowledge and methodological rigour.

As mentioned earlier, a number of published reviews have investigated the effectiveness of peer support for specific mental health disorders. For example, Lloyd-Evans et al.'s (2014) systematic review and meta-analysis of 18 RCTs (*n* = 5000) focused on peer support for people with severe mental health problems such as schizophrenia They concluded that the evidence regarding peer support is relatively poor due to the small number and quality of studies. They noted no evidence that any form of peer support led to reductions in hospitalisation, severity of symptoms or satisfaction with services. Importantly however, they reported that in some studies of mutual support and peer support services, there was some evidence of improvement in recovery-related variables such as hope and empowerment. The authors highlight that the evidence base is far from conclusive in this regard.

Lastly, in a recent Cochrane review, Chien et al. (2019) included 13 studies (with over 2000 participants) that compared standard care with both peer support and standard care for people with severe mental health problems such as schizophrenia. These studies included a number of outcome variables, ranging from hospital admission, relapse and mortality to global functioning, quality of life and costs. The authors report that all of the trials they examined were of very low quality and most did not provide sufficient data for the variables in which they were interested. Overall, the findings highlight little or no impact of peer support on hospital admission or mortality rates. While some benefits were observed in relation to recovery domains such as hope, agency, confidence and empowerment, the data were considered

insufficient to make any firm conclusions. The authors conclude that at present, there is insufficient high-quality evidence available to support (or not) the use of peer support interventions for people with severe mental health problems.

A number of reviews have been carried out on the effectiveness of peer support for other mental health problems such as depression and anxiety (Pfeiffer et al., 2011; Shorey & Chua, 2023; Simmons, Cartner, et al., 2023). For example, one of the earlier studies by Pfeiffer et al. (2011) involved a meta–analysis of 7 RCTs which compared peer support to usual care for depression. The authors made no distinction between peer support groups and peer support workers. They concluded, on the basis of the review findings, that peer support interventions were effective and as effective as group cognitive behaviour therapy (CBT). However, they acknowledge the small number of studies available to the review.

More recently, Shorey & Yan Xin Chua (2023) reviewed 17 RCTs of peer support interventions for depression which they defined as any intervention delivered by peers with minimal or no assistance from health care professionals. Peers were lay people who had either ongoing, or a history of, depression or healthy volunteers who shared similar characteristics to participants receiving the interventions (e.g. age, gender etc). The authors did not specifically examine data in relation to peer support workers or peer-led services. The interventions which they reviewed, fell into three categories including: peer delivered psychotherapy; individualised peer mentoring; and peer support discussion groups. The authors conclude that there is some evidence of effectiveness for the first two of these, both of which were more effective than discussion groups. The authors go on to suggest that peer support workers could be trained to provide some forms of psychological therapy (e.g. behavioural activation or problem solving), although none of the studies in their review, compared such interventions with professional-led therapies/interventions so it is difficult to be clear as to the relative effectiveness of peer-led versus mental health professional-led interventions.

All of the studies described so far have been quantitative in nature, but a large number of qualitative studies have also been undertaken to examine the lived experiences of peer support workers, as well as the experiences of non-peer staff and of people in recovery. For example, Walker & Bryant (2013) carried out a meta-synthesis of qualitative research findings, the results of which showed that, in general, service users tend to view the role of peer workers very positively, with reported experiences and feelings of increased hope, motivation and better social networks. The study findings also imply that service users can build rapport with peer workers more easily than other types of staff. The review does note, however, that a minority of service users held negative views of peer workers due to their perceived lack of

formal training and their own diagnosis of a mental health problem. It is also worth noting, from this study, that non-peer staff had positive views of peer workers whom they felt were instrumental in increasing empathy and understanding toward service users in general.

COST EFFECTIVENESS

The research on the cost-effectiveness of peer support (as with much of the field of mental health intervention) is very limited and only a very small number of studies have included economic evaluations. Nevertheless, initial findings in this regard appear promising (e.g. (Iemmi et al., 2015; Le Novere et al., 2023).

An interesting, albeit now 10-year-old, report by the UK-based Centre for Mental Health (Trachtenberg & et al., 2013) identified a further six studies in this field that examined the associations between the employment of peer support workers and inpatient bed usage. The weighted average cost:benefit ratio was 1:4.76; that is, for every £1 spent on peer support, £4.76 was saved on bed usage. Four of the studies identified, had a ratio substantially better than one, while only one study showed a small negative cost-benefit ratio. While these findings suggest good value for money, a need for many more (high-quality) economic evaluations is indicated.

In summary, the general effectiveness literature on peer support, while far from conclusive, provides some promising findings, but it is also important to remember that “current gaps in implementation and limitations in the evidence base should be viewed not as obstacles to ideas adoption, but as building blocks for more consistent service integration and thoughtful empirical research” (Yim et al.2023, p.17).

DECISION-MAKING AND ADVANCE CARE PLANNING

Cleary and colleagues (Cleary, Raeburn, Escott, et al., 2018) described 'walking the tightrope' in their study of PSWs employed to facilitate decision-making. Six peer support workers employed in psychiatric hospitals or community mental health settings were interviewed and identified common challenges associated with their role including difficulties about the role definition, power imbalances and the medical-centric approaches to care. Lack of resources were also identified as a problem. PSWs in this study developed strategies to tackle these problems in order to achieve meaningful involvement for service users, appropriate use of lived experience and adopting a rights-based approach. A second paper from the same study explored nurses' perceptions about their role and those of peers identifying frequent tensions about how lived experience should be used and the potential impact on professional and therapeutic boundaries if not appropriately managed (Cleary, Raeburn, West, et al., 2018).

The CommonGround programme is an internet-based software programme designed to assist consumers make decisions around psychiatric medication use and promote shared decision-making between consumers and prescribers (Deegan, 2010). Campbell's PhD dissertation examined the use of CommonGround and peer support in a community mental health centre, the first 'Decision Support Centre' (Campbell, 2010). A pre- and post-test design was used for the 4-month intervention. Analysis demonstrated that patient-centred communication increased using the CommonGround and peer support model. It was the subject of a pilot randomised controlled trial in an outpatient setting in Japan (Yamaguchi et al., 2017) and while relationships between patients and doctors improved, there was not a significant effect on clinical or recovery-related outcomes.

The Choice Project also used an online decision-making tool and PSW with youth mental health services (Simmons et al., 2017; Simmons et al., 2018). Using a historical comparison group, intervention participants (N = 149) worked with a peer worker and used the online tool before and during their intake assessment. Ratings of perceived decision-making was higher in the intervention group compared to the control group and young people reported feeling more involved in the decision-making about their care and experienced less conflict about decisions which in turn contributed to improved client satisfaction.

In more recent developments, Zisman-Ilani and Byrne (2023) discuss how social prescribing led by peers can help better support.

OPEN DIALOGUE

The Open Dialogue (OD) model, first developed in Finland, supports a person-centred social network model of crisis and continuing health care and is designed to promote agency and long-term recovery. In the UK, OD draws on the experience and skills of PSWs to deliver the OD model (Chmielowska et al., 2022). Currently, the evidence in support of Open Dialogue is of low quality, and randomised controlled trials are required to draw further conclusions (Buus et al., 2021; Freeman et al., 2019).

CRISIS/INPATIENT/DISCHARGE SUPPORT

CRISIS SUPPORT

Many people experiencing a mental health crisis will find themselves in the emergency department (ED) of a hospital and providing an appropriate and measured response can be crucial. A number of schemes have been developed to provide peer support for people experiencing distress in crisis with some evidence that they can be effective by bringing specialist skills and knowledge such as empathetic listening, de-escalation, and building trust (Brasier et al., 2022; Heyland et al., 2021). However, there is a consistent theme in the literature that a lack of recognition and misunderstanding of the role impedes implementation and significant changes to workplace culture and adequate funding is required.

Brasier et al. (2022) describe some of the physical limitations of the ED setting that may impede the delivery of high quality peer support:

- Entrances and wayfinding – entrances are not visible from the street, wayfinding signage is poor and arrival by ambulance or police escort involves entering through the ambulance bay;
- Waiting room – limited private spaces making private conversations difficult to have, access to basic necessities is limited and the environment is described as ‘unhelpfully stimulating’ with 24-hour florescent lighting, TVs on the wall;
- Clinical spaces – are reserved for clinicians only, desks and clinical spaces are very crowded, the presence of forensic/police staff are evident, and features that could help support recovery such as family spaces are limited in availability.

Peer-run hospital diversion programmes have been the focus of a number of research studies (Bologna & Pulice, 2011; Burns-Lynch & Salzer, 2001). Despite a successful pilot demonstrating cost effectiveness, the Connections scheme described by Burns-Lynch and Salzer (2001) was closed within 12 months because of problems relating to systemic

implementation. A comparison of a peer-run diversion programme and a non-peer acute inpatient programme was undertaken by Bologna and Pulice (2011) using qualitative methods. Unsurprisingly perhaps, services in the peer-run programme were considered to be more client-centred and less restrictive. People reported reductions in stigma, better life satisfaction and enhanced social involvement. The authors recommend the extension of peer support work to emergency departments to provide empathetic support and facilitate de-escalation. However significant workforce and organisational change is required for successful implementation.

PEER RESPITE

Peer respite offers a community-based, non-clinical residential short-term support for people experiencing a mental health crisis and while the research evidence for their use is limited, they have been associated with a reduction in inpatient admissions, and higher levels of satisfaction and improved self-esteem compared to locked inpatient settings (Croft & İsvan, 2015; Croft et al., 2021; Fletcher et al., 2020; Greenfield et al., 2008). Many peer respite models are based on intentional peer support. Croft, Weaver and Ostrow (2021) interviewed twenty 'guests' of a respite centre in the US. Content analysis of the interviews identified a number of important aspects of the service:

- Belongingness – feeling a belonging to a community and being able to share experiences that were shared by others, in a safe and home-like environment;
- Confidence and hope – the centre offered a setting that was motivating and encouraged independence;
- Crisis self-management – provides a place where you can remain connected to your community but can take a break from day-to-day responsibilities and stressful situations;
- Experiencing mutual support;
- Freedom and responsibility – and being accountable for personal decisions and actions;
- Linking to community – the importance of connecting people to external resources and community integration during their stay; and
- Conflict and confrontation – although this can be challenging and was also described as being transformative.

Fletcher and Barroso (2019) explored some of the organisational dynamics that affected the delivery of a peer respite programme in the United States. Issues included dealing with the fallout from systemic pressures on mental health services that has created large gaps in services and continuity of care. There was confusion from peer staff about the organisation's

goals and objectives, and interpersonal tensions and experiences of discrimination in the governance of the scheme. In another qualitative study by the same authors (Fletcher et al., 2020) that spanned 5 years of the delivery of the programme, operational policy recommendations were made to promote the transformation of peer services, particularly around leadership:

1. Substantive peer leadership positions should be established within public health administration, including making decisions about budgets, evaluation and staff recruitment in all mental health programmes;
2. Provide ongoing leadership and advocacy training for peer staff;
3. Facilitate flexible funding and mechanisms to allow for new strategies to be implemented based on programme evaluation and stakeholder feedback.

INPATIENT SETTINGS

Kuek, Chua and Poremski (2021) considered qualitative data collected in a large psychiatric hospital in Singapore to explore the barriers and facilitators of peer support. Four subthemes of facilitators were identified: supportive figures; defined role; opportunities for personal growth; and identifying personalised coping strategies. Three types of barriers were identified including unclear roles, hostility from non-peer-support/specialist staff and unsupportive working environments. In a second paper from the same study, Poremski et al. (2021) explored how peer support roles changed over time as they become established. Ten peer support specialists were followed over the course of a year and interviewed at three time points. Participants worked in a variety of departments in the hospital, and their service use experiences generally echo those of their service users. There appeared to be four phases over the course of their employment: early beginnings, establishing the role, role narrowing, and role sustainability. The authors recommend that time is required to integrate new peers, specific and clear job descriptions should be developed as a lack of role clarity may create difficulties. Pairing new staff with mentors may improve outcomes.

Nossek et al. (2021) report on the evolution of PSWs within inpatient settings in Germany using a longitudinal qualitative observation study over a period of 6 months. Data were collected by non-participant observation of team meetings and PSW meetings. Themes of team integration and the PSW role were identified in the data.

Team integration features of success included: equal treatment in conversation and recognition of PSW specific skills and knowledge. Challenges to team integration were associated with a lack of resources and lack of contact with mentors. PSWs being available for individual follow-up and conversations was beneficial and a gradual process of developing self-confidence, good support from a PSW mentor and external supervision was key.

Otte and colleagues (2020) explored the challenges faced by PSWs (*n* = 9) integrating into hospital-based mental health teams in five psychiatric hospitals in Germany. On beginning the role, respondents felt a pressure to succeed, possibly self-imposed, and afraid to call in sick in case absence was associated with their mental health problems. Some felt that they were treated as a patient rather than a colleague, and also reported non-peer suspicion and fear they would replace non-peer roles. Problems with clearly defined roles and responsibilities could create tension and conflict with non-peer staff. PSWs also felt equipped to work with service users with similar histories, however, they could feel out of their comfort zone working with other illness profiles. Experiences of stressful situations could also feel potentially triggering.

A recovery-focused intervention was co-facilitated by PSWs in acute inpatient wards in an NHS Trust in England and feedback demonstrated it was both feasible and acceptable (Pownell et al., 2023). The Recovery Group was a locally designed, psychosocial intervention with a focus on:

- teaching a basic understanding of mental health difficulties
- teaching essential coping skills for mental health difficulties
- building empowerment
- challenging stigma

Participants reported high rates of improved understanding, greater empowerment and value but identified some areas for improvement including dealing with disruptions, the group setting, personal barriers and lack of time.

A randomised trial of a peer-delivered service for compulsory admission psychiatric inpatients included intensive one-to-one peer support to help with recovery and meet mandated court-ordered services was conducted by Rogers et al. (2016). The setting was challenging in terms of recruitment, service provision, intervention retention and research attrition. Intent-to-treat analyses revealed no significant differences in outcomes by study condition (*n* = 113). As-treated analyses comparing high- and low-use peer support groups with the control group found significant differences favouring peer support recipients in quality of life and functioning, but no differences in other study outcomes.

Rooney, Miles and Barker (2016) explored patients' experiences of intentional peer support in inpatient wards. An overarching theme of communication was identified together with six main themes: person centredness; practical support; building connections; emotional support; modelling hope; and recovery interventions. There were no negative comments expressed by interviewees in this small-scale qualitative study.

A similar study considered the perspectives of PSWs using intentional peer support on inpatient wards (Stone et al., 2010). Their research highlighted the value of the role for PSWs own recovery journey, who also continued to receive services. Those interviewed highlighted the importance of recognition in the process of employing PSWs in order to challenge stigma and discrimination and create a positive example of meaningful and rewarding employment.

REDUCING THE USE OF RESTRAINT

The use of restraint as a way of managing patients is contrary to the recovery concept (Badouin et al., 2023). Employing PSWs as a way of reducing restraint was assessed by Badouin and colleagues on a locked ward in Berlin, Germany. A pre- and post- comparison of peer support and TAU was based on routine data on the proportion, frequency, duration of mechanical restraint, and forced medication. Results suggest that the use of peer support may be protective in the use of restraint however difficulties associated with Covid-19 and staff reorganisation affected the trial.

IMPROVING THE DISCHARGE PROCESS

The evidence base reports mixed findings for peer-support designed to improve the transition from hospital to community, with some studies finding no evidence for superior outcomes for peer support (Gillard, Foster, et al., 2022; Kidd et al., 2021) compared to TAU. In contrast, other trials have reported more positive findings (Johnson et al., 2018). Brenisin, Padilla and Breen (2023) used phenomenological analysis to explore PSWs' own experiences of discharge from inpatient services. Their experiences highlighted the importance of: service users being actively involved in their discharge planning; continuity of support; and the potential for PSWs to provide important support during the discharge and resettlement process.

Forchuk and colleagues (2002) tested the Transitional Relationship Model to support people making the transition to the community with a Canadian sample of 390 patients across three sites using a randomised cluster design. With a focus on building interpersonal relationships, the programme involved provision of peer support for one year and an overlap of in-patient and community staff which allowed for inpatient staff to continue working with clients until the relationship with the community staff was established, this could take up to one year. The study reported that savings of more than $12 million were achieved as a result of shorter hospital stays, and was most helpful for those who reported feeling lonely. Developing effective collaborations between health and community providers was crucial to achieving cost savings and helped form more effective support systems once individuals resettled back into the community. A series of subsequent studies led by Forchuk (Forchuk, Martin, et al., 2021;

Forchuk et al., 2020; Forchuk et al., 2012, 2013; Forchuk et al., 2007; Forchuk, Solomon, et al., 2021) examined how best to implement TRM into clinical practice.

More recently, Gillard et al. (2022) conducted a parallel, two-group, individually randomised controlled trial to compare peer support for discharge from inpatient care versus TAU in a sample of adult psychiatric inpatients *(n* = 590) from seven mental health services in England. The peer support intervention was a manualised, one-to-one strengths-based programme focusing on engaging in community activities. Service users began receiving the support during the index admission and it continued for 4 months post discharge, plus care as usual. Care as usual consisted of follow-up by community mental health services within 7 days of discharge. The primary outcome was psychiatric readmission 12 months after discharge (number of patients readmitted at least once), analysed on an intention-to-treat basis. There were no statistically significant differences between groups 12 months after discharge on a range of measures including readmission and serious adverse events. The authors recommend that further research is required to improve engagement with peer support in high-need groups, and to explore differential effects of peer support for people from different ethnic communities.

Participants recruited from crisis resolution teams in England were randomised in a controlled superiority trial comparing a peer-supported self-management programme and results demonstrated that peer-delivered self-management reduced readmission to acute care (Johnson et al., 2018).

The Peer Supported Transfer of Care (Peer-STOC) programme has been established state-wide in New South Wales, Australia to support individuals transitioning from inpatient to community settings. Hancock et al. (2022) interviewed stakeholders including service users, peer support worker service providers, and other mental health workers/clinicians working on the interface. All of the stakeholders (n = 82 questionnaires; n = 58 individual interviews) reported positively about the programme. Benefits included: less traumatic and improved experiences for service users; feeling understood, cared about and less lonely; easier discharge from hospital and reintegration into life and daily routines; building and re-establishing community connections; new skills and feeling hopeful for recovery.

Peer support plus a supportive text-messaging service was trialled by Shalaby and colleagues (2021; 2022) in Canada. This prospective, controlled observational study included 181 patients who were discharged from acute psychiatric care. Patients were randomised to one of four conditions: TAU (follow-up care); daily supportive text messages only; peer support only; or peer support plus daily supportive text messages. A standardized self-report measure of recovery (Recovery Assessment Scale) was completed at baseline, 6 weeks, 3 months,

and 6 months. A total of 65 patients completed the assessments at each time point, higher scores were found for the peer support plus text message condition compared with the text message only and treatment as usual condition on several scales. The authors suggest incorporating both interventions as part of routine practice for patients with psychiatric disorders upon hospital discharge.

SUICIDE PREVENTION

Two scoping reviews have focused attention on peer interventions for suicide interventions. In a review of peer-delivered suicide prevention services, Bowersox and colleagues (2021) included 84 studies of which only three were randomised controlled trials. This demonstrates the development of these types of interventions but also the need for more robust evidence about their effectiveness. They identified four primary functions of peer interventions: gatekeeper; on-demand crisis support; crisis support in acute care; and crisis/relapse prevention. The feasibility and acceptability of peer-based interventions was high, particularly as a complement or alternative to more formal approaches and, this was facilitated by their ability to respond quickly to need, low cost and perceptions of confidentiality and discretion. The authors conclude that gatekeeper training programmes may be effective in increasing awareness of suicide risk and empowering people to intervene when a person is in crisis. Peer-based interventions targeting specific subgroups demonstrate an ability to reach people who might not access traditional types of mental health support. The evidence suggests that peer workers use many of the same therapeutic techniques as traditional trained therapists which are valued by service users.

Schlichthorst and colleagues (2020) drew similar conclusions about the paucity of the effectiveness evidence identifying only 7 programmes (8 records) of peer-led support programmes in suicide prevention in a variety of different settings including schools, communities, rural and online. Only three of the studies reported effectiveness data. Areas of effectiveness included an increased sense of community and better understanding of suicidal thoughts in support groups. Online peer support forums decreased the intensity of suicidality by providing constructive advice, being actively listened to, receiving sympathy and being offered alternatives to suicide (Kral, 2006; Niederkrotenthaler et al., 2016).

Pfeiffer et al. (2019) conducted a randomised pilot study of a specialist peer intervention designed to reduce suicide risk (PREVAIL). Seventy high risk adult psychiatric inpatients were enrolled and randomised to treatment as usual (TAU) or the 12-week peer support intervention based on the recovery model and drawing on components of motivational interviewing and specific psychotherapies to reduce suicide risk. Qualitative feedback was extremely positive reflecting peer specialists' skills in connecting with and advising participants especially around

discussions about suicide. PREVAIL has also been considered for use in veteran populations (Schmutte et al., 2023).

Van Zanden and Bliokas (2022) endeavoured to understand the mechanisms of change in programmes using interviews with peer workers and clinicians in a suicide prevention service identifying four key factors that drive change:

1. utilising lived experience
2. emotional availability of peers
3. building lives worth living
4. consumer driven care

They identified a further indirect mechanism they refer to as 'consultation in the context of risk' which highlights the importance of consultation and collaboration to help manage risk and provide appropriate supervision in this difficult area of work. Developing agency amongst service users was also considered extremely important to reduce suicide risk.

MEDICATION

A single study using a quasi-experimental time-series design measured the effect of problem-solving peer support to improve medication adherence for people with schizophrenia (Boardman et al., 2015; Boardman et al., 2014). Six peers contacted service users (N = 22; 19 males, mean age 35.1 years) for an 8-week period via a weekly 20-minute telephone call. Improvements were observed in medication adherence, negative symptoms and overall mental state between baseline and week 8 and were sustained at 14-week follow-up. The authors suggest that a problem-solving community-based peer support programme could benefit service users who are non-adherent with oral antipsychotics.

ACTIVITY/EMPLOYMENT

Engaging in meaningful and active employment forms an important element of recovery for many and is associated with increased motivation, improved social connections and self-esteem and confidence. An occupational therapy intervention, Meaningful Activities and Recovery (MA&R), has been designed to be co-led and delivered by occupational therapists and peers (Bjorkedal et al., 2023; Tepavicharov et al., 2022). MA&R consists of 22 sessions, 11 group and 11 one-to-one sessions covering topics including activities, health, recovery, and engagement strategies. In a randomised controlled trial in Denmark, 139 participants were randomised to MA&R and standard mental health care or to standard mental health care alone. Activity engagement was the primary outcome measure, and assessed at baseline and post-intervention follow-up using the Profile of Occupational Engagement in People with

Severe Mental Illness (POES-S). Unfortunately, COVID-19 impacted on delivery of the programme and the authors suggest that this may have confounded the reporting of effects. The intervention was feasible and delivered with high fidelity and 83% rate completion.

The value of vocational peer support (VPS) has been explored in a number of research studies but the sample sizes are invariably very small, based on pilot programmes with limited data on their effectiveness (Haertl, 2007; Kern et al., 2013). Cheng and Yen (2022) recruited 46 service users to co-lead and assist workplace problem-solving groups and care skills training in a vocational rehabilitation programme for people with schizophrenia in Taiwan. The programme was connected to a sheltered and supported employment programme for people with schizophrenia who had worked in elderly care, including meal delivery, housekeeping and care attendant services, drawing on existing work experience. Trainees received training 1-2 classes a week over a 16-week period. This pilot programme demonstrated statistically improved social support and improved occupational outcomes for service users. Curtin and Hitch (2018) reported difficulties with the power imbalance between PSWs and Occupational Therapists in the WORKS vocational rehabilitation group programme but this was based on analysis of only four semi-structured interviews.

Larger samples and a randomised design was applied to evaluate a new model of vocationally oriented peer support by Maru and colleagues (Maru et al., 2021). Participants (N = 166) were randomly assigned to Vocational Peer Support or peer support-as-usual for a 12 month period. Peer support specialists were trained and supervised and outcome measures included work hope, quality of life, and work readiness at baseline, 6- and 12-months. Minor improvements were observed in work readiness and vocational activity; secondary analyses demonstrated a stronger working alliance with the peer specialist, which mediated some aspects of a better quality of life and greater work hope. The authors conclude that VPS may assist individuals receiving peer support as they choose, get, and keep employment.

Simmons et al. (Simmons, Chinnery, et al., 2023) conducted a non-randomised pilot of an Individual Placement and Support (IPS) programme with young mental health service users (aged 15-25 years). Almost two thirds of the 326 young people enrolled in the programme achieved competitive employment and around half were able to achieve sustained employment.

Of note, was Jimenez-Soloman et al.'s (Jimenez-Solomon et al., 2016) development of a framework for a peer-supported economic empowerment intervention designed to improve financial wellness, an area of rehabilitation so often neglected. Their work identified six different functions of peers to help overcome economic barriers, achieve financial wellness

goals and help reduce some of the psychosocial impacts of poverty and dependency. These were identified as:

- “Engaging in culturally meaningful conversations about life dreams and financial goals;
- inspiring individuals to reframe self-defeating narratives by sharing personal stories;
- facilitating a financial wellness action plan;
- coaching to develop essential financial skill;
- supporting navigation and utilization of financial and asset-building services; and
- fostering mutual emotional and social support to achieve financial wellness goals” (Jimenez-Solomon et al., 2016, p. 222)

In recognition of the important role that employment and sustaining meaningful work have, Ustel et al. (2021) describe the role of peer specialists in the development of a Virtual Reality Job Training programme and how sharing recovery stories can be useful.

PHYSICAL HEALTH

The physical health of people with mental health problems is an ongoing concern, particularly in recognition of the mortality gap that has identified that those with serious mental illness will have a life expectancy of between 15-20 years shorter than those without.

Peer support interventions have been developed to improve health behaviours (Kelly et al., 2020; Stefancic et al., 2021) including smoking cessation (Ashton et al., 2013; Dickerson et al., 2016; McKay & Faith, 2012), healthy eating (Bochicchio et al., 2019; Bochicchio et al., 2021; Bochicchio et al., 2023; Vogel et al., 2023; Young et al., 2017), promoting physical activity (Mawani & Ibrahim, 2021), oral health (Lapidos et al., 2023; Lapidos et al., 2022) and addressing some of the barriers to accessing physical health care (Bocking et al., 2018; Storm et al., 2020; Swarbrick et al., 2016).

Stubbs and colleagues (2016) summarised the available evidence in a systematic review of peer support interventions to improve the physical health of people with SMI. Seven articles were included including three pilot randomised control trials and four pre- and post-test studies involving a total number of 230 participants across the included studies. Interventions ranged from personalised fitness training delivered by a trained instructor with peer 1:1 and group coaching, peer-led self-management programmes, and peer-led weight loss groups. They reported considerable heterogeneity in the type and role of peer support and inconsistent evidence to support their use in physical health and lifestyle change. The quality of the evidence makes it difficult to make firm conclusions about their effectiveness.

Tweed et al. (2021) conducted a scoping review of peer support as a component of community-based physical activity or sport programmes. Thirteen studies were included and improvements in perceived social support (9 studies), mental wellbeing (7 studies) and physical activity (5 studies) were observed across some of the findings. The authors recommend that community-based physical activity programmes that incorporate a peer support element should be the focus of intervention design.

Group smoking cessation programmes were developed and delivered by peer support workers in South Australia in Ashton et al.'s (2013) study and evaluated by surveying group participants (*n* = 108) and PSWs (*n* = 33), with both quantitative and qualitative measures. Participants reported increased confidence in their knowledge about stopping smoking and improved wellbeing and that by involving peer support, may increase acceptability and effectiveness of the intervention. McKay and Dickerson (McKay & Faith, 2012) identified four tobacco cessation interventions in their review of the literature with peer support roles including leading a smoking cessation educational group, individual counselling, and PSWs working as outreach advocates. They identify the need for more robust research to assess their impact.

In Western Australia, Bates, Kemp and Isaac (2008) piloted a Peer Advocacy and Support Service (PASS) to support people with mental health problems to attend to their physical health needs as part of the *HealthRight* programme. *HealthRight* offers practical support to consumers and caregivers to attend GP and other appointments with GPs, increase the number of visits to GPs to discuss physical health needs and improve assessment with the view to ultimately improve the effectiveness of interagency collaboration. A training programme for PSWs was developed, along with a resource kit that provided information about stopping smoking, physical activity guidelines, healthy eating, alcohol guidelines, breast cancer and screening amongst others.

As part of the development of the programme, clear roles and responsibilities were established at the outset for each partner (project workers/non-governmental agencies, health services, and peer supporters). For the peer supporter role, these include:

- Set health-related goals with participants
- Encourage and assist participants to find and consult GPs
- Encourage and support participants to locate and utilise allied health professionals and related services and make health-related appointments
- Provide information, resources, and support to attend appointments
- Advocate where necessary
- Maintain contact with mental health professionals

- Disengage when appropriate to encourage independence
- Maintain appropriate records and documents

All peer supporters reported improvements in confidence and self-esteem, two observed better mental and physical health and another reduced their tobacco use. Other positive comments included feeling like a peer with other health workers and the personal reward associated with the role. Early concerns from clinicians (e.g. issues around confidentiality, risk for PSWs own mental health) prior to the pilot were dismissed once the programme was underway. Dickerson and colleagues (2016) discuss some of the challenges experienced by PSWs in a smoking cessation intervention and recommend greater anticipation of some of the complexities and tensions of delivering a behaviour change intervention whilst promoting person-centred support.

Bocking et al. (2018) conducted focus groups with consumer participants about the role of PSWs in promoting the physical health of those with mental health problems. The role that peers currently provide was seen as underestimating their potential for changing policy and their role should be integrated to reduce physical health inequalities.

Peer specialists have also been used successfully to support a lifestyle intervention for overweight and obese individuals living in supported housing (Bochicchio et al., 2019). They found that sharing their own experiences was central to building motivation and encouraging lifestyle change in others. Interviews with participants described their relationship with peers and non-peers positively but identified key differences in their approach to practice, the power dynamics and how they identified with workers (Bochicchio et al., 2021). PSWs were described as 'process-oriented' compared to task focused non-peer staff. While each staff member sought to motivate individuals, PSWs were perceived as building hope and non-peers emphasised the negative consequences of inaction.

Kelly and colleagues (2020) conducted a randomised controlled feasibility trial to increase healthy living choices in a community mental health setting, confirming the feasibility and capability of peers delivering a programme which now warrants a sufficiently powered trial.

Oral health can be an important element of health and quality of life, particularly in mental health populations where there are increased risks of oral disease (Lapidos et al., 2023). Lapidos and colleagues successfully developed a peer-specialist led wellness intervention delivered by a multi-disciplinary team within a community mental health centre and three drop-in centres. The peer specialists were responsible for providing health education and linking participants with dental care (Lapidos et al., 2023; Lapidos et al., 2022).

Peer walking groups have also been shown to successfully promote physical activity and social inclusion and improving access to green spaces that can be beneficial for mental wellbeing. The Building Roads Together intervention described by Mawani et al. (2021) offers a comprehensive training programme combining peer leadership, inclusion, communication and the practical skills required to successful run a walking group.

Key Messages From the Effectiveness Literature

- There is some evidence to suggest that peer support has a positive impact on recovery-oriented variables such as hope, empowerment, relationships and agency. However, this approach is unlikely to impact clinical variables such as symptoms, psychosocial functioning or service utilisation.
- The effectiveness of peer workers appears to be enhanced when they deliver a specific intervention. As a result, there needs to be a clear vision as to what peer workers are employed to do (e.g. deliver recovery-oriented interventions).
- The training of peer workers and supervisors needs to be aligned to this vision.
- Evidence on the cost-effectiveness of peer support work is very limited and it is not possible, therefore, to draw any conclusions in this regard despite some initial positive evidence.
- There is a need for more high-quality effectiveness studies as well as longitudinal designs and economic evaluations.

PERINATAL

Considerable work has been undertaken by the Scottish Government to include a peer support strategy as central to their perinatal mental health action plan (Scottish Government, 2021). A review of the literature and responses from stakeholders informed their strategy and identified that peer support models can:

- Significantly reduce depressive symptoms for women experiencing postnatal depression (based on quantitative data)
- Improve self-efficacy, self-esteem and parenting confidence (qualitative data)
- Reduce social isolation and increase social activities outside the home
- Bridge to build trust with clinical services
- Can be highly rewarding for both peer supporter and mother/carer when safe and appropriate

The Action Plan makes a number of recommendations built around five key themes:

1. Identify and support existing good practice including training and support, different models and regional perinatal mental health networks to help share best practice and improve referrals.

2. Ensure safety and quality involving specialist approaches to recruit, training (including ongoing training) and support with systems that enable PSWs to maintain their recovery and wellbeing with strong systems to safeguard everyone.

3. Prioritise accessibility and inclusivity by providing a range of different formats, with targeted support for vulnerable populations. Peer support for men should also become more widely available.

4. Respect the unique value of peer work and not be used to replace clinical staff. Clear boundaries should be established for the role.

5. Integrated, robust evaluation should be built in and measured using validated tools.

A number of interventions have been developed to support women at risk of developing postnatal depression, many using the Edinburgh Postnatal Depression Scale to demonstrate impact (Baumel et al., 2018; Caramlau et al., 2011; Dennis, 2003, 2010) including prevention (Dennis, 2010; Fang et al., 2022; Huang et al., 2020). There is some evidence too of PSWs rejected formal counselling approaches and instead relying on their own lived experience to

provide support (Carter et al., 2018) and for many women, peer support can be a very positive experience (Rice et al., 2022).

In a Cochrane systematic review of the effectiveness, economics, and satisfaction of peer support intervention on perinatal depression, Huang et al. (2020) identified 10 RCTs for inclusion, demonstrating PSWs reduced standardised mean depressive scores (-0.37, 95% CI -0.66 to -0.08) and reduced risk ratio (0.69, 95% CI 0.49-0.96) of depression but differences in the study designs makes it difficult to identify the recommended intensity, frequency or type of intervention. Similarly, an evaluation of Home-Start, although positive, could not identify which aspects of the programme women found helpful or why (Jones et al., 2015). In a narrative review of peer support intervention studies, Leger and Letourneau (2015) suggested that interventions should be individualised and tailored, taking into consideration the age of the mother, any cultural and linguistic differences, the mother's circumstances and her needs, issues raised in other research (Shorey & Ng, 2019) suggesting that parents should be matched on mutual characteristics (Weston, 2023). McLeish, Ayers and McCourt (McLeish et al., 2023) used a realist review to explore community-based perinatal mental health peer support and included 29 studies covering 22 antenatal and postnatal one-to-one interventions. They concluded that peer support works in complex ways that are influenced by personal and social contexts but could be beneficial for mothers through empathetic listening, acceptance, affirmation and normalisation which helped develop coping skills, self-care. Peers used therapeutic techniques and developed meaningful social relationships with service users. Negative aspects identified included self-criticism from downward-upward social comparison, peers being judgemental or directive, and distress experienced at endings.

Carter, Cust and Boath (2020) used qualitative data from log books to examine the impact of a 6-week peer support programme and concluded that women valued peer support highly, reducing feelings of alienation, isolation and stigma with increased social support, confidence, self-esteem and feeling hopeful for recovery. In turn, PSWs also reported increased wellbeing and positive reflections on their own recovery journey.

The 7 Cups of Tea intervention is a digital platform (primarily accessed via mobile phone) that provides self-help tools and 24/7 emotional support delivered by volunteers. The authors reported that computerised training was efficacious for lay peers and may enhance treatment outcomes however a fully powered trial is necessary to establish effectiveness (Baumel et al., 2018). Kaplan et al. (Kaplan et al., 2014) explored the feasibility of an online peer support parenting programme for women with SMI using a RCT design, demonstrating improved parenting and coping skills and reductions in parental stress.

In contrast, Letourneau and colleagues' research tested the effectiveness of home-based peer support using a randomised design. The programme included maternal-infant interaction teaching for mothers with symptoms of postpartum depression and their infants. They found that teaching by peers was not well received by mothers with postnatal depression and recommended that the intervention should be delivered by professional nurses instead (Letourneau et al., 2011).

CAMHS/CHILDREN'S SERVICES

Child and Adolescent Mental Health Services (CAMHS) are under pressure and regularly face criticism that they are failing to meet the needs of children and young people. Canada is only one example where less than one third of young people access the mental health services they need (Halsall et al., 2021) and, since the pandemic, there has been a significant increase in demand for services in Ireland and the UK. Initiatives to improve services have increasingly begun to address the role that young people with lived experience can offer to better treatment and support (Halsall et al., 2022).

YOUTH PEER SUPPORT

Simmons et al. (2023) carried out a systematic review of peer support for young people (aged 14 – 24 years) with anxiety and depression. They reviewed 9 randomised controlled trials with over 2000 participants. Two of these trials targeted anxiety and depression in particular and the other targets other mental health problems such as eating disorders or psychosis but included measures of anxiety and depression. Again, the authors note the paucity of evidence of effectiveness hampered by the lack of research but also by the definitions of peer support and the broad range of different types of interventions. They conclude that there is some evidence of positive improvements in depression and anxiety with peer delivered interventions particularly in a university setting and that the successful interventions were acceptable, suitable and cost effective. Importantly the authors note two studies they reviewed were delivered online (Alvarez-Jimenez et al., 2021; Ellis et al., 2011) and suggest peer support is capable of embracing a digital environment.

Effectiveness evidence is limited for Youth Peer Support Worker (YPSWs) however, the Institute for Mental Health worked in partnership with Nottinghamshire Healthcare NHS Trust, recruiting 8 PSWs to support 247 inpatient and community clients. The study found that children and young people found it easier to talk to the peer support workers than other staff and demonstrated a 14% reduction of inpatient stays among the children and young people that they worked with (Theodosiou & Glick, 2020).

Analysis of administrative data of a sample of transitioning young adults aged 16-24 (*n* = 6329) in outpatient services in Los Angeles county with peer specialists on the staff team (Ojeda, Jones, et al., 2021). Peer staff received training in evidence based practices including Mental Health First Aid, Motivational Interviewing and WRAP. Quantity of peer support services was associated with increased use of outpatient services and was higher where peer specialists had received training in three or more evidence based practices. Use of peer specialists was also associated with decreased use of inpatient services.

YPSWs are young adults with lived experience of child or adolescent mental health problems providing support to young people receiving treatment in mental health services. de Beer et al. (2022) identified 24 studies in their systematic review of youth peer support and reported that while the workforce is rapidly expanding, embedding YPSW is challenging and requires careful planning, nonetheless they consider it to be a valuable addition to the youth treatment context.

Transitions from child and adolescent to adult services can be problematic, often leading to disengagement, characterised by long delays and poor collaborative working (Leavey et al., 2019; Singh, 2009). Analysis of administrative data in the US has also demonstrated increased use of outpatient services and a reduction in inpatient use in transitioning young adults with serious mental illness aged 16-24 years where trained peer support specialists are included in the staff team (Ojeda, Jones, et al., 2021; Ojeda, Munson, et al., 2021). Pilots of YPSW to support transitions from CAMHS to adult services have been successful in the UK but relies on clarity of roles, team members' understanding of the role and established processes for training, management and support (Oldknow et al., 2014). Trauma-informed approaches have also been identified as being important (Siantz et al., 2023).

Described as 'the best of both worlds' by a young person in Orygen's Specialist Program (OSP), peer support combines the different and complementary strengths of both clinicians and peers (King & Simmons, 2023). The rapidly expanding evidence base suggests that YPSWs promote treatment engagement, can help reduce stigma associated with mental health problems, give hope and provide more culturally and developmentally appropriate support (de Beer et al., 2022; de Beer et al., 2023; Hiller-Venegas et al., 2022; King & Simmons, 2023; Ojeda, Jones, et al., 2021). Young people perceive YPSWs to be more reliable than non-peer staff however the evidence base is mostly based on small scale studies, serving young people with a single mental health problem, and primarily in outpatient settings (de Beer et al., 2022; Vojtila et al., 2021).

Qualitative evidence suggests that there is room for improvement to improve collaboration and increase recognition of the contribution that YPSW can bring to young people's mental health

services. Arguably more barriers than facilitators currently face implementation with reports that YPSWs experience condescending attitudes and stigma from non-peer professionals (de Beer et al., 2023). Greater clarity and understanding of their roles and expertise, good quality supervision and demonstrative organisational commitment are all important facilitators to counteract the given obstacles.

The analysis conducted by de Beer and colleagues in their systematic review identified the different roles in YPSW practice:

1. *Engagement* – this was the strongest theme in the data and involved building trust, reaching out, reducing isolation and re-engaging the young person in mental health care. Relationships were "grounded on equality, authentic empathy and a non-judgemental attitude" (de Beer et al., 2022, p. 5). Care can also be given to match young people based on their ethnicity, background and shared personal experiences.
2. *Emotional support* – a number of studies reported the YPSW role as empowering to others, by providing comfort, hope, sympathy and help to manage the expectations of the young person. They also act as positive role models, demonstrating that real-life recovery is possible.
3. *Navigating and planning* – nine of the included studies reported the YPSW role as supporting service users and treatment teams based in part on their knowledge and experience of the mental health care system, this can also involve sharing experience of transitions from CAMHS to adult services.
4. *Advocacy* – this is an important aspect of the YPSW role and can include attending team consultations, training staff, designing policy and sharing their stories to help reduce stigma and discrimination.
5. *Research* – three of the studies included in the review described the role of YPSWs in the design of new programmes, interventions and evaluating services helping to improve the relevance and understanding of research findings.
6. *Educational* – by being realistic role models, YPSWs can use their lived experience to educate others, including family and friends but also healthcare professionals to help promote a recovery-approach.

Five overarching themes were identified as barriers and facilitators to implementing YPSW and reflect much of the literature on general peer support, some of the practical issues identified included:

THE NEEDS OF YPSWS

Supervision is valued and can be delivered by experienced YPSWs or clinical staff. This can help young people to establish boundaries, understand and process interactions with staff and

service users, and tackle some of the organisational issues working in a healthcare context e.g. use of language, systems and administration. Often they will need more supervision than other clinical staff and will benefit from someone who has influence, available time and resources to meet on an ad hoc basis as and when needed.

Training and education can help facilitate practice and should include information about mental health problems, conflict management and recovery principles. Work experience prior to the YPSW role may help prepare young people for the job.

The flexible nature of the role can be confusing for everyone and role clarity is important however a balance has to be struck between monitoring and tailoring the role towards the needs of the young person and the organisation they work for, “Time and space for YPSWs to explore this new identity facilitates confidence, recovery, wellbeing and readiness of YPSWs to fully embrace the role of YPSW.” (de Beer et al., 2022, p. 7).

EXPERIENCES OF YPSWS

When YPSWs are first employed, there is a period of transition when they move from being an ex-service user to a more professional role and this will take time and may cause some anxiety which can be considered as a barrier by services to implementation.

For YPSWs with experience of the juvenile justice system, involvement in peer support work can be a way of taking back control of their adverse experiences. Control was also identified as a negative aspect, with YPSWs more likely to feel treated unequally compared to non-peers and can experience feelings of powerlessness and lack of control.

These included adequate coping skills, resilience and capacity to deal with stressful events. Self-reflection, understanding recovery and being able to act in a professional and authentic way with young people was also valued. One study reported that good social support outside of work increased satisfaction with the role.

RELATIONSHIP BETWEEN CLIENTS AND YPSWS

Challenges between personal and professional boundaries were often identified as barriers especially when sharing personal histories of service user status. YPSWs should be encouraged to recognise and protect these boundaries.

A non-judgemental approach was considered to be the basis of a good working relationship with young people, especially as many have a deep sense of mistrust of services. As a relative ‘outsider’, the YPSW role increases the potential for greater trust.

The data from de Beer and colleagues suggests that there is still a long way to go to improve collaboration and understanding of the role. Non-peer staff reported concerns around privacy,

professional boundaries and the confidentiality of service users working with YPSWs, often perceiving YPSWs as vulnerable, young and avoided giving them too much responsibility. As a result of this, YPSWs can feel "*belittled and ignored*" (de Beer et al., 2022, p. 8).

Co-production can facilitate the collaboration process where non-peers and peers are equal partners allowing for YPSWs the time to learn and consider themselves as equals.

Everyone on the team needs to have a clear understanding of the role and the tasks that will be involved and YPSWs must be afforded the time to educate non-peers about the value of their role. The workforce should be educated and prepared to support peers within the team.

ORGANISATIONAL READINESS

Organisations need to place a high value on the expertise of people with lived experience and have robust planning and structures in place at all levels in the organisation to support its implementation, this will need to include adequate financing and avoiding zero hours contracts.

Non-peer staff training can enable the integration of YPSWs in teams.

Eight of the included studies demonstrated the value of YPSWs in promoting recovery-oriented practice and helping organisations to become more youth-friendly. Importantly, the evidence suggests that YPSWs can reduce relapse rates, improve the quality of life of young people using their services and ultimately improve care.

CHILDREN & YOUNG PEOPLE: FAMILIES AND CARERS

Examples of parental peer support includes wraparound service delivery models for parents of young people with severe emotional and behavioural problems (Gopalan et al., 2017). Research demonstrates parents' perceptions of a need for a peer support service, wishing to talk about their shared experience with other experts by experience, benefit from practical knowledge and assistance and get help accessing resources but there are barriers to access and implementation. Expectations can be unrealistic and time limitations on wraparound support can feel inadequate. The very nature of behavioural and emotional problems can mean that escalating behaviours can lead to greater placement restrictions, problems scheduling appointments and caregivers feeling overwhelmed (Gopalan et al., 2017).

Grennan et al. (2022) reported on online parent-led support groups for parents of children with eating disorders (EDs) and parents' feedback found that it was beneficial to connect in with others with similar experiences. Participants found that the educational and resource content was beneficial in helping them to better understand EDs. Parents also recommended that

diagnosis specific groups could be facilitated as well as linking in parents where children had similar durations of illness.

Orygen in Melbourne, Australia, is recognised as world-leading in evidence-based child and young people mental health care and King and Simmons (2023) explored young people's experiences of group work facilitated by peer workers and clinicians using the Intentional Peer Support model. Qualitative interviews demonstrated that the sharing of lived experience helped young people to engage in discussion, fostered a sense of belonging and created hope for the future, *"'It's also sort of helped me to sort go easier on myself, I guess, because at times I used to think that my difficulties were not that big of a deal, and that I was making a big fuss about things. Now, I'm less likely to do that because I've met other people who have similar problems.' (Jack)"* (King & Simmons, 2023, p. 70). Clinical input provided safety, structure and purpose, *"'They provided a really good structure to the group. So like, um, it felt really … like every session felt planned … and like they had a plan. And so that was really nice. It wasn't like aimless and meandering it was you know … quite contained. And having them. There was also … it's kind of like … when you are a kid and there's like an adult around and you just feel safer because there's an adult. Um. It kind of felt like that.' (Megan)."* (King & Simmons, 2023, p. 70).

FAMILY PEER SUPPORT

Families with children or young people experiencing mental health problems can become isolated, withdraw from normal social life and experience disruption to work that can have a knock-on impact on family finances (Kayaalp et al., 2021). It is common for relationships with other family members to be affected also further contributing to their stress as a caregiver. Research has shown that primary caregivers can experience clinical levels of anxiety and depression when caring for others with mental health problems. Interactions with healthcare professionals can be difficult, with perceptions that clinicians may hold family members responsible or the cause of the young person's distress or be dismissive of the caregiver burden (Shor & Birnbaum, 2012). In acute circumstances, parents can feel excluded and blamed by hospital staff (Hickman et al., 2016).

Family peer support can take a range of forms (Hopkins et al., 2021) including:

- Empathic listening
- Sharing stories, reducing isolation, offer hope and alternative models of supporting their young people
- Practical support and advice
- Guidance navigating the mental health system

- Liaison (building bridges between families and clinicians)

Limited research and anecdotal evidence suggests that family peer support is beneficial by helping to alleviate carer burden, increase wellbeing and contribute to improved outcomes for the young person but there is a lack of good quality data (Hopkins et al., 2021).

Markoulakis et al. (2018) described caregiver peer support in a Family Navigation service where peers offered a valuable service helping families to navigate sometimes complex and confusing mental health services. Extra consideration is required to establish safe guidelines, these can include dealing with privacy, confidentiality and disclosure. FPSWs can often see parents in high distress where disclosure of very sensitive information can be shared. Record keeping needs high levels of discretion and consideration. Whether all disclosures are recorded in a young person's health record accessible to them at a later date requires careful thought. As Hopkins and colleagues describe, the family peer support role can be balancing act, "The work of the FPSW is unique and challenging in the way it must balance the needs of the family in distress with the therapeutic needs of the young person as well as supporting the work of the mental health clinicians, within a framework of privacy and trust." (Hopkins et al., 2021, p. 927).

Hopkins et al. (2021) explored the required skills, needs and practices of FSWs using an online survey of health care professionals and qualitative interviews with FSWs. Familiar themes about sharing personal stories as a way to offer hope emerged from the data and being authentic in providing support. One FSW explains, "*I'm there to hand them Kleenex. I'm there to hold their arm and you know to be there, because it's really, really, terribly confronting to see your young person unwell, to hear what they have to say about you as a parent is often confronting, but, and I'm there to say, they are unwell, it's not always going to be like this, so it's really reassurance."* (Hopkins et al., 2021, p. 930).

There was consensus that the skills required went well beyond lived experience, and included the importance of being an open and empathetic listener, supporting self-care for families and for themselves, and using skills often associated with social work such as providing emotional support. Challenges of working within a multi-disciplinary team was considered an ongoing process for both peer workers and clinicians and the best way to facilitate this was demonstrating good leadership at both team and senior management level. The help PSWs gave liaising with health care staff was valued by families; families interviewed in Hopkins and colleagues' study suggested the only improvement for improving services was to recruit more PSWs. This chimes with discussions with an expert interview with a peer support worker in

Ireland, *"It's boots on the ground, more boots on the ground, it's old fashioned face-to-face connection we need".*

The consideration of self-care was also raised in Lammers and colleagues' (2019) assessment of 'parent partners', a peer support intervention for parents of children admitted to an inpatient psychiatric unit, highlighting the challenge of providing peer support when peer workers experiencing behavioural crises with their own children.

CHILDREN OF PARENTS WITH MENTAL ILLNESS

Reducing stigma is an important consideration for supporting children and young people living with a parent with a mental illness (Parkinson et al., 2021). Peer support programmes are common approaches for school-aged children of parents with mental illness (COPMI) typically offering opportunities for normative recreation, peer socialisation and support, as well as providing respite, mental health education, and skills training (Foster et al., 2014; Grove et al., 2015). Parkinson's research involved interviews and focus groups with child service users of peer support in Aotearoa/New Zealand (*n* = 24) aged 8-18 years (Parkinson et al., 2021). Experiences of stigma were prolonged and significant but having the opportunity to mix with other peers was beneficial, helping young people to feel understood, accepted as well as a stronger sense of belonging.

EARLY INTERVENTION

Chien and colleagues (2022) tested a four-month peer-facilitated self-management programme (PFSMI) for recent-onset psychosis in a randomised Chinese sample. The intervention was compared with a psychoeducation group (PEG) and TAU. Outcomes were measured at 1 week and 6-months post-intervention. A total of 161 participants (89.4 %) completed their interventions, with an overall attrition rate of 7.8 % (n = 14). Based on intention-to-treat principle, estimates reported that the PFSMI group reported significantly greater improvements in levels of recovery, functioning and insight into illness/treatment and reductions in psychotic symptoms and duration of rehospitalisation (p = 0.0007–0.02, with moderate to large effect sizes) than the TAU group at 1-week post-intervention, and both the TAU and PEG at 6-month post-intervention. Significantly fewer PFSMI participants were hospitalised than the TAU and PEG over 6-month follow-up (p = 0.003). Nguyen et al. (2022) demonstrated the role of peer support in reducing stigma associated with psychosis in their exploration in early intervention research.

Two members of the same study team conducted a randomised controlled trial of a mutual support group in a similar population of recent onset psychosis to test the long-term effects of a 9-month family-led support group for Chinese participants with schizophrenia in Hong Kong

(Chien et al., 2022). Peer-led family support reported consistently greater improvements in overall functioning (family and individual functioning) and reductions in hospitalisations over the 4-year follow up. In a similar peer-led family support intervention in Canada, Levasseur and colleagues (2019) reached similar conclusions with families valuing the mutual and emotional support provided by peers, gains in insight into the illness and treatment, and improvements in self- and caregiving skills. Other studies have confirmed the feasibility and acceptability of peer-led family interventions (Murphy et al., 2022).

LGBTQ+

The LGBTQ+ community are disproportionately at risk of experiencing mental health problems as a result of intersecting risk factors including adverse childhood experiences, discrimination and bullying, social isolation, poverty, poor education and work outcomes. They may be reluctant to access mental health services and identifying as LGBTQ+ can be conflated with mental health problems which may impair the assessment, referral and treatment process (Hudson-Sharp & Metcalf, 2016). Mental health services may structurally exclude LGBTQ+ groups, lacking recognition or including relevant support networks. The Centre for Mental Health review identified 88 organisations offering mental health services in the UK for LGBTQ+ individuals. Benefits for LGBTQ+ mental health peer support have particular benefits as they have the potential to directly address significant risk factors for this group i.e. experience of discrimination, isolation, and difficulty coming to terms with identity (Borthwick et al., 2020).

Challenges for peer support highlighted in this review include boundary setting, the need for specialist knowledge and skills to address a wide spectrum of identities and experience in the LBGTQ+ community. Caution was also raised about creating specialist services that may slow the development and competencies within mainstream mental health services. Higher levels of risk require careful consideration, with statistically higher rates of self-harm, suicide and victimisation in this population. Assumptions about heterogeneity can lead to tokenism. A lack of sustainability of services creates additional pressures on delivery.

Willging et al. (2018) piloted a peer advocate intervention for rural gender and sexual minorities in New Mexico, USA. Lay people from LGBTQ+ communities were trained in outreach and education, mental health and support services with the aim of strengthening social support in rural areas, teach advocacy behaviours to help navigate heteronormative systems and facilitate contact between LGBTQ-affirmative treatment providers and LGBTQ+ people with mental health or substance use problems. Sixty-five participants were randomised to experimental peer support or a control setting of receipt of LGBTQ-affirmative resources. Mixed methods were used to evaluate the peer advocate programme. Results showed that the advocates helped to reduce social isolation, strengthened social networks but these were

not statistically significant in the quantitative analyses. Participants also reported increased confidence in advocacy skills and increased openness to treatment. Practical issues relating to the feasibility of the pilot were identified including maintaining contact, a lack of dedicated office space and feeling isolated from other peer advocates.

MIGRANTS

In our conversations with experts, many directed us to work conducted with other communities of risk including peer support work with asylum seekers and refugees and victim-survivors of sexual violence and abuse. For example, Ho et al. (2022) conducted a scoping review of mental health peer support in migrant domestic workers and identified 12 studies involving mainly two different types of peer support: mutual aid; and para-professional trained peer support. The main reason reported for seeking support was mutual aid for emotional comfort and while trained peer support programmes were considered feasible and culturally appropriate, there were barriers to implementation including concerns about risk of emotion contagion, disclosure and confidentiality and lack of support from health professionals. The wider literature about the mental health needs of refugees and asylum seekers will also be relevant to considering how peer support work could be developed for the needs of these specific groups.

EATING DISORDERS

How best to involve people with lived experience in the design and delivery of services is a focus of much of the literature, but for some areas of work and specific mental health problems there is limited evidence available. Peer support in eating disorders has a limited evidence base. Lewis and Foye (2022) attempted to forge this gap with their systematic review of involving lived experience in eating disorder interventions. Ten studies met their inclusion criteria and they describe a spectrum of involvement and engagement and some of the benefits and risks involved.

The majority of the interventions engaged the role of lived experience to share personal narratives of recovery (including written versions), but there were also examples of co-design of interventions, online peer support discussion fora, schools education and provision of emotional support. Recovery and absence of disordered eating behaviours was a consistent requirement across the studies, although the length of recovery required varied. Clear safeguarding procedures were demonstrated to protect the wellbeing of peer support workers, triggering content and language were avoided (mentioning weight, BMI etc. were forbidden in 3 of the included studies) and additional supports put in place to ensure comprehensive psychiatric assessments and monitoring were completed before, during and after the

intervention. Other support mechanisms included regular clinical supervision, online forums monitored by a psychologist, and individual wellness plans. Training was a central requirement and the intensity of training varied across the included studies, ranging from one day to 25 hours over an 8-week period. The most popular training approach was motivational interviewing, but there were also examples of intentional peer support, communication and conflict resolution. Training content was not described in four of the 10 included studies. Only three studies reported that they reimbursed people with lived experience for their time. The majority of studies also involved third-sector involvement to recruit, train, provide resources, evaluate and support dissemination.

Data were qualitatively analysed to explore themes of the benefits or risks of involving people with lived experience. The normalisation and de-medicalisation of experiences was considered a novel approach to care which felt "more relaxed and more person-centred" and helped to develop practical skills such as eating out and re-building relationships with friends and family and improve social functioning as a result. Lack of judgement and stigma through "the sense of a 'shared experience'" could help facilitate the journey to recovery. There was a danger that where peer support involvement was considered passive, the integrity of the intervention could be questioned or feel tokenistic but a balance needs to be struck to avoid risks associated with active involvement that could trigger distress. In one study, Beveridge et al. (2019), peer mentors delivering the intervention reported an increase in eating disorder symptomology as measured by the Eating Disorder Examination Questionnaire (EDE-Q).

The authors conclude that consideration of recovery need to be considered before involving people, as well greater consistency of what and how training is delivered and recompensing peer workers for their involvement. The evidence from the small number of studies on peer support in eating disorders suggests that they can offer hope, recovery and normalise the experience in a non-judgemental way but there are risks associated that may trigger ED symptoms requiring well-designed and managed training and safeguarding procedures.

EATING DISORDERS: FAMILIES AND CARERS

Eating disorders have the highest rate of mortality of mental health problems and more research is required to understand how peer support and family peer support might contribute to improving treatment and support for service users and their carers. O'Hara et al. (2023) recruited participants through the website of the Japan Association of Eating Disorders and surveyed 314 family members and carers of individuals with ED about their peer support needs. An overwhelming 87.3% of respondents felt that a group peer support system was necessary. Measuring current mental wellbeing using the GHQ-12 (Goldberg et al., 1997) and carergiver burden with the Zarit Caregiver Burden Interview (Zarit et al., 1980), respondents

reporting poorer mental health and a high burden of care were more likely to feel the need for individual peer support. Those with family members who had improved ED symptoms demonstrated a greater willingness to become peer supporters irrespective of their own mental health needs.

Treating children with EDs requires significant parental support and parents have expressed the need for greater peer support including the opportunity to connect in with other parents with similar experiences (Grennan et al., 2022). Grennan et al. (2022) delivered four virtual parent-led peer support groups in Ontario, Canada, over a 6-month period, bi-weekly for 12 sessions. The groups provided support and access to education and resources about EDs. Suggestions for improvement included organising groups according to the type of diagnosis and duration of illness.

FORENSIC

Forensic peer support involves trained peer specialists with experience of mental health services and the criminal justice system, with an emphasis on understanding the impact of incarceration and the role of trauma in this population (Rowe et al., 2017). They can provide support within secure settings or offer help and advice when people are integrating back into the community following a period of incarceration. They are not without their challenges; mental health stigma and the nature of secure settings can make implementation more complex although there are benefits in terms of reducing stigma, improving help seeking and enhancing self-esteem and wellbeing for peers and service users (Adams & Lincoln, 2021; Thekkumkara et al., 2023; Wolfendale & Musaabi, 2017).

The opportunity to instil hope and act as credible models of recovery are important aspects of the role (as in general mental health peer support work) with the added responsibility for many to help people reintegrate if they return to their home environment and help them engage with treatment and support and address “the psychological, social, and financial challenges of re-entry.” (Rowe et al., 2017, p. 45). Research shows some evidence that peers may be able to engage hard to reach service users more quickly than non-peers and for those with substance use problems, may also contribute to reductions in alcohol and other substance use (Rowe et al., 2017).

Rowe et al. (2017) describe their *Peer Engagement Specialist Project* that was trialled in Connecticut in 2000 which involved the employment of eight FTE Peer Engagement Specialists, two based in four community-based treatment teams. Using an RCT methodology, 137 participants were randomised to peer specialist and case management (peer) or regular case management alone. At six-month follow-up, those supported by the peer specialists

reported higher positive regard, understanding and acceptance, and greater engagement from peer providers compared to regular provision. Positive regard and understanding at six months positively predicted 12-month motivation for psychiatric, substance use problems and attendance at AA/NA meetings. Statistically significant improved quality of life and fewer obstacles to recovery were also observed at six months but were not sustained at 12-month follow up. A second study by the same study team, the *Citizens Intervention*, offering wraparound peer mentor support demonstrated effectiveness in reducing psychiatric symptoms, alcohol and drug use, and increasing quality of life for persons with serious mental illness and criminal charges within two years previous to enrolment (*n* = 114). However at 6- and 12-month follow-up, increases in anxiety and depression, negative symptoms and agitation were observed suggesting that community-oriented citizenship interventions may improve clinical outcomes in some domains, they may not be sustained in others.

Qualitative research has identified the value of lived experience support workers in secure settings, demonstrating their importance to clinical staff, service users, the employing organisation and the peer support workers themselves (Fisher & Gingell, 2017; Griffiths & Hancock-Johnson, 2017). As with general mental health peer support work however, common problems have also been identified. Not providing appropriate supervision, poor understanding of the roles, and a lack of career progression are commonplace (Griffiths & Hancock-Johnson, 2017).

Adams and Lincoln (2021) conducted interviews with stakeholders (*n* = 14) and peer specialists (*n* = 37) in forensic peer support in Pennsylvania to explore the barriers and facilitators of the adoption, implementation and sustainability of community-based mental health peer support and while many of the same issues experienced in general mental health peer support were raised (e.g. organisational culture, staff willingness) important differences were identified. The analysis identified a number of factors that facilitated forensic peer support including:

- *Adoption:* gatekeepers in the criminal justice system that were recovery-focused and facilitated access to those in forensic settings; and additional context in the US health system is lack of access to funds/Medicaid once someone is incarcerated;
- *Implementation:* philosophical mismatch between the criminal justice system and peer support which then has a knock-on effect on implementation and the recovery journey in a punitive setting can be at odds. A criminal justice background can exclude some people applying for jobs in some organisations.

- *Maintenance*: being able to build a relationship with prison staff, social workers etc. considered very important and without their support, access and maintenance was very difficult. Lack of sustainability of funding also created additional barriers.

The authors recommend further research that considers recovery and criminal justice-focused outcomes, greater funding stability and to explore the potential for a certified peer specialist programme that trains incarcerated individuals to be employed as peer support workers within state prison settings. The need for more research is a common theme in the literature (Fisher & Gingell, 2017).

A mixed-methods study of a 19-month peer support intervention (individual peer support, patient advisory committee and patient-led research) in a Canadian forensic mental health hospital demonstrated improvements on both quantitative and qualitative measures (Livingston et al., 2013). Peer support impacted positively on internal stigma and personal recovery. The peer support programme offered positive role modelling, provided openness and emotional support and was able to give hope and encouragement to participants, ""*I think it's [peer program] been a positive experience because it's nice to know that some people who have mental illness are still able to contribute to society."* (Patient) (Livingston et al., 2013, p. 38).

A more recent feasibility testing of a peer support programme for prisoners with common mental health problems and substance use was conducted by Thekkumkara and colleagues (Thekkumkara et al., 2023) in a prison in Bangalore, India. Thirty-five prisoners were selected for training as peer supporters based on positive ratings of their behaviour and attitude by the mental health team and prison authority. The training included identifying prisoners with mental health problems, basic peer support and counselling skills over a five-day programme. Mental health literacy and self-esteem was measured pre- and post-training with improvements observed in recognising common mental health problems and significant improvements in self-esteem. Qualitative feedback following the training and feasibility testing recognised the benefits of being a peer support worker, *"This training would improve our self-confidence, and it's all part of the reformation. Whether I have committed the crime is secondary; I am convicted and sent for reformation because of factors. This is all part of our reformation process. More than that, I felt very proud that I could help someone who is in need'.* (Mr K, 35 years) (Thekkumkara et al., 2023, p. 235). Barriers included the stigma associated with mental health problems which would discourage people from seeking support from peers. Five semi-structured interviews were conducted with service users who had experienced the peer support programme generating an overall theme of 'subjective satisfaction', participants felt a sense of being helped, cared for and being supported, improved mood was also reported and the benefits of feeling accepted by the peer supporter,

'Yes, they ask me about my health and other issues. So, I felt happy; at least some are bothered about our health. Here most of the prisoners were having difficulty getting support from the family, so help from others makes us so happy'. (Mr V, 23 years) (Thekkumkara et al., 2023, p. 238).

FORENSIC: FAMILIES AND CARERS

"Carers within secure care can feel marginalised and unheard." (Machin et al., 2023, p. 183). Caring for someone with a mental health problem can be stressful and the stresses for those in forensic settings can be more complicated and difficult, particularly due to the stigma, guilt, physical separation, and involvement of the criminal justice system relating to the offences that have led to forensic service involvement (Ridley, 2014). Carers often face a battle of support for those they care for and thinking about their own support needs can often be neglected.

"If we are lucky, we may have an understanding GP [General Practitioner] or there may be a mental health professional who is supportive of carer health and wellbeing to whom we can talk, but more often, there is nobody suggesting to us that looking after our own health and wellbeing is essential if we want to continue to look after somebody else." (Machin et al., 2023, p. 183)

Service users may also request that their carers are not involved in their care or for reasons of confidentiality may withdraw permission to involve them in discussions about their care, increasing carer isolation. Despite this complicated landscape, having someone to talk to and share experience can be extremely valuable and many of the same principles apply to peer support work, the importance of relationship building, reflecting on personal needs, and being able to share experiences in a safe place but as with the rest of the literature, investment and resource is required to provide good quality training, supervision and support. One carer peer support worker articulates this in a powerful way,

"We live with the impact of mental ill health 24/7, there is no end of shift. When a person is discharged, if they have a carer, it's the carer that will take up the reins. It stands to reason that if a carer is well empowered with the right Carers and forensic services skills, knowledge, access to resources, and is able to influence service delivery, there will be a profound effect on whether a person is able to sustain recovery or not." (Machin et al., 2023, pp. 190-191).

Nash et al. (Nash et al., 2022) explored staff experiences of working alongside forensic peer support workers using structured individual interviews with mental health professionals from a range of disciplines (n = 8). While views were generally positive and the alternative perspective

and sense of hope FPSWs provided was valued, there remained concerns about role ambiguity, boundaries and potential risks.

PERSONALITY DISORDER

Barr, Townsend, and Grenyer (2020) used qualitative methods to explore the perceptions and models of peer support for people with Borderline Personality Disorder (BPD) in an Australian sample of consumers, carers, and mental health professionals (N = 36; 12 participants from each category). There was consensus across the different groups that peer support facilitates hope, connection and validation to service users' lived experience although there was some differences in opinion as to whether medical records should be shared with peer workers highlighting for role clarity for all partners. Health professionals recognised that peer support workers experience stigma in the workplace and problems with boundary settings, and further work is require to acknowledge and demonstrate that the role is valued with healthcare settings. This could be achieved by establishing a clear duty of care, confidentiality code and ensuring quality supervision is available.

In a follow-on study, Barr et al. (2022) examined peer work delivered in five different mental health settings including outpatient and independently peer-run facilities. Staff and service users were interviewed and the findings reinforced common themes already identified throughout the literature where peer support workers present as positive role models, inspiring hope and recovery and in the context of personality disorder services, were able to understand the unique experiences associated with a BPD diagnosis. The benefits were mutual, engaging with other service users served as a reminder to peer support workers about self-care, practising their own wellbeing skills. Clinicians interviewed also reported greater insight and understanding of BPD as a result of discussions with PSWs.

Cawood (2013) examined the effectiveness of peer support specialists delivering Dialectic Behaviour Therapy (DBT) for BPD. DBT therapists and peer support specialists (PSSs) were employed in community health agencies in Michigan, USA. Using a qualitative methodology, Cawood reported that both non-peer and peer staff found the peer role suitable and did not find the transition from service user to peer specialist problematic despite evidence for inadequate training and vague ethical guidelines. Moderate levels of burnout were reported in both peer and non-peer staff, but PSSs had significantly lower scores of burnout than therapists on one subscale.

PERSONALITY DISORDER: FAMILIES AND CARERS

Our searches retrieved one pilot study that reported findings from a peer-led education group for BPD involving 15 participants (Martin et al., 2020). Data were collected before and after the group intervention, and at four-month follow-up. The findings showed that caregiver burden reduced over time following group engagement, while improvements in wellbeing were also observed as a result of the information, new skills, support and validation they received. They also reported improvements in clinical symptoms of their relatives with BPD. The authors suggest that peer leadership, skills-based learning, and focusing on caregiver wellness may improve family outcomes.

SUBSTANCE USE

The evidence base for substance use peer support work appears to be somewhat limited, with only two studies included in our review. Milani et al. (2020) describe the first UK Dual Diagnosis Anonymous (DDA) integrated peer-support programme for concurrent disorders. Developed in the USA, the programme aims to address co-occurring mental health and substance use problems using an extended 12-step model (12 plus 5 steps, Monica 2015). DDA encourages feedback and questions from participants in contrast to the AA model and includes a workbook of reflective exercise to guide the approach.

Six DDA participants were interviewed 3 times over a 12-month period, peer-facilitators of the programme also participated in two interviews and the funding commissioners were interviewed once. DDA attendance was associated with a positive impact on five main areas: acceptance of self, of others and from others; social functioning; self-development; recovery progression; feeling of hope. The ability to address both mental health and substance use problems at the same time fostered recovery. Rowe et al. (2009) demonstrated similar benefits in their wraparound peer support programme for forensic service users with co-occurring substance use problems.

TRAUMA/PTSD

In the wake of the devastating attacks of September 11, the Project Liberty Peer Initiative (PLPI) delivered services to New York residents. They offered individual counselling and referral, group counselling, public education and a ‘warm line’ of telephone support, counselling and referrals. The programme was evaluated using mixed methods and reported that engaging peers with lived experience in outreach work as part of disaster relief planning was beneficial and allowed for ‘deep permeation of the region’s diverse neighbourhoods’ (Hardiman & Jaffee, 2008, p. 122) and helped establish social connections that link them in

with caring communities. Similar barriers and challenges were experienced by peers familiar with non-emergency settings including realising and recognising the legitimacy of PSWs.

Seeking Safety is an evidence-based intervention for trauma and substance use (Najavits, 2002; Najavits et al., 2006) and Crisanti and colleagues (2019) conducted a randomised controlled trial to compare Seeking Safety led by PSWs compared to non-peers. The programme was rated positively and while those randomised to the peer-led group reported slightly higher rates of overall and topic-specific helpfulness, the differences were not statistically significant.

Peer support interventions have been successfully developed and well-received by veteran populations (Stefanovics et al., 2017). In a veteran substance using population, Possemato et al. (2019) explored the effectiveness of 'Thinking Forward', a combined peer support and web-based CBT intervention for PTSD and hazardous drinking levels. Thirty participants were assessed at pre-, post-treatment and 24-week follow-up. Peers reported conflicting approaches between peer support and CBT but all experienced significant improvements in PTSD, quality of life, resiliency, and coping from pre- to post-treatment. The authors recommend that peer support interventions designed to facilitate eHealth programmes should comply with the person-centred, recovery approach.

POSSIBLE IMPLICATIONS FOR DEVELOPMENTS IN IRELAND

There are a number of possible implications of the findings of this scoping review for the further development of peer support work and family peer support work in Ireland.

Definitions and roles

- There is a range of helpful definitions of peer support, peer support work and family peer support work in the literature including from the Department of Health (2020), the HSE, and the MHER Office (2023) although the language used may continue to develop and change. As outlined earlier, this review focused specifically on the literature on mental health peer support work and family peer support work
- The developing role of peer support workers and family peer support workers also needs to be considered. Although lived experience is a central component of both roles, it is not the only requirement in becoming an effective peer support worker or a family peer support worker. The evidence reported here suggests that these roles require specific training, knowledge, skills and values. There are very helpful sources of guidance and toolkits available which summarise the roles. The HSE's (2021) toolkit to support peer support workers provides a clear outline of what is included in the role, but also what should not be included. Again, as the work of peer support workers and family peer support workers develops and evolves (and is further researched), it may be useful to revisit this guidance.

Training and Support

- How to encourage and enable people to become peer support workers and family peer support workers requires consideration. This may include: providing introductory courses; reasonable adjustments for all forms of disability; financial support for initial training, including initial training as part of the role; and identifying and addressing potential barriers to becoming a peer support worker or family peer support worker, including for specific, underrepresented groups.
- The recruitment process for roles also needs to be carefully considered. The literature suggests that there should be a focus on motivation, values and skills so effective ways to assess these should be developed and utilised.
- In addition to initial training, there is a need for ongoing specific training for peer support workers and family peer support workers (including accredited qualifications at all levels) as well as access to all relevant general, multi-disciplinary and inter-agency training.

- A key message from the literature on the development and implementation of peer support work is the need for training for all professions to help them understand the role of peer support workers and family peer support workers. This training should be co-produced and it should be considered for whom this should be mandatory. Arguably training, at some level, is needed for all staff involved.
- Assessment of the readiness of multi-disciplinary teams and services to adopt peer support worker roles is recommended; this will include the training, support and supervision arrangements that are in place.
- Access to peer supervisors as well as line management supervision, is also highlighted as an important component of the effective implementation of peer support work and family peer support work and there may be possible attendant training needs for peer supervisors.

Career development

- The development and implementation literature also identified the importance of a clear career structure for these roles, including more senior roles in the direct provision of support as well as supervisory and leadership roles at all levels, including in senior management.
- The research literature also repeatedly identifies the need to protect peer support workers from isolation. The literature also reports ongoing issues of power imbalances, stigma and discrimination. Training, ongoing support, supervision and supportive networks may help to address these issues. It should also be considered whether further implementation should prioritise ensuring there are at least two peer support workers and/or family support workers in each setting.
- Although this scoping review focused on formal peer support and family peer support roles in the HSE, it will also be important to further consider how these roles are developed across sectors and also how formal support roles interact and facilitate informal peer support.
- The findings from the international literature can also help to inform and support the further development of these roles in specialist mental health services in Ireland. There are some additional, service specific considerations, as identified in this scoping review.

Effectiveness and cost-effectiveness

- There is a need for further rigorous, co-produced research on the effectiveness of peer support work and family peer support work. The research literature included in this

review is largely positive about the impact of these roles, but the service evaluation studies are based mainly on qualitative data. These are important and useful findings but research designs which include comparison groups, and ideally randomisation, would more convincingly establish the effectiveness of peer support work and family peer support work, including exploration of specific aspects of these roles.

- There is a specific need for well-designed research on the cost-effectiveness of these roles, including in the Irish context.

Conclusion

Although it was not the focus of this review, in general, the potential benefits of involving people with experience of using services, are well established across all aspects of health and social care, and also across other areas of service provision. This includes the importance of involving people with relevant lived experience, in informing the planning, design, delivery and evaluation of services and in all levels of the organisation. The potential benefits of facilitating access to informal support from people with experience of similar issues, have also been explored in the wider literature. The role of formal peer support workers and family peer support workers in these related aspects of mental health services, is also important to consider.

There is also now an emerging consensus about the potential benefits of**,** and current need for, the further development of peer support work in mental health services. A further consideration, however, may be specifically how these roles might develop in the longer term. There appears to be limited development of formal peer support roles across most other aspects of health and social care, although this may happen in the future. A key rationale for the development of peer support work and family peer support work in mental health services includes: the ongoing need to address stigma and discrimination, including within mental health services; negative experiences of some service users; the continuing transition of mental health services to more recovery-oriented approaches; power imbalances in service provision; and inequities in access to support. There is perhaps an interesting, but at present theoretical, debate about whether, if these issues with mental health services and wider society were effectively addressed, there would continue to be a need for specialist peer roles. This debate may be informed by research which can isolate the key components of peer support work and family peer support work roles to determine whether it is the unique aspects of these roles that is critical for their effectiveness. At present, a need for, and the potential benefits of, peer support work and family peer support work have been identified and the findings presented here should help to inform the further development of these roles.

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