



# Evaluating a peer support model of community wellbeing for mental health: A coproduction approach to evaluation

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## ABSTRACT

**Background:** Political changes imposed on mental health service provision alongside an increased number of people living with mental health problems, requires innovative approaches to community based interventions. Undertaking peer support for those living with mental health and social care issues has been long established as an effective approach to sustained wellbeing.

**Aim:** An evaluation to capture and formulate evidence of how a community based peer support group approach can be used to tackle sustainable mental wellbeing.

**Method:** An academic institution with an ethos for applied research, inclusivity and citizen engagement was engaged to undertake an integrated evaluation to capture the subtleties and uniqueness of a peer support group approach. The People's Academy provided a peer researcher (as someone with a lived experience of mental health services), to undertake a coproduction approach to the evaluation.

**Results:** Findings reveal that those who utilise peer support, whether as peer support facilitators or as group members, state how such a fundamental 'life line' has improved social integration and self-confidence.

**Conclusion:** The study examines process and outcomes of an integrative evaluation, providing evidence for how peer support group work can be used effectively with underserved communities to promote mental health recovery.

## 1. Introduction

Many countries around the world are aiming to ensure mental health care services are moved away from large institutionalised care provision, as there is a growing evidence base around how optimising a person's human rights in itself contributes to sustainable wellbeing (Mezzina, Rosen, Amering, & Javed, 2019). This paper reports on a commissioned stakeholder evaluation of the impact and outcomes of community based peer support, undertaken by the School of Health and Social Care's 'People's Academy' at London South Bank University (LSBU); achieved through a process of integrated evaluation, replicating a process of peer support through the method of evaluation used.

The LSBU based People's Academy engages people with lived experience of health and social care as partners in all aspects of University activities. The experiences of people (whether as patients, service users,

carers, consumers or clients) in effective health and social care service delivery is gaining recognition as an important quality marker and effective resource; not only for informing government, policy-makers and commissioners of health and social care innovations, but for shaping future community led wellbeing. The School of Health and Social Care People's Academy (HSC\_PA) has taken coproduction as a firm commitment to work in partnership with citizens leading on how to co-create healthy communities.<sup>1</sup> The HSC\_PA works to co-produce health and social care education, research and enterprise; by providing a creative platform for citizens to come together for the generation of innovative approaches to sustained wellbeing across health and social care (Hardy et al., 2017; Malby, Boyle, & Crilly, 2017).

### 1.1. Background

Peer Support was first introduced into mental health services during

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<sup>1</sup> cf. The People's academy manifesto (2018) <https://doi.org/10.18744/UB.002104>

the 1920s by Harry Stack Sullivan, in America, who sought employment from young men who had recovered from a personal experience of mental health problems to come and work in his 'psychiatric unit for Schizophrenia' (Perry, 1982). The notion of mutual support offered by peers was soon taken up across Canadian services and emerged in England during the 1980s.

Research into the benefits of offering peer support has been utilised as a supportive bridge between professional carers, improved community engagement and sustainable recovery process (Davidson, Bellamy, Guy, & Miller, 2012; Duckworth & Halpern, 2014; Mead, Hilton, & Curtis, 2001; Repper & Carter, 2011). There are a number of peer-support models. For example, Peer Supported Open Dialogue (POD) has core principles of flexibility, responsibility and psychological continuity (Hetherington, 2015). This model is based on person-centred principles through frank, honest conversations (or dialogues) in order to promote sustainable social inclusion; helping people strengthen their social interactions within familiar surroundings. This is often a significant problem for those who, through their mental health problems, often suffer isolation including lack of friendships group and social connection (Windle, Francis, & Coomber, 2011). POD focuses on the importance of having a safe place to meet and form meaningful peer relationships. By offering non-biased relationships, power based relations (real or imagined) is not an issue and there can be some freedom of expression without fear (Newlin et al., 2015). Having a peer-led group helps to take high levels of anxiety out of the equation. Therefore, peer support is not based on clinical models or diagnosis but centres on the person, sustaining wellbeing within their social context.

There are a number of models of Peer Support, based on modes of delivery (See Fig. 1) or aims (See Fig. 2). For example:

- Health-led group support – this is most often set up by a mental health care provider and is usually focused on promoting self-help strategies.
- Support groups: Participants will normally have a common bond, either through condition or experiences.
- One-on-one individual support: Traditionally delivered face-to-face but is moving more towards being delivered using digital approaches, or by phone based. This is a more intensive approach and is tailored specifically to the individual's problem.
- Family support: This can be similar to a family therapy approach, with one peer supporter or may bring families together for mutual support.
- Peer Supported Open dialogue: A group of practitioners, including a peer works with the person, and their family to discuss all aspects of a person's situation and context (further outlined below).

In practice, peer support groups are described to reflect the aims or focused activity of the group. For example:

- Self-help
- Mutual peer support
- Recovery and intentional peer support
- Peer mentoring
- Peer support open dialogue

In reality, local mental health support groups, as part of a larger national organisation, will aim to adopt a model suitable to the local communities' requirements, and function commensurate with the philosophy of the founding organisation. Therefore, peer support models may be adapted, rather than work from a singular approach, will incorporate aspects from different approaches to provide support based on recovery principles suitable to local cultural need.

Peer-supported open dialogue is an evolving new model of community based recovery, offering peer support as an intervention strategy, being researched as it remains in its infancy in terms of an evidence base for long term benefit. However, it is gaining popularity

across Europe, largely for its flexibility and holistic approach to mental health recovery with significant anecdotal evidence of its effectiveness. It is based on a peer support philosophy to mental health recovery, as outlined in the 'open dialogue' approach, delivered within a social network level of peers (Razzaque & Wood, 2015). Peer workers, have a number of advantages including lived similar experiences and understanding of peers. The peer supporter can provide confidence to a group and address issues without requiring any clinical input and therefore is not reliant on using a medical model to interventions, but instead focuses on making best use of existing networks, such as those close to the service user, their family, friends and engaging with clinicians only as appropriate.

As a Mental Health registered Charity in England, 'Mind' was established in 1946 and brought together three different organisations working in the community to improve people's lives. According to the Mind website (www.mind.org.uk), original and pioneering work ensued, to provide several firsts in terms of providing specialist education and training, and in providing homes and schools for children living with intellectual and physical disabilities. Today, Mind has a national network of community based activities. The local Mind model is characterised by the establishment of a number of participant specific peer support groups, catering for the different needs and requirements of the local population. For some, these groups provide social connections, whilst for others, the groups offer practical support in gaining confidence needed to return to work. Owing to the level of black and ethnic minorities represented in the local communities of London, the peer support group also offers specialist input around stigma associated with mental health and culture.

The model at Mind, is to have group facilitators who are themselves mental health survivors. It is generally accepted there are benefits and challenges encountered when group facilitators are also peers (Newlin et al., 2015; Seebohn et al., 2013). Peer Support workers are people who have survived a mental health disability or crisis, who offer useful support, encouragement and hope to others in similar situations (Davidson, Chimian, Sells, & Rowe, 2006).

According to Repper and Carter (2011) people attending peer support groups view their facilitators as role models in recovery and ideas for sustained wellbeing. A key component of peer support identified is the support it offers, which instils hope to people suffering the impact of long term mental health related problems. Hope is instilled when a person can envisage themselves achieving recovery, as they witness and encounter this through the role modelling behaviours shown from the peers who are working as peer support group facilitators. People could then begin to entertain the idea that if the facilitators could have this role, so could they at some point. Walker and Bryant (2013) support this finding in how people in recovery experienced increased hope and motivation as their facilitators could de-stigmatise mental illness and built a rapport with them. This can be through positive self-disclosure, role modelling, conditional regard, to increase group members sense of hope, control of their own lives to affect domains such as self-care, sense of community belonging, improved quality of life and symptom reduction (Davidson et al., 2012).

Issues of power and hierarchy within an organisation are an important factor to consider. Power dynamics are influenced by a number of factors such as class, gender, ethnicity and distribution of status and wealth of individuals. Power differences such as these where apparent can be reduced by good facilitation, where the facilitator helps group members feel safe, and choose and control over how they participate. There also needs to be space so participants do not feel obliged to disclose or listen to disclosures that may adversely affect their wellbeing on any given day (Side by Side Research Consortium, 2017).

Given the past experiences of facilitators, support is required to ensure they do not take on the role of a clinician rather than act as a facilitator; where the outcome might be the group being led in a more prescriptive rather than facilitated style. This role reversal can be a benefit or risk to facilitators. For some it might improve confidence,

MODELS OF PEER SUPPORT	WORKING DEFINITION
Peer Listening	Delivered by a peer supporter, trained in counselling skills that includes active listening, verbal and non-verbal communication, confidentiality and problem solving. Once trained, peer supported can offer formal peer support.
Peer Education	Peer support in this model focuses on support for specific topics, such as coping with depression, anxiety or addiction. The group will normally comprise of peers of similar age, status and background to the peer supporter(s)
Peer Tutoring	This model is aimed at those of similar or a younger age, and focuses on academic or social learning. The support may include paired reading or paired writing.
Peer Mentoring	The peer supporter in this model, acts as a friend, mentor and guide, to ease people into a new environment or situation. For example, starting a new school, job or voluntary work. The peer supporter acts as a positive role model. The relationship involved a fixed or long term commitment between the peer supporter and mentee.
Peer Mediation	Peer Mediators are trained in conflict resolution skills, to assist helping individuals find solutions to disputes in both formal and informal situations. This often is seen in practice, as part of a wider peer support service, rather than a sole model adopted by organisations.
Peer Brokerage	In this model a peer broker is someone who has used mental health services is available to assist a service user to design their support plan based on the best services and opportunities available to them.

Fig. 1. Models of peer support based on <https://www.mentalhealth.org.uk/a-to-z/p/peer-support>.

whereas other may intentionally or unintentionally abuse power. The peer support facilitator, for the group to work, must be self-aware of their own recovery process, and feel very much a part of the group. Therefore, adequate support and supervision is required, as sharing of personal stories may increase vulnerability of the facilitator to maintain a mutual and reciprocal relationship with the group (Mead & McNeil, 2006).

## 2. Method

This evaluation undertook a collaborative peer supported evaluation through a process that involved principles of inclusion and collaboration with all stakeholder groups (Guba & Lincoln, 1989; Lord and Rush, 2002; McLean, Biggs, Whitehead, Pratt, & Maxwell, 2009; Stake, 1986). Stakeholder led integrative evaluation was delivered by London South Bank University's (LSBU) School of Health and Social Care's People's Academy (experts by experience) supervised by academics with expertise in coproduced evaluation projects using mixed method evaluation (cf. Hardy, Titchen, & Manley, 2007; Hardy, Wilson, & Brown, 2011; Hardy, Wilson, & McCance, 2013; Taylor & Hardy, 2009).

This evaluation consisted of a variety of data gathering approaches, utilising information from research literature, documentary evidence (such as national reports and commissioning organisation documentation) plus stakeholder interviews and a focus group. The review aimed to identify any significant impact of a community led peer support group programme on mental health rehabilitation, though the evaluation of the impact and outcomes of community based peer support. Given the eclectic nature of these groups POD and PSG are used interchangeably.

An integrated model of evaluation was chosen in order to provide internal and external stakeholder engagement to the peer support group activity (Hardy et al., 2013). Involving people as experts by experience who were external to the peer support group, including People's Academy members at LSBU, the local Mind members and commissioners, provided an additional level of scrutiny to triangulate the evidence as an 'external' layer of validation to any identified outcome measures derived from the 'internal' peer support group participants.

LSBU provided personnel working as peer supporter researchers through the HSC People's Academy. Each had received training by peers and their contribution was paid as hourly paid lecturers by the

<b>Search terms (AND, OR, NOT) and truncation (wildcard characters like *)</b>	Peer support OR Peer Mentoring OR Open dialogue AND Mental Health OR Mental well*
<b>Databases searched</b>	<i>Psychinfo</i>
<b>Part of journals searched</b>	<i>Title and abstarct</i>
<b>Years of search</b>	<i>1990-2017</i>
<b>Language</b>	<i>English</i>
<b>Types of studies to be included</b>	<i>Quantitative and qualitative studies</i>
<b>Inclusion criteria (why did you include it?)</b>	<i>Peer support Age 18 upwards Reporting on Mental health service users (past or present) engaging in peer support</i>
<b>Exclusion criteria (why did you rule it out?)</b>	Peer support not mental health Peer support not involving service users Adults not CYP Computer, online, social media delivery modes

Fig. 2. Detail of peer support literature search.

University for both their peer support, research and training roles. A peer support researcher led on the project and produced all elements of the project report and subsequent project materials, working to co-produce materials with participants. Throughout the project, the peer support lead researcher was provided with supervision and sought advice as necessary in each step of the evaluation process. Below is an overview of the peer support led process of integrated stakeholder evaluation. Each stage was led by the peer support researcher, and cross checked by the co-authors as research supervisors and project co-ordinator.

Step 1: A literature search was undertaken, drawing on published and 'grey' literature on the subject of Peer Support. Second, organisational data of the peer support group activities was gathered from local documentation and any peer support information, supplied from early discussions with the commissioners. Each of the 4 peer group facilitators and over 30 peer group participants were contacted and invited to participate. Third, 4 telephone interviews were achieved with each peer group facilitator and then cross matched with the literature search information to inform the peer group interview question guide. Fourth, a focus group was undertaken to gather data from the peer group participants. This intensive data collection period was completed between December 2016 and January 2017 see Fig. 2 for the search strategy.

Ninety-eight papers were identified and reviewed. Additional material from grey literature was also reviewed, with particular attention given to such reports as McLean et al. (2009)) and Faulkner (2013) that specifically referred to peer support in mental health. Whilst this material provides important and interesting issues, it is not the focus of this paper. We wish to report on the impact and evaluation of a community led peer support programme from those who were engaged in this work as 'active' participants, foregrounding and using their words and experiences as the core data set.

### 2.1. Telephone interviews

All four peer support group facilitator participants were invited to take part in a telephone semi-structured interview. The key issues raised were used to compare information gleaned from the preparatory

literature review, distilled to inform content and structure of the focus group. All four telephone interviews were transcribed with each participant given the opportunity to add to the transcript if they wanted to amend or add anything after the interview had been completed. Only one participant wanted to remove a whole paragraph of the transcript which, they felt on reflection, was detailing more their personal situation than offering information about peer support.

### 2.2. The focus group

An inclusive stakeholder approach was used for conducting the focus group, with both peer support facilitators and PSG members in attendance together. This partnership approach to undertaking the focus group intended to mirror and replicate a peer support open dialogue approach to the focus group process where hierarchy, power and status are not used to manipulate or dominate agendas, leaving the group members free to raise issues as and when they felt moved to do so, as equal partners in the exploration of peer support (Green, Kao, & Larsen, 2009).

The focus group was held at the University, providing a mutually convenient impartial locality. The focus group aim was to collectively discuss experiences and opinions of peer support. Particular focus was to examine the impact and value of the peer support group activities for individual members, but to also capture any collective impact on sustained community wellbeing. The LSBU People's Academy lead researcher had prepared a series of prompt questions, derived from the literature review and telephone interviews with peer group facilitators, plus conversations undertaken with project commissioners and LSU academic staff, prior to leading on the group discussions (see Table 2 below). Another researcher was present from LSBU to help keep accurate notes and to prompt avenues of discussion as required. A guide to the process of questioning during the focus group included prompts such as those shown in Table 1 below.

In total 10 PSG participants attended a focus group held at London South Bank University (12th January, 2017). Analysing focus group discussion was achieved through transcription of tape recording of the session which was then further collated with all field notes, taken from both LSBU focus groups facilitators. All transcripts were collated using a

**Table 1**  
Detail of peer support literature search.

Search terms (AND, OR, NOT) and truncation (wildcard characters like *)	Peer support OR Peer Mentoring OR Open dialogue AND Mental Health OR Mental well*
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Part of journals searched	Title and abstract
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qualitative thematic analysis (Fereday & Muir-Cochrane, 2006). Overarching themes were identified as meaningful descriptors arising from common statements and then cross referenced with other sources of evidence. This allowed for emergent themes to be identified as convergent with other evidence. Also noted was any anomalies that were appearing to be divergent, or unable to fit neatly with existing or alternative evidence. These anomalies were used to either be followed up by further investigation with participants, or used to make reference to and identify them as specific to the local context (Fereday & Muir-Cochrane, 2006).

Following the morning focus group sessions all participants were offered opportunity to be involved in creating a short documentary film. Group members were invited to be filmed discussing their experiences of Peer Support. Two additional PSG members who had arrived too late for the focus group, were able to join this specific activity. The project commissioner had asked to attend the morning focus group, but was advised not to. Instead, they were invited to attend the afternoon activities only. This allowed focus group members to speak freely about all aspects of the PSG experience without fear of reproach from the local commissioner.

Those participants who did not wish to be involved in the filming option were invited to view the People's Academy artist in residence exhibition, that charted his own experience of recovery through use of

**Table 2**  
Focus group guiding questions evaluating experiences of peer support groups.

WELCOME	We are going to be speaking to you about your experience of your Peer Support Groups
Thank you for attending the Peer Support evaluation focus group	We want to hear your experiences and your story of being part of the Peer Group at MIND
My name is Nina, and my colleague is Sally	We are going to record our discussions to help us remember what you have said.
OPENING:	2 – What prompted you to become involved in becoming part of a peer support group?
1 – How did you hear about the peer support group you are involved in?	3 – What were your initial expectations from the group?
DURING:	5 – What are your views regarding the facilitation?
4 – How long have you been part of the group?	6 – What focus do the facilitators want from the group?
	7 – How does being in a group help you in your day-to-day life?
	8 - In what other ways does it help you?
	9 – Do you want to meet more or Less often?
	10 - Why would that help?
	11 – What do you think are some of the benefits of being part of a peer support group?
	12. What are some of the limitations encountered in being part of the Peer support group?
On REFLECTION	14: In your view, what makes the peer support group something unique?
13 – If funding were not an issue, what changes would they want to see?	15: What other experiences do you have to compare the PSG with?
	16: Is there anything you would like to see be done differently?
	17: What are some of those areas that you think would be a priority
CLOSURE	Thank you again for your time today
18: Is there anything else you wish to share with us about the PSG?	If you think of anything else you wish you had said, do send it to us
	We aim to get our report back to you as soon as possible for comments and anything more you wish to add.

various creative art works (White, 2016, 2017). However, following the release of the short film to the group participants for feedback, one member asked for face shots not to be included and then a second participant withdrew their consent. This meant no further use could be made of the short documentary film produced.

### 3. Results

Participants' experiences of being involved with PSG ranged from a matter of months, through to over 15 years. Yet, they all reported how quickly they had felt engaged with the PSG process. They described this as an emotional connection with fellow group members; like family. This level of familiarity in turn encouraged a renewed confidence try new things, and to keep coming back to the group. For example, being encouraged to meet for a coffee outside of the group which would have been a painful and frightening experience without the support, through gentle, yet persistent persuasion and encouragement from other group members.

The focus group participants reported how attending the group regularly had helped them learn how to structure their time (e.g., adopting a routine to their day), which then filtered into learning how to structure different activities across the week. This previously unknown benefit of time management skill enhancement had a knock-on impact in how it had helped them to become more independent functioning in their local community. Social integration through the PSG further sustained their ability to function better in the community and led to a sustained recovery and an improved sense of self confidence and overall wellbeing.

Other core themes of PSG outcomes identified were captured and themed, expressed as:

- **Opportunity to be heard**

Being a member of a PSG enabled participants a freedom to openly discuss and speak about all aspects of their lives and mental health experiences. Talking with people who understood the subtleties of stigma and prejudice experienced, was a unifying experience; whether as a mental health patient, but also mirrored in how they had experienced prejudice and social stigma, for example as a member of black and ethnic communities. One participant stated:

*“It felt OK to go, because the people had a lived experience and the facilitators as well”.*

As focus group participants were able to quickly open up, they also

revealed a high level of mutual respect for each other and a willingness to hear (sometimes repeatedly) aspects of an individual's personal stories. As one person spoke, it was noticeable how each PSG member sat quietly until that member had finished talking. They sat still, but were listening intently to what was being said, nodding, or smiling in recognition, seeking out similar experiences, emotions and shared consequential outcomes of a lived experience of mental health problems. Having an ability to connect, through shared knowledge, shared experiences and a mutual understanding proved to be an integral ingredient that enabled the PSG members feel included, listened too, accepted. One person succinctly stated the impact of attending the PSG as:

*“It has given me my life back, it was empty before, I really enjoy going along”.*

• **Trust and safety** (in social networks, relationships, emotional support)

The PSG members all discussed importance of being in a safe, trusting place as a subsequent impact of being involved in the PSG. They recognised how this ‘safe place’ had a knock-on effect on their willingness to engage with other social networks and seek relationships outside of the PSG. Through being involved and having a trusted and supportive network, (as provided by the PSG) allowed, over time, an improvement in their ability to speak openly about things that were highly significant, very personal and pertinent to their mental well-being.

*“It's like a breath of fresh air. It doesn't mean I have an axe to grind, it just means these things matter to me and I want to talk about it. It's very therapeutic - to articulate these things, like sexual abuse etc. that's really hard; to talk to the psychiatrist about such things. It's only over time I have learnt how to talk satisfactorily about myself. I am still finding ways of experiencing my life; I now have a mechanism to talk about my life”.*

As outlined in the quote above, this PSG participant reflects how, over time, being involved in the PSG had allowed them to talk through life events in a way that was safely contained, ‘confessional’ and therapeutic. They were able to recognise how disclosure was a process that had altered their personal insightfulness into their own behaviour. Importantly, they had realised how certain (socially taboo) topics of conversation in different settings could act to further alienate them from people. Having this insight enabled them to tailor their interactions in different social circumstances.

• **Increasing resilience** (emotional well-being, ability to bounce back to function socially):

The process of remaining well and achieving a sustained level of functionality within and across their social circumstances had altered through being involved in the PSGs. For the PSG facilitators and PSG participants, the fact that if they became unwell, and needed some time out of the group, they were able to know that once they felt able to, they would be welcomed back, with no sense of failure, rejection or judgement. Yet, in contrast, some of the PSG facilitators were less confident in the financial security of the charitable founding organization, and this had a negative impact on any sense of long term stability for the PSG. The facilitators had a heightened awareness of impact of an economic climate of cut backs and year on year savings.

It's understood we can have our own relapse as facilitators, but now we can never be sure there will be a job to come back too, because of funding. In the older times, they would look out for you and assure your return, but this has changed and it seems we are not so well looked after.

For the PSG participants, financial security of the health economy was not raised or discussed in the Focus group. Perhaps, as this was

something not on their political radar, when their own personal struggles were more dominant and immediate in terms of their learning how to survive and socialise in community based group activities. What was evident, was the trust and support provided by the PSG enabled them all (whether as facilitator or group member) to try new strategies for social inclusion, such as spending time eating together.

A notion of nurturing, both psychologically as well as physically (i.e. eating together and learning to cook healthy food) is recognised in the quotation offered below. All of which provided a subtle expansion of an individual's sense of wellbeing; extending their scope of skills, and helping them to remain a group member and learning how to be resilient during times of poor health.

*It is good to have food and eat together, it's a unifier. A meal attached to the peer support group is good, as it helps us consolidate what has been discussed, adds to the social aspects as well; two things feeding ourselves and each other.*

Another participant recognised how each PSG Facilitator brought their own individual coping mechanisms and skills into the group sessions. The introduction of some complementary therapies had really opened their eyes to seeking alternative mechanisms of looking after self and sustaining wellbeing.

*The inclusion of complementary therapies, is a really lovely way of looking at healing. When I get a massage I can feel my whole body responding, it helps me manage stress better. I know I am broadening my knowledge about how to be well, and remain well. I can feel it in my body as I relax better. I know some of the medications are not good for me, and have a negative impact, but these other therapies I can literally feel it doing me good.*

The differentiation between PSG participants and PSG facilitators was spoken about with the facilitators being seen as healthy role models who gave hope to the members. They inspired participants to continue to progress in their own recovery. Below is a tabulated collection of comments and descriptions of the value the PSG Facilitators brought to the group, (Table 3) compared to other health care professionals, who were identified as cold and dispassionate in contrast. This was seen as largely due to not having themselves experienced the stigma and social deprecation a serious mental illness had brought into people's lives.

### 3.1. Peer support group facilitation

The following key themes were identified as significant outcomes that support effective PSG facilitation. The PSG Facilitators also

**Table 3**

Contribution of peer support group facilitators: key impact factors.

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- Being able to contribute personal experiences recognising and celebrating individual members achievements, no matter how small.
  - Creating a safe space for people to bring their personal issues,
  - Acting as a conduit between the person and their professional carers .
  - Being an advocate for people, particularly when members mental health deteriorated and they become more suspicious and annoyed at the support on offer from conventional mental health services, and how difficult it is to access the right care in good time.
  - Enabling participants of the group being to speak openly on personal issues about their health and circumstances
  - Acknowledging the recovery process is slow but sustainable due to being involved in the peer support groups.
  - The role of peer support facilitator was also identified as beneficial for the facilitator's own health and wellbeing, and seen as part of their own journey of recovery, allowing their own confidence to grow with the group
  - Encouraging social events, i.e. cooking and eating together, going to the cinema etc. helped open up opportunities for group members to experience and enjoy a social life together
  - The ethnicity of the group facilitator was significant, in that when there was a high representation of Black and Minority groups represented, the Facilitators allowed for cultural sensitivity and shared learning amongst members.
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**Table 4**

Participant quotations: theme; 'it works both ways'.

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- *Other health professionals don't have a clue about what your experiencing, it's so them and us, but in peer group it's all about being seen as equals. It makes us all equal; they listen and bear with you.*
  - *It works both ways, giving more control and direction to the groups, the facilitator learns from us and we from them.*
  - *The user led facilitators, it makes the whole thing more democratic, equal as you say, I like that a lot.*
  - *People who have lived experience of mental health themselves, they know, you know they know and that raises the empathy, they are able to empathise with your experiences. They work as peers, it's so important. Give me the confidence to see them being able, it makes me think – maybe I can do that too someday, gives me hope, and inspiration.*
- 

reported how they too gained so much from other group members which helped keep themselves well, as a process of mutual benefit.

- **It works both ways:** Being a peer support facilitator meant being involved in how the group was run and what activities took place, being able to witness and support the group members recovery plus celebrating their achievements each members made. The peer support facilitators spoke of these issues as mere 'pebbles in the stream', but recognised how each pebble helped the wider group, and how this ripple also influenced and sustained their own mental well-being.

Focus group members expressed how important it was that the peer support facilitator has a lived experience, as an inspiration to their own recovery (Table 4).

### 3.2. Peer support group facilitator: style and unique contribution

Members enjoyed different approaches gained from peer support facilitators, who brought different ideas for how the group functioned. For example, introducing complementary therapies, cinema trips out, eating and cooking together (Table 5).

### 3.3. Formal and informal approaches to peer support

Further clarity in terms of different approaches to formal and informal peer support approaches that might be considered in the future, including the need for peer support facilitator training was discussed. Throughout the evaluation of the peer support groups delivered in the community, the function and role of the group facilitator was evidently a core aspects of peer support. Having a person who led the group as a peer, is a delicate balance, in terms of training the trainer (e.g. Side by Side Research Consortium, 2017). See Table 6.

### 3.4. Challenges & boundaries

A request for regular supervision and a formal mechanism for external support, e.g. an external Peer Support Facilitator, to help deal with the issues raised in the peer support groups, and help with keeping

**Table 5**

Participant quotations: theme; 'facilitator style' and 'unique contribution'.

- 
- *It's crucial people with lived experience are open about that as facilitators*
  - *They are an inspiration to others*
  - *Good to have food and eat together, it's a unifier. A meal attached to the peer support group is good, it helps us consolidate what has been discussed, adds to the social aspects as well, two things feeding ourselves and each other.*
  - *Each facilitator has a style and brings a unique contribution. The inclusion of complementary therapies is a really lovely way of looking at healing. When I get a massage I can feel my body responding, it helps me manage better. I know I am broadening my knowledge about how to be well, and remain well. I can feel it in my body as I relax better. I know some of the medications are not good for me, and have a negative impact, but these other therapies I can feel it doing me good.*
- 

**Table 6**

Participant quotes: theme; formal and informal approaches from PSG facilitators.

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- *Some facilitators feel they don't have structure as they have very little training, no supervision, financial instability and just enough funds to run the groups.*
  - *They feel lots of investments need to be made because they need support though they are dedicated and committed. They don't know what the future holds.*
  - *We don't get formal supervision anymore, and sometime you are up against some tricky situations*
  - *I think we need to know more about the difference between formal and informal approaches to groups and peer support – that would come with more training*
- 

### boundaries

- 1 Facilitation of a strong group of people can be hard. All the changes that are happening in health care, dealing with vulnerable people can knock your confidence sometimes.
- 2 It's understood we can have our own relapse as facilitators, but now we can never be sure there will be a job to come back too, because of funding. In the older times, they would look out for you and assure your return, but management has changed and the quieter people it seems are not so well looked after and are the first to get kicked out. I don't feel confident if I have a relapse that I would get this job back
- 3 Really rocky ground sometimes, and our work is being cut
- 4 Don't know our future – it feels like things are falling apart, but the strength of the group is a real benefit. With new people coming in, it's brilliant what we do, and how things are growing.

### 3.5. Key impact on individual peer support group members

- A safe space to discuss and share life stories;
- Access to kindred spirits with shared backgrounds and cultural upbringing;
- Being with people who listen and do not judge;
- Experiencing a high level of empathy from group members;
- Learning to talk about shameful, traumatic life events and making sense of it all;
- Developing new levels of confidence by overcoming social isolation and anxiety;
- Seeing the PSG Facilitators as role models and inspirational in their recovery journey;
- Encouraging each other to try new things (e.g. going to cinema, coffee shops, cooking);
- Being able to come and go as a PSG member without criticism;
- Being amongst people who understand mental health problems as BME culture specific experiences of Mental Health services.

### 3.6. Sharing stories and backgrounds

The focus group members were comfortable talking about themselves and their experiences in front of each other, which could be seen as a direct response to them being involved in Peer Support Groups. The group were asked what were their expectations of being involved in Peer Support groups? One member put it that:

I had no expectations really – I was attracted by the peer support and peer led elements of members and facilitators with experiences of mental health themselves. I began to open up after a while, almost without noticing it myself. Sometimes I'm not aware of how much being in this group has allowed me to be vulnerable with others, and them not judging me, but empathising with me and my experiences.

Another member spoke of the positive outcomes of being able to share their story with others in the Peer Support groups:

What I have experienced was really hurtful, and traumatic, so being able to talk and explore those things helped me to make sense of it

all, of those experiences. Whereas in other groups you get funny looks and people don't want you to talk about that stuff; but people understood. It allowed me to speak about what I have been through, it really helped me. Something shifted, altered; I could put stuff out there and leave it there.

Key findings from the telephone interviews and focus group discussions were around the following three core themes.

The Peer Support Group activity was seen as:

- a) Common ground: Creating a safe space to share stories and histories with likeminded/kindred spirits

Problems I have had for years, go back a long way that have had a profound negative impact on my relationships, work, lost my home, it's all been detrimental to everything until I found Kindred Mind. I had been associating with the wrong people, now I have got people who are empathetic to me, listen and allow me to talk about things that other people don't want to hear. I need this.

*It's encouraging to be in a space together and feel safe.*

- b) I don't have to hide: Providing a non-judgemental space to talk about things no one else would be willing to hear, or members just would not discuss outside of the group due to mental health stigma (e.g. racial tensions, abuse and addictions)

*We are not allowed to talk of some things – but in Kindred Minds, we are able to talk freely, learning about certain things, understanding the culture. We go out together learning all the time from each other. Building up my confidence and self-esteem – I feel safe – and understood.*

*I have not been judged. People are not judgemental.*

- c) Giving me my life back: A place of empathy, support and self- help guidance where confidence and self- worth regrows

It felt OK to go, because the people had a lived experience and the facilitators as well. It has given me my life back, it was empty before, I really enjoy going along.

*It's like a breath of fresh air, it doesn't mean I have an axe to grind, it just means these things matter to me and I want to talk about it. It's very therapeutic. To articulate these things, like sexual abuse, etc., that's really hard to talk to the psychiatrist about such things. I just used to make things up before. It's only over time I have learnt how to talk satisfactorily about myself. I am still finding ways of experiencing my life; I now have a mechanism to talk about my life.*

All three themes are intertwined and participants saw these areas as key to the process of Peer Support and significant to their sustained and ongoing wellbeing.

#### 4. Discussion and recommendations

Specific outcomes presented in this paper focus on the experiences of engaging with PSG and the impact of having PSG group facilitators, themselves as peers. Qualitative data presented here was obtained mostly from the focus group and then themes derived at form a process of integrated verification triangulated against other sources of data. However, the aim here is to foreground participants experiences of PSG, as the central tenet of this paper. We have also deliberately avoided identifying participants demographic details, so that their expressions and phrases capture reality of the impact and experiences of exposure to peer support group activities, plus outcomes described for sustainable community living as mental health survivors.

A common benefit of peer support identified from participants was a recognition of increased self-confidence and a growing awareness of an improved ability to live independently. Both aspects were improved through participants having been involved in PSG activities, whether as

a group member, or as a facilitator. Changes in self-confidence (in domestic activities) and an associated increased level of structured social interactions had led some participants to undertake voluntary work and then subsequently move on to undertake paid work. For example, of the 10 focus group participants present at the focus group, 4 (i.e. 40%) had taken up paid employment during their time engaged with peer support group activities.

Significance of incremental change over time was described, with emphasis made by PSG participants, that despite being a slow process, or incremental, overall the change was seen as a monumental achievement. These subtle changes were significant, particularly when participants had experienced several years of debilitating mental health issues that had prevented them from any form of social interactions. For example, one of the PSG members described how they had experienced severe social agoraphobia, but were now embarking on a new job, in stark contrast to how they had been functioning for many years under more conventional health care support services, prior to engaging with the PSG.

All PSG facilitators identified a positive impact on themselves, a part of which was related to the pleasure of recognising positive changes taking place for PSG participants. These positive changes were accredited to being involved in the consistent supportive network of the PSGs. These findings are in line with previous research, which identified mutual benefit to group facilitation as a process of altruism (Schwartz & Sendor, 1999), although others would argue benefit can be understood through a theory of motivation enhancement (Miller, 1995).

According to Walker and Bryant (2013), peer support workers do experience non peer staff discrimination and prejudice, low pay, long hours and difficulty managing the transition without guidance and supervision. The need for effective work based supervision, training, and adequate pay (as a measure of value) are important factors for maintaining the well-being and good mental health of the peer support group.

The effect a facilitator has on the function of group processes is still an under researched area. The feelings and reactions working in groups can surface should not be underestimated (Winship & Hardy, 1999), with supervision and a sensitivity to participants individual circumstances can help to aggregate against potential distress aroused in the facilitator. As identified by the focus group participants and PSG Facilitators themselves, the need for effective, regular supervision, within which the facilitator can air their concerns and seek their own supportive learning, is an ethical responsibility from the organisation promoting group work (DOH/NMC docs). Walker and Bryant's (2013) metasynthesis of peer support published papers identified supervision and training as the highest recommendation occurring in 44% of the papers they reviewed. However, it is worth considering what level of training may begin to negate the very essence of peer support.

A variety of approaches to peer support within a single organisation, appears to be appreciated by participants who then can chose the level of activity, structure and formality of groups on offering most suitable to them (Walker & Bryant, 2013). Many of the participants from the local organisation appreciated the unique contribution the facilitators brought to the PSG activities and structure.

What was central to the effectiveness of engaging with a PSG was ability to be in a group, with others who understood, shared and empathised with each person's individual situation and circumstances. Solomon (2004) categorises peer support engagement as a challenge for facilitators, in particular in maintaining boundaries between becoming friends and being group members. This is a theme in previous research, particularly when introducing peer support workers into conventional mental health settings (Asad & Cherim, 2016). However, a high level of sensitivity, empathy and acceptance seen from the PSG participants were clearly displayed in their sensitive interactions, seen at the focus group session. This highlights the therapeutic outcome of open honest articulation achieved when involved in an effective PSG. Participants

called this ‘talking through my issues’, whilst it can also be identified as highly effective communication and insightful, tempered amount of self-disclosure. The level of self-disclosure and comfort in which people were able to address openly their personal fears, prejudices and life’s traumas was reminiscent of a highly effective therapy group session (Winship & Hardy, 1999; Yalom & Leszcz, 2005).

## 5. Limitations

This peer support integrated study aimed to evaluate outcomes of engaging with a community based peer support group, through utilising approaches integral to the notions of peer support. Exploration of the utility of a peer support approach, using stakeholders as active participants in the evaluation process was achieved. However, results reported here rely on core themes generated by a small number of active peer support participants, peer group facilitators and input from the project commissioners. Therefore, these participant views and opinions can be influenced positively or negatively by localised factors, such as group cohesion and relationship with facilitator. Using an external facilitator as an expert by experience (i.e. peer) offered an independent ear and provided someone the group would not have pre conceived ideas about, or an existing relationship with, nor seen as biased from having a position of power/authority. This study is designed to inform the use of peer support facilitators on the acceptability and potential effectiveness of the intervention. Therefore, ethnicity, age, gender and other protected characteristics have not been reported, given the small sample size. Although, this may limit the ability to compare this study by participant characteristics, it offers a basis for future larger scale research where issues between groups can be addressed

Most of the evaluation participants were able to provide clear, detailed examples of other forms of mental health service provision, which had fallen short of their expectations. In comparison, the PSG provided a local connection and a level of security. In offering regular contact with others undergoing similar mental health issues, participants had seen a subtle change in themselves and their peers, which over time could be ‘monumental’ in their future wellbeing. Predominantly, participants revealed a series of favourable outcomes in their experience of participating in peer support groups, describing the PSG as a ‘life line’.

Specific benefits were identified around personal wellbeing, ascribed specifically to the process of peer support group facilitation. Although peer-support groups offer participants and leaders many positive outcomes (Seebohm et al., 2013; Repper & Carter 2011; Faulkner, 2013), as further verified here from direct stakeholder experience, there are still barriers to adopting this approach more widely, such as:

- Economic, social and structural factors

The issue of funding for the locally delivered PSG was identified as an ongoing area of concern, which denied the group a sense of permanence, and had a negative impact on the PSG facilitators ability to access training and access to regular supervision. The PSG participants also raised issues of cultural sensitivity and how the local PSG provided a community focus, that represented the diverse cultural groups found in their local communities. This added another layer of collegiality and cohesion, enabling participants to feel a familial connection to their fellow PSG members.

- Lack of funding (especially for the more disadvantaged and or disabled)

None of the participants attending the focus group had physical disabilities, or any level of adaptation required to allow them to attend and engage. Working with a peer support researcher brought an

additional layer of inclusion and sensitivity, addressing any unconscious bias, or power differentials that potentially a conventional research personnel might bring to the focus group discussion.

- Lack of interest from GPs, failure to inform patients about groups

All participants identified they heard about the PSG from word of mouth, a recommendation from other attendees. Few had been offered the PSG as part of a professional referral process. This gives rise to a need for ongoing research that can showcase the subtle benefits of PSG engagement on a person’s mental health recovery.

- Lack of research in this domain (Seebohm et al., 2013).

Undertaking a mixed methods evaluation allowed for a rigorous investigation into the process and outcomes of PSG engagement. However, as outlined in the limitations section, this is a small and localised project group, yet we hope rich qualitative data offered here allows for the reader to identify potential impact PSG engagement offers those who feel marginalised and alienised from society.

The next stage is to conduct a larger study and to see if the benefits expressed by self-report can be quantified in terms of the role of peer support, OD, social network on quality of life, levels of engagement with the programme and symptom reduction.

## Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.mhp.2019.01.007.

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