‘The System is Mad Making’: Peer Support and the Institutional Context of an NHS Mental Health Service

Emma Watson

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Abstract

In the past decade, peer support has become a common feature of mental health service provision, both in third sector organisations and in statutory mental health services. Most NHS mental health services now employ peer support workers, who use their lived experience of mental distress and recovery to build supportive relationships based on shared understanding, and to offer hope to people using services. Research suggests that the introduction of peer workers can benefit people receiving services, the peer workers themselves, and the teams/services that they are employed within, as peer workers positively influence the culture of mental health services. Despite research interest in the potential of peer support to transform services, the introduction of peer support workers into formal mental health services has been met with criticism from those who believe that psychiatric conceptualisations of mental health are at odds with its philosophy. In addition, little is known about how peer support brings about the outcomes it has been found to, and what gets in the way.

The aim of this research was to develop an understanding of the process of offering peer support in an NHS context using the experiences of peer workers, as well as my own experiences of working in a peer support leadership role in this setting. This study drew on feminist standpoint theory, survivor research epistemologies and critical realism to inform its epistemological and methodological approach.

Eighteen peer workers from Nottinghamshire Healthcare NHS Foundation Trust were interviewed and their transcripts were studied repeatedly during in-depth analysis, which first coded each transcript, before combining the codes across transcripts to identify emerging patterns and points of divergence. In addition, I used my own auto-ethnographic reflections in my role as peer support development lead as data. Findings are presented creatively, in the form of constructed conversations between peer workers, as well as single

narratives, diary entries and creative non-fiction. These devices have been used in order to evoke for the reader a sense of the experience of working as a peer worker within an NHS setting.

The study argues for a shift in focus away from peer workers, and onto the context that they are employed within. It highlights how the institutional context of NHS mental health services contributes to a construction of a specific peer identity which both empowers and stigmatises peer workers. Peer workers described their experiences of building valuable peer to peer relationships, but in the context of the wider system, these were reported to be inconsistently respected, as were the peer workers themselves. There were frequent examples of the structural powerlessness of peer workers, including their low pay and lack of opportunities to progress, as well as difficulties created by the ongoing austerity agenda across mental health services. Despite this, peer workers described their hopes to be a part of a wider change within the NHS, as well as acts of resistance and self-preservation which contributed to this. The culture of NHS mental health services does need to change, but this requires collective and concerted effort in a range of contexts and levels, and should not be the task of individual peer workers who have little power within the wider systems and structures.

The study furthers the understanding of how mechanisms within the medical, hierarchical context of mental health services, underpinned by neoliberal economic models impacts peer workers and their work of peer support, which is an under-explored area of peer support research.

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[1] Permission has been granted by Nottinghamshire Healthcare NHS Foundation Trust's Research and Development Department for the Trust to be named within the research

Glossary[2]

CAMHS – Child and Adolescent mental health services – provided by Nottinghamshire Healthcare NHS Trust to children and young people (up to the age of 18) as well as their families and care givers

Co-production – Doing things ***with*** people rather than ***for*** or ***to*** them. Co-production means designing and delivering services in an equal and reciprocal relationship between professionals, people using services, their families and communities, where everyone's assets are valued.

Care Quality Commission (CQC) - An independent regulator of health and social care in England. They are responsible for monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety. They publish reports based on their inspections including recommendations for improvements.

HEE – A Non-Departmental public body established to support the delivery of high quality healthcare and health improvement across England by monitoring, supporting and advising on the skill mix, values, behaviours and numbers within the health workforce.

ImROC – Implementing Recovery through Organisational Change programme - a quasi-independent, not for profit organisation hosted by Nottinghamshire Healthcare NHS Foundation Trust. It aims to work with people using services, service providers, commissioners and wider communities across the world using co-production as a method to facilitate recovery-oriented improvement in the outcomes and experience of health and social care.

Lived experience – Personal knowledge that is gained through direct, first hand involvement. In the context of peer support, lived experience refers to a person's experiences of distress, trauma, oppression, service use and recovery.

[2] Extracts from this glossary have been published in: Watson, E. & Meddings, S. (Eds) (2019) *Peer Support in Mental Health*. London: Red Globe Press p160-161.

Nottshc - Nottinghamshire Healthcare NHS Foundation Trust is an integrated healthcare provider which offers services, including mental health, intellectual disability and physical health services. It employs over 9000 staff in settings ranging from community mental health teams to acute wards, as well as secure forensic settings. It employs approximately fifty five peer workers within its mental health services. Its budget for 2019/20 is £465m.

Peer Support – Giving and receiving support based on shared experience, culture or identity. Peer support is 'mutual' in that it is based on equality rather than power imbalance and is founded on principles of shared respect, self-discovery and emotional safety.

Peer worker – A person who is employed in a role where they are expected to draw on their personal experience of distress and recovery to support others. Organisations use a variety of terms to describe this role including peer provider, expert by experience, consumer provider, peer specialist, peer mentor and recovery coach. While there may be differences in the key responsibilities within each role, the use of peer support skills and lived experience is a common thread.

Peer-led provisions - Services and organisations where those with lived-experience have control over all aspects of provisions such as service design, delivery, development, management and evaluation.

Recovery – Refers to personal recovery, rather than clinical recovery. Personal recovery is a self-defined unique process of building a meaningful life which may or may not occur alongside the remission of 'symptoms' (clinical recovery)

Recovery College – A college with a recovery-educational approach offering courses to increase people's knowledge and skills and promote self-management, usually about mental health or other long-term conditions, recovery and wellbeing. They are underpinned by principles of co-production, inclusivity, being strengths based, recovery-oriented and progressive.

Recovery-focused / recovery-oriented – a supportive approach which helps a person to achieve their own self-defined goals and places them in control of the direction and pace of progress. It is underpinned by hope, not taking control away from a person and helping a person connect with opportunities which they have identified as important in their recovery.

Strategic essentialism – The strategic coming together of people within minority groups, or with shared identities so that they can best represent themselves. This involves the temporary disregard of strong difference which may exist between group members, so that they can foreground their shared identity to achieve political goals

Survivor – An empowering descriptive term for a person who has experienced (and survived) traumatic or distressing life events. People describe themselves as surviving the experience of mental distress and as surviving mental health services.

Survivor knowledge – A specific form of expertise derived from personal experience of mental distress, trauma, service use and recovery.

Third sector / voluntary sector / non-governmental organisations – Organisations or collectives which sit outside of the public sector (government provided services such as the NHS) and the private sector (profit making businesses). The third sector includes independent organisations including charities, self-help services, community organisations and social enterprises and other not-for-profit organisations. These may be peer-run, such as Recovery Partners in Sussex, or not, such as Mind.

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We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time

T.S. Elliot

Chapter 1 - Introduction

1.1 Locating myself

All my life I have made sense of things by writing them down in a way that I could not by speaking them out loud. In my recovery, after the wave of loss and sadness had broken and I stood confused in its wake, I wrote in circles. Trying to find meaning in something that felt alien, trying to find the familiar in the person I had become that I could not recognise.

Maybe for this reason I began to consume the words of others. I found narrative after narrative of recovery and distress and illness and madness and survival and I drank them in like cool water. I thought that if they could find their meanings, maybe I could borrow them, maybe I would find some meaning of my own by understanding what others believed about madness and experience. But still, after having read so many stories from other people, I am wary about writing my own.

I hate the thought of pinning myself down, of creating a narrative about myself and being defined by that. I am a spider under a glass; sealed in, unable to become anything else, unable to breathe any other air. The language I use here will be the language that follows me. The labels I select for myself will divide me up into different parts, one part survivor, one part doctoral student, one part peer worker, and the thought of being pulled apart into some kind of pie chart feels disappointing.

If you do not tell a story, you do not have to give it language. That is preferable when the language my ‘story’ naturally falls toward is claustrophobic, and worse than that, is anchored in a swamp of stigma. I could describe myself using psychiatric labels, although I would rather tear my own skin off. I could say I have a mental illness, and feel the shame and injustice hit me like a cigarette butt on my skin. I do not choose to buy into those particular social constructions, which never got me anywhere really. I could describe myself as mad, and join the ranks of people who have reclaimed the word. Except that going mad did not feel like madness to me. It felt desperate at times, and sad,

but mostly, it felt like an emptying out. A becoming lost, losing myself. And finding myself again does not equate to sanity, as if madness and sanity are two sides of one neat little coin. Because I am still lost in so many senses, but I have found my way back too. Both things can be true.

Maybe it is enough to say that when I came to peer support, I had been living for some time in this altered identity with the feeling that I had got something wrong, that I was silly and had failed. I lived with the frustration that the people around me could not see that I was working and achieving still, it was not as important as the fact that I could not achieve recovery. I felt low and tired and alone and talking to anyone about it felt like revealing the most shameful part of myself. If felt like I was proving them right. I saw a mental health team every week – not exactly out of choice but not exactly out of compulsion either - and I would select tit-bits to share with them.

In 2010, I was on a short term contract in a previous job and I was facing unemployment. I was scrolling through the NHS jobs pages at work one day and I came across this ‘peer support worker’ post. ‘The role of peer support worker has been developed specifically for people who have lived experience of mental distress. Through sharing wisdom from their own experiences, Peer Support Workers will inspire hope and belief that recovery is possible in others.’ As I read it, I felt a wave of excitement wash over me. This is what mental health services need, this is what I can do, this is such an important idea.

In my application I wrote about my diagnoses and made it clear that I had the ‘lived experience’ that they were looking for. In the interview I talked some more about my diagnoses and my psychology degree because I thought it was important for them to know how well I understood mental illness. There was a group task which I think saved my skin because I listened and asked questions; it showed I could do more than just talk about labels.

So, I began working in Nottinghamshire Healthcare NHS Foundation Trust (Nottshc[3]) as a peer support worker in the Early Interventions in Psychosis (EIP) team and the City Recovery Team. I was employed with 6 other peer workers as a one year pilot project. We took referrals from other team members, as well as self-referrals from people using services. We met with people in their homes, each of us holding a caseload, and we tried to build peer relationships where we shared our experiences of recovery and trusted that each person knew what was best for them. I continued to use mental health services and the professionals that supported me were a little wary about what would happen if I should work with people they were supporting or if I bumped into one of them at a meeting.

At first, I had no idea what a peer support worker should do. I felt celebrated, like I was being employed with some excitement, like the seven of us were going to shake things up, like we had the answers and no one else did. When staff asked me what my story was, I told them the whole thing. I thought I had to, I thought that was part of the requirements of the job. It left me wondering what they were thinking about me. I was surprised by the kindness of the EIP team and how they spoke about people like they were just going through something, for the most part.

All of us new peer workers had peer support training. We spent 11 days together and I absorbed messages of recovery and strength like a sponge. I stopped talking about illness and I started talking about distress, because everybody else did. One Saturday I went round to a fellow peer support worker's house for a coffee. She began to tell me about her experiences with mental health services, and I began to wonder what her diagnosis was. Her experiences had taken her to wild places and different countries and funny situations. Mine had only taken me to an empty flat and a bed by myself.

At one point over coffee, my fellow peer worker said 'I can't recover, because I was never ill.' It rang in my ears that she thought she was never ill. What did

[3] Permission has been granted by Nottshc's Research and Development Department for the Trust to be named within this research

she mean by that? Of course, she was ill, we were all ill, surely? And there began this gradual unpicking of everything I had learnt at university about mental illness. We had been taught those diagnoses and the DSM criteria as if they were fact, was it possible that they were not? These people who talked about recovery did not seem to use them very much, so I stopped using them too, I got that the labels did not matter, and the person underneath was more important, but I did not yet grasp that the labels were social inventions rather than science.

A few months into working as a peer support worker, I was offered a place on the Recovery and Social Inclusion Masters course at Nottingham University. I read narratives, I read Laing and Szasz, I read Mary Boyle's 'Schizophrenia- a scientific delusion.' The more of other people's narratives I read, the more I got a sense of my own. I began to break free of this idea that our understanding about mental health is set in stone. I had never questioned my diagnoses but now I was coming across the opinions that diagnoses are a form of social control, that mental illness is a social construct, even the view that people exhibit 'mental illness' as a way of caricaturing the ideals of the society they inhabit.

The Masters woke me up to the way we throw around terms such as empowerment and what we actually mean by them. It made me begin to understand the context of peer support and recovery in the NHS and what it means for these things to be absorbed into such a big system. I began to understand these things on an intellectual level but I still enjoyed my job. I understood that there was something sticky about staying in the sick role as a peer, but I liked it there. I also understood that I was employed at a 'Band 3' alongside other peer workers who were highly qualified, but whose qualifications were not taken into account: just their lived experience. I understood and yet I was just grateful to be in the role and I was young, white and privileged enough that I could plan financially later down the line.

Through the MSc, I began to realise that I did not have to accept the version of me that mental health services offered. All this time I had been going once a week to see the mental health team and I began to feel more irritated by the

mental health support I was receiving. I realised that I did not really have any idea of the purpose of my meetings or feel that the conversation was particularly helpful or fulfilling. The more I read about and listened to other peoples' poor experiences of mental health services, the more I recognised my own within them. I was spoken down to, I felt controlled, pathologised and dismissed. I even said that in one meeting to my mental health worker and she was outraged. She said that she did not dismiss me. I suppose it was a little harsh but in those meetings, we had both stopped seeing the other person as human. She saw me as a broken illness and I saw her as a passive monster, trying to poke me for a reaction, checking up on me. And yet I still came to her, because I believed I needed help.

Early on as a peer support worker, I used to say that peer support saved my life. Rather melodramatic I now think, but I was swept up in the excitement that surrounded us peer support workers. And maybe it did save my life, I do not know. It certainly gave me a sense of purpose, it gave my shameful experiences meaning and reason, it gave me a job, several jobs actually, and it funded my Masters. It gave me a 'peer' identity, which is far preferable to a service user identity. 'Peer' opens doors too. While I would never have been able to get a job as a researcher or a mental health trainer, I was employed as a peer-researcher and a peer-trainer without interview. But it is a funny thing to use services and to work in them: on the one hand receiving a message that I wasn't working hard enough on getting better; and on the other a message that I was the embodiment of hope and recovery for others. And really, neither message resting easily with my own perception of myself, but one being very alluring.

Being around people who casually rejected diagnoses, who were cynical about psychiatry (and psychiatrists) opened me up a little. I borrowed a little of their cynicism to try out for myself and I quite liked it. I liked feeling the injustice of how I was treated, I liked having some vantage point to criticise professionals from, to be able to say, it is the service that is wrong and not me. But mostly what was on offer to borrow was positivity and working in respectful relationships with nurses and doctors. Sometimes I was outraged by services,

and saddened by a sagging system, but more often than not, I just got on with it without too much questioning.

In 2014, my appetite for offering peer support had not diminished, but I had become wary and fatigued by the service re-designs and funding cuts that adult mental health services in Nottingham had gone through. I applied to become a peer support development worker because it felt like a way out and a move toward a relatively safe part of the Trust, where supervision and support would be guaranteed. Peer support development workers are based within the HR and Learning and Organisational Development Departments and their roles involve supporting the introduction of peer worker posts, rather than directly offering peer support. They are paid at a band higher than peer support workers, but I did not move because I wanted more power or influence, I moved simply to survive. I had a role which involved developing peer support roles in services outside of adult mental health, including child and adolescent services, mother and baby services and older people's services. I missed the direct peer support role and I felt a new kind of pressure to 'sell' peer support to services and convince people of its value. I became more aware of the weight of a medical culture and the economic pressures. I sat in more meetings about strategy, budgets and culture and I felt weighed down by it, especially as people began to notice that all the 'recovery focussed' ways of working that had been so popular when I was first employed had begun to suffer in the face of shrinking budgets and growing demand for services.

In this role I began my PhD, working on it one day per week. I began with the idea that understanding the mechanisms that underpin peer support as an efficacious intervention was an important missing part of the current literature (Rogers, 2017). While I still believe that the mechanisms require further exploration, my role had made me more aware that context is key; peer support in the NHS is very different to peer support in the third sector, in a crisis house or in non-medical systems. While undertaking my PhD, I moved into the team leader role in the peer support development team. This involves managing a small team, co-facilitating peer support training, as well as other staff training, supervising peer workers, and working with teams to develop

peer support worker roles. I also found that the role involves other things that are designed to contribute to culture change within the organisation. I am asked to speak from a place of lived experience in recovery steering groups, staff training and broad service change projects.

In my current role I hear weekly stories of staffing shortage, burnout, budget constraints, disillusionment and the tone is one of panic. I wonder how peer support can survive, really how compassion can survive in such a climate of scarcity where psychiatry so fiercely guards its expertise and territory. In 2010 when I started as a peer worker, we were aware of the conflicts of working in a medical system, and the compromises it involved to the values of peer support. Nine years on, I feel that those compromises have become larger and harder to bear. I also feel that they are not restricted to peer support workers. Many people feel compromised in their working roles, frustrated that they are not able to be the worker they hoped they would be. And many others decide to leave. The task of culture change given to the role of peer support worker feels less and less tenable.

In this thesis, I explore how peer support is offered, challenged and constrained by and within the context of an NHS Trust. I begin by providing an overview of peer support, including how it has developed within the UK and the research literature and the values which underpin it. My literature review in Chapter three explores the mechanisms which have been identified as underpinning peer support and here I identify the rationale for the importance of context. Following on from this, in Chapter four I describe some of the debates surrounding the employment of peer support workers in medical systems such as the NHS, and the ‘small p’ politics of employing peer workers in general. I use this literature to refine my research questions in Chapter five.

In Chapter six I describe my methodological approach to undertaking research in peer support, drawing on feminist and survivor research as well as critical realism to develop an epistemology which is aligned to my values and those of peer support. I use this to underpin the method I used to undertake my research, described in Chapter seven. Chapter seven also describes the ethical considerations I made during the study, including the formal

governance procedures and the relational ethics concerning my existing associations with participants and my role in the organisation. I have tried to make my reflexive approach to research clear throughout this thesis.

In Chapter eight I present my findings, ordering these using three themes. Each theme is presented using a combination of styles to creatively evoke for the reader what was found, and the messiness inherent in this. Chapter nine is a discussion of these findings, situating them within the wider research on peer support, as well as the political context, and highlighting the unique contribution that this study offers. In Chapter ten, I offer a conclusion.

1.2 The personal impact of undertaking this inquiry

I have tried to maintain a reflexive awareness throughout my thesis of the ways in which my relationship with the area I am studying affects my perceptions, both in helpful and unhelpful ways. I came to this research with some preconceptions about what I would find, based on my growing awareness and discontent with peer support in mental health services. I had read countless critiques of peer support within statutory mental health services from authors who believed that peer support would be heavily compromised within medical/institutional settings. I was personally affected by these critiques and they had left me questioning whether my role within peer support in the NHS was doing more harm than good.

I saw that peer workers were not able to work in ‘mutual’ ways that the literature said they should, because when one person is employed to support another, the power balance cannot be equal. I saw this as proof that peer support had failed, because I suspected that having power could never be positive within peer support relationships. I also talked to peer workers who used the language of medicine, and I saw this as more evidence that the peer workforce had been absorbed into the NHS culture. These concerns about peer support in the NHS left me with a simultaneous urge to conceal how peer support had been compromised, and to expose it to the world.

I am relieved that I was aware of the axes I was preparing to grind before I began my research interviews. This awareness, coupled with supervision and my own reflexive process, helped me to set them down and learn from the experiences of the peer workers I interviewed, rather than assume that I knew what they were going to say, and use it as fuel for my own anger. The peer workers talked about the ways that they had found to cope and to thrive within a stretched system. They too recognised some of the compromises that peer support has had to make, and while some were angry about this, others were pragmatic. Many peer workers described issues with the peer identity, or with working in the system that I had not considered, and this rounded my own perception of peer support. They explained to me how power is not inherently bad or good, and how sometimes using medical language is the best way of being heard in a medical system. Their collective voice showed me that peer support is far more nuanced, messy and beautiful than my dwindling and challenged perceptions allowed.

Because my study is about my own area of practice it has been vital that I remain aware of the judgements and expectations that I hold about peer support, so that I may be transparent and explicit about my collection and interpretation of my data. Although there are likely to be times where I did not achieve this in the way I had hoped to, for the most part, I believe I have been able to make use of my peer support standpoint to offer sensitive critical analytical and robust insight.

Chapter 2 - An Overview of Peer Support in UK Mental Health Services[4]

2.1 Introduction

In mental health, 'peer support' is the support provided and received by people who have their own experiences of distress and recovery. It is considered to be a 'mutual' approach, in that it does not invite the overt power hierarchies that are involved in professional helping relationships, where one person has expertise over the other. In this chapter, I provide an introduction to peer support in the UK, including a brief history of how peer support workers came to be employed within mental health services. I also explore the policy and evidence which supports the introduction of peer support workers, as well as the work that has been undertaken to clearly articulate the values base which peer workers should employ in their work. Because my research is based in Nottinghamshire Healthcare NHS Foundation Trust, I also provide a local overview of how peer support has developed and how it is currently offered by peer support workers within mental health teams.

2.2 The introduction of peer support workers into UK mental health services

The roots of peer support reach far back into the histories of psychiatry, social change movements, self-help and survivor-led initiatives. They lie most deeply in the self-help, hearing voices and service user movements which predominantly unfolded during the twentieth century.

The growth of the survivor and hearing voices movements in the 1970s created an influx of narratives of service use, abuse, trauma and recovery. These narratives challenged the assertion that recovery is something that professionals affect, something that can be done to an individual, and argued that recovery is something that individuals must do for themselves (Chamberlin, 1978). The understanding of recovery which has emerged from

[4] Extracts from this chapter have been published in Watson, E. (2019) What is peer support? History, Evidence and Values. In: Watson, E. & Meddings, S. (Eds) (2019) *Peer Support in Mental Health.* London: Red Globe Press (p.6-20.)

the narratives of people who have lived through experiences of distress and madness has a radically different focus from clinical recovery. The centrality of hope, identity and personal responsibility has replaced the focus on functioning, symptoms and interventions (Ralph, 2000).

The importance of support from those who have also experienced mental distress has become a common theme within survivor narratives. This early message has since been reiterated by countless others who describe the helpfulness of informal (peer) support from other survivors. For example, Mary O'Hagan (2014) writes:

> *'Over the years I met many good people who were mad like me. Their madness had taken them to a foreign land where only mad people could go to…Mental health professionals stood at the border trying to pull people out of the mad land, even the ones who wanted to stay. They knew the mad land was a bad place where people get lost, sometimes forever. But most of them had never been there. My peers showed me that the mad land, for all its perils, had some of the most enchanted scenery in the world. Like a land that has mountains and ravines, rivers and caves, blinding sun and swirling storms, the mad land could be a place of beauty as well as danger. My peers helped me to understand that I was not alone in the mad land, that there was a whole tribe of us who had been there and seen many of the same things. Things that other people did not easily understand. Things they feared and denigrated.'* (p.111)

In the 21st Century, the potential of peer support to inspire hope and support the recovery of people using mental health services has been recognised by a number of mental health service providers, leading to the widespread creation of peer worker roles in the US (Davidson et al., 2012), Australia (Franke et al., 2010), New Zealand (Scott et al., 2011) and Europe (Castelein et al., 2008). Peer worker roles have now been established within most NHS Trusts in the UK, and peer support has been included within commissioning

and policy documents worldwide (e.g. JCPMH, 2012; MHC Canada, 2012; NICE, 2016).

Nottshc employed its first peer workers in 2010, a time when several NHS Trusts around the country were beginning to introduce peer support workers into their workforce. The opening of Recovery Colleges (Perkins et al., 2012) created more opportunities for peer support roles and pilot projects helped this role to become established in mental health teams. Nottshc now employs approximately fifty-five peer workers in various roles, including within the recovery college campuses, Child and Adolescent services, Mother and Baby services, and inpatient and community adult mental health services. Initiatives and policies relating to recovery have advised the introduction of peer workers throughout the workforce. This is the case both nationally and locally.

2.3 Peer support in local and national policy

Government policy relating to peer support was preceded by publications from influential institutions, including the Mental Health Commission of Ireland (Mental Health Commission, 2008), ImROC (Implementing Recovery through Organisational Change; Shepherd et al., 2008), Together (2010), the Scottish Recovery Network (2011), the Mental Health Foundation (2012a, 2012b) and The King's Fund (Foot et al. 2014, Hibbard & Gilburt, 2014, Gilburt, 2015), all of whom recommended the introduction of formal peer support worker roles into mental health services. The National Institute for Health and Care Excellence recommended that peer support by paid, trained and well supported peer workers should be considered for people experiencing psychosis. It also acknowledged that there is a need to better understand the impact of peer support and how this can be optimised (NICE, 2014).

In England and Wales in 2016, the independent mental health task force acknowledged that previous policy initiatives had been largely unsuccessful in their goals of transforming mental health services and improving outcomes for people who use them (NHS England, 2016a). This report offered a Five-Year Forward View for mental health services, based on the views of care leaders

and people using and working in mental health services. The report contained nine references to peer support, including:

> *'Everybody in mental health services should be able to say […] I am provided with peer support contact with people with their own experience of mental health problems and of using mental health services. I can find peer support from people who understand my culture and identity. Peer support is available at any point in my fluctuating health – in a crisis, during recovery, and when I am managing being well.'* (p. 37)

Despite this report, the subsequent implementation plan contained only one reference to peer support in relation to their employment in crisis and acute care pathways (NHS England, 2016b)

In Nottshc, peer support was included in the Trust's first recovery strategy in 2009. This strategy focussed on Adult Mental Health services and advocated for the employment of peer support workers and the development of a recovery college. The second recovery strategy widened its focus to all Trust divisions and recommended that there should be two peer support workers employed in each clinical team across the Trust. In a 2015 report, the CQC recognised recovery to be a 'signature' of the Trust, and that it is evident in practices throughout services. The Trust is also host to ImROC programme which supports services to develop recovery focused cultures, practices and systems. In its newest recovery strategy (Nottshc, 2016a), there are 29 references to peer support; it is identified alongside seven other areas as a key priority for the development of recovery in the Trust. Despite this, the current Trust strategy (Nottshc, 2016b) contains no reference to peer support workers; this parallels the national context, where the intentions of the mental health taskforce were not translated into implementation. The Trust has identified four strategic objectives, including a goal to 'make the Trust a great place to work.' Within this objective, it states that the Trust will 'improve the diversity of our workforce to reflect the diverse communities we serve.' There is some opportunity for peer support to be considered within this objective.

2.4 Peer Support Worker roles at Nottshc

In 2010, Nottshc employed 10 peer support workers in community and inpatient adult mental health services as a pilot project. Following this, eight more peer workers were employed in adult mental health community teams. In these first few years of employing peer support workers, evaluation projects were undertaken in order to establish best practice and explore the challenges that peer workers faced (Repper & Watson, 2012a,b). The evaluation reports also described the expected roles of peer support workers, which predominantly involved offering one to one relationships with people under the care of the mental health teams in which peer workers were based. People could self-refer to peer support workers, or could be referred by a member of staff, for example their Community Psychiatric Nurse (CPN) or psychiatrist. Over the past decade, the Trust has increased the number of peer support worker roles within its services. It now employs approximately fifty-five peer workers in different services. In each of these roles, peer workers bring lived experience that is relevant to the service (for example in perinatal mental health, peer workers have used perinatal mental health services). They use this experience to offer one to one and group support to people receiving the service. Support can involve practical and social support, for example, helping a person to build social connections, or helping someone to access benefits or do their food shopping. The length of peer to peer relationships varies depending on the service setting. On an inpatient ward, peer workers can work with somebody until they are discharged, in other areas, peer workers may have a specific time limit, for example twelve weeks, to work with someone. These time limits help peer workers manage the demand for their time.

Peer support workers all receive peer worker training, lasting ten days, to support them in their role. This training is provided by the peer support development team, based in the Trust's learning and development department. The training covers the eight core principles of peer support (see below; Repper, 2013) as well as skills including active listening, strengths spotting, how to share lived experience, wellbeing plans, group facilitation, working in clinical systems, building and ending relationships, and exploring

personal and professional boundaries. Each student has to meet five competencies relating to their work experience and classroom reflections. These are:

- Reflect on the development of your listening and communication skills
- Demonstrate an understanding of recovery focussed peer support
- Demonstrate an understanding of a person's life outside of mental health services
- Use personal experience of recovery when supporting people and talking to staff
- Demonstrate an ability to use strategies to support personal wellbeing during placement

Students are supported to meet these by a mentor in their workplace and a member of the peer support development team.

Ongoing support for peer workers is provided by their line manager and the peer support development team. As 'Band 3' members of staff, peer workers receive supervision and annual reviews in the same way as other members of a clinical team. In addition to this, peer workers receive monthly peer support supervision which is facilitated by a member of the peer support development team, most often me in my role as team lead. This supervision provides an opportunity to reflect on peer support practice, how it is developing and the barriers or challenges that peer workers encounter. The peer support development team also facilitate quarterly peer support development days, which peer workers are expected to attend. These involve guest speakers, updates on developments within the Trust and space for reflection and developing new ideas within peer support.

2.5 The principles and values involved in peer support

There is a growing argument that the distinctiveness of peer support is due to a unique set of values which have emerged from the organic support offered to and by people with experiences of emotional distress (Mead & Macneil, 2004). As peer support has grown into a more formal approach, there have

been many attempts to describe and define these values as a way of protecting its uniqueness.

In New Zealand, survivor and activist Mary O'Hagan and her colleagues (2009) established three values which they believe are central to peer support:

- A commitment to consumer/survivor choice and control over peer support, at individual and organisational levels
- Identification with each other – a sense of mutuality, camaraderie and acceptance between peers, reciprocal roles of helping and learning, and minimal distinction between 'staff and clients'
- A holistic understanding of madness – emphasising the whole of life, a strengths rather than illness focus, and confirming the validity of personal experience

In the USA the Intentional Peer Support programme has defined peer support as (Filson & Mead, 2016):

A shift in focus from:

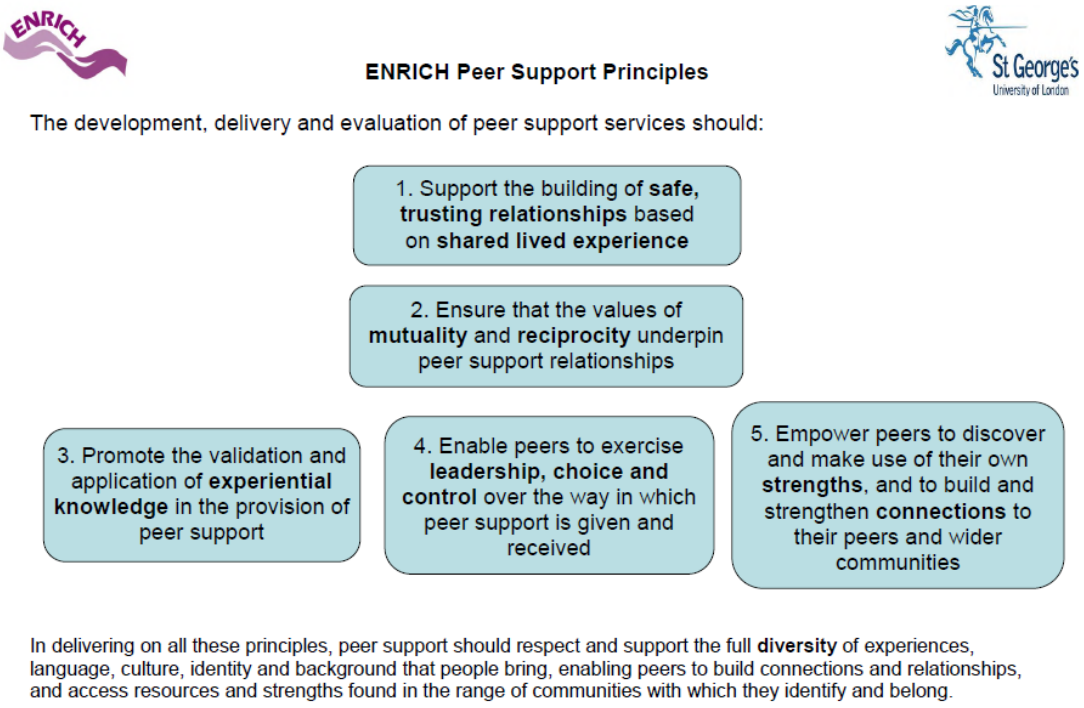
- Helping (problem solving or fixing) to Learning Together
- The individual to the relationship
- Fear-based responses to Hope-based responses

From their work in supporting organisations wishing to employ, support and evaluate the impact of peer workers, ImROC (https://imroc.org/), a not-for-profit organisation, developed eight 'core principles' of peer support (Repper, 2013):

- Recovery-focused – supporting people to have hope, control and opportunities in their recovery
- Mutual – through shared experience of service use and recovery, peer support relationships are non-hierarchical

- Reciprocal – both people in a peer relationship share experiences and benefit from the other person's experiences rather than claiming expertise over each other
- Strengths-based – viewing experience as a source of strength and exploring a person's skills and assets which they can use in their recovery
- Non-directive – not prescribing solutions or courses of action but allowing an individual to find the solutions and understandings which work for them as experts in their own experiences
- Safe – cultivating emotional safety through negotiation of boundaries, a non-judgemental attitude and respect
- Inclusive – of different experiences and circumstances, helping a person to connect with the communities which are important to them using a shared understanding of stigmatised identities
- Progressive – rather than being a static friendship, peer support enables people to build further connections and move forward in their recovery

The core principles established by O'Hagan, Filson and Mead, and ImROC are three attempts to articulate the values base which underpins peer support. Values have also been identified by charity, government- and consumer-led services in the USA, Europe and the UK. The resulting frameworks have been used to evaluate and understand peer support projects. One of the most recent and comprehensive attempts to establish a values base, which underpins peer support, has been the 'ENRICH' project (Gillard et al., 2017). This used an extensive literature review alongside consultation with peer support providers and experts in the field to establish five 'fidelity criteria' by which peer support can be evaluated, and as a tool for reflection (Figure 2; Gillard et al., 2017; reproduced with permission).



A clear understanding of the values which underpin peer support relationships is helpful in communicating the approach a peer worker may take. Rather than focusing on specific tasks and responsibilities of a peer worker, focusing on how these are undertaken, using particular values and principles, offers a deeper understanding of the varied roles a peer worker may fulfil – it is not what you do, but the way you do it.

2.6 The evidence base for peer support

Reviews describe the positive impact of peer support on the person providing it, the person receiving it and for the service that they work within (Davidson et al., 2012; Repper & Carter, 2011). These reports used evidence from both randomised controlled trials (RCTs) and qualitative studies. Peer workers can reduce readmission rates and provide a range of positive outcomes for people receiving peer support, including increased levels of empowerment and social functioning and decreased stigma. Research also shows that working as a peer worker can increase self-esteem and support a person's continuing recovery.

The benefits for people receiving peer support range from decreased hospital admissions and relapse rates as well as increased early discharge from inpatient settings (Chinman et al., 2001; Clarke et al., 2000; Forchuk et al., 2005) to emotional benefits such as increased empowerment and hope and social functioning (Corrigan, 2006; Ochocka et al., 2006; Salzer, 2002). This could be attributed to the new ways of thinking and behaving that occur when reciprocal peer relationships are developed (Davidson et al., 1999; Kurtz, 1990). In both cross-sectional and longitudinal studies, members of peer support initiatives have reported greater community integration, more social support and an increased sense of control, compared with participants not receiving peer support (Davidson et al., 2012; Forchuk et al., 2005; Lawn et al., 2008; Ochocka et al., 2006; Trainor et al., 1997).

The social support provided by a peer relationship promotes feelings of empathy, hope and acceptance through a sharing relationship (Davidson et al., 1999, 2006). People receiving peer support have reported greater feelings of being accepted and liked compared with individuals receiving traditional care (Sells et al., 2006; Mowbray et al., 1998). In a qualitative review of the experiences of 52 people offering and receiving peer support across five organisations in England, Faulkner and Basset (2010) found that peer support benefited people by offering them a sense of shared identity, increasing their confidence, breaking down stigma, signposting them to other opportunities and giving them the opportunity to help others by sharing skills and experience.

More recently, work in the UK has investigated the cost-saving potential of employing peer support workers into the inpatient care pathway. Trachtenberg and colleagues (2013) identified six studies which provided information about the relationship between peer support and inpatient bed use. By using the cost of an average day for an inpatient bed in the UK and the salaries of peer support workers reported by each study, they created a ratio of pay cost versus money saved. Although there was a high level of variability between studies, the average ratio was found to be 3.81:1. So, for every £1 spent on peer support, £3.81 can potentially be saved.

More work is required to assess the relative value of peer versus professional services and to understand the underlying mechanisms which are causal to the outcomes of peer support (Watson, 2017). Many have expressed challenges in synthesising data across studies due to differences in the way peer support is provided and evaluated (Lloyd-Evans et al., 2014; Repper & Carter, 2011).

Recent reviews of solely quantitative evidence have presented more conservative findings of the benefits of peer support, in general concluding that peer support leads to the same or slightly better outcomes than traditional mental health services. A recent review, based on meta-analyses and systematic reviews of studies on peer services in the last 25 years (Bellamy et al., 2017), found that peer support results in at least equivalent outcomes to traditional mental health services, providing increased hope, recovery and empowerment and decreased hospital admissions. This review concludes with a call for more rigorous research, which may well identify a clearer picture of the benefits of peer support versus clinical support. It is difficult to establish an evidence base for peer support in part due to a lack of clarity about what exactly distinguishes it from the care provided by 'non-peer' staff. Reviewers have noted an absence of information about what peer workers do, in what way it is 'unique' and how it might facilitate positive outcomes (Lloyd-Evans et al., 2014; Pitt et al., 2013). The focus on outcomes rather than process within the research on peer support is further explored in Chapter four.

Despite the need for a more concrete understanding of peer support, a recent RCT exploring the use of peer support for people discharged from mental health crisis teams across the UK, found that readmission rates were lower and the time in between admissions was longer for people who received peer support, compared with the control group who received a wellness planning workbook in the post. The research also found that those who received peer support rated their satisfaction with mental health services more highly and scored higher on self-rated measures of recovery (Johnson et al., 2018). In line with previous research, the authors call for a better understanding of the mechanisms that underpin peer support, as well as a clearer understanding of

how to embed and sustain peer support approaches within mental health services.

More attention must be paid to understanding the process and values that underpin peer support, what makes it unique and the mechanisms of change which underpin peer support relationships. Examination of these factors is essential for three reasons. First, to better understand what can be meaningfully measured within peer support as evidence of its impact. Second, to understand what exactly is unique to peer support and thus whether what is being measured is actually different to the support offered by other helping roles. Finally, to understand what elements of peer relationships are efficacious, which could inform other helping professions and our understanding of how, and by whom, support can best be provided. There is also a need to understand the concept of 'peer'. This is often narrowly defined as being based on shared lived experience; however, who is a peer to each of us differs, depending on other factors including race, culture, age, gender and class. A clearer understanding of this is important so that peer support and peer workers are not defined by their experience of mental distress alone:

> *'if peer workers are going to be introduced into mainstream mental health services anyway, irrespective of whether we think that is desirable or not, is it not morally important to somehow ensure that peer support is delivered in a way which is potentially as beneficial as possible for those involved?'* (Gillard et al., 2017, p. 136).

For these reasons, in the following chapter, I review the literature relating to the process of peer support, in an effort to determine from this literature its underlying mechanisms.

Chapter 3 - Literature Review: the mechanisms underpinning peer support[5]

3.1 Introduction

In the previous chapter, I described the evidence relating to the employment of peer support workers. It has been found that peer workers can promote recovery at an individual and organisational level. While research examining the benefits of peer support within mental health services continues to grow, an understanding of how, and through what processes, these benefits are reached remains under-developed.

This chapter aims to scope the existing research into the mechanisms or processes which underpin one-to-one peer support relationships in mental health. I will employ the critical realist concept of mechanisms which are used as a means of describing social causality. Bhaskar (1998) defines a mechanism as a causal structure that explains a phenomenon. While in physical science, mechanisms are deterministic, critical realism identifies that social systems and structures can be causal in that under certain conditions they may contribute to given outcomes. Critical realism argues that the conventional approach of observing regularities and correlations in order to isolate causation is misguided. Rather, that explanation depends on identifying causal mechanisms as well as understanding how and under what conditions these may be activated.

Critical realism also contends that the outcome of any mechanism activation is contextual, in that it may produce different outcomes in different contexts, depending on the presence of other mechanisms and the manner in which they interact. This focus on mechanisms acknowledges that, depending on the context, peer support relationships unfold in different ways, leading to different outcomes that can be positive, negative or neutral. Some have argued that before any meaningful focus on outcomes in peer support can be developed, understanding the mechanisms that underpin peer relationships is vital

[5] Parts of this literature review have been published in: Watson, E., (2017). The mechanisms underpinning peer support: a literature review. *Journal of Mental Health*, 28(6) 1-12.

(Rogers, 2017). Further, some argue that, in the search for broadly applicable, measurable effects, the focus on outcomes in peer support misses what people receiving support identify as important (Gillard et al., 2017). In the current review, mechanisms were found to underpin peer support relationships (lived experience; love labour; the liminal position of the peer worker; strengths-focussed social and practical support; and, the helper role). The identified mechanisms can underpin both the success and difficulties associated with peer support relationships.

Mays, Roberts and Popay (2001) describe scoping reviews as a means to 'map rapidly the key concepts underpinning a research area […] especially where an area is complex or has not been reviewed comprehensively before.' (p.194) As a scoping review, the focus will be limited to published, peer-reviewed literature, which may provide a starting point for further systematic reviews.

3.2 Method

3.2.1 The literature search

The ASSIA, PsychInfo, Cinahl, Web of Science, Embase, Cochrane Library, Google Scholar and Medline databases were searched, up until January 2017. The following keyword search strategies were combined:

> Peer support* OR peer expert OR peer provide* OR expert ADJ experience OR using lived experience OR using lived expertise OR peer navigator OR mutual support OR consumer survivor OR consumer provide* OR peer specialist OR consumer-operated services OR consumer-employee OR service user workforce (Abstract)
>
> AND relationship* OR mechanism* OR character* (full text)
>
> AND mental health OR mental illness OR mental distress OR mental disorder OR schizophrenia OR depression OR personality disorder OR OCD OR eating disorder OR anorexia OR bulimia OR addiction OR psychosis (full text)

AND client* OR service user* OR patient* OR consumer* (full text)

Search terms included some diagnostic terms as well as broader terms within full texts of articles, with the aim of capturing the full spectrum of papers relating to peer support in mental health. Some papers focussing on specific diagnostic categories may have been missed, however search terms were felt to be inclusive enough to ensure the inclusion of research relating to a variety of mental health populations.

Equivalent searches were used in each database. In addition, reference lists of identified articles were hand-searched to identify further literature. 10 Leading researchers in the field of recovery and peer support were also contacted with a request to provide additional relevant research papers. These researchers were based within the UK, USA, New Zealand, Australia, Canada and Norway.

3.2.2 Inclusion and exclusion criteria

The search targeted research which had aims relating to the examination of the components, nature or processes of adult (over 18 years) peer relationships, their defining characteristics and the mechanisms (understood within a critical realist epistemology) by which peer support is successful. Papers including samples of peer workers, non-peer staff and peers were included.

To retain the focus for this scoping review, studies on peer support in physical health, peer involvement in research, group or carer peer support were excluded as these are likely to involve different mechanisms and processes. Because the identity and underlying philosophy of peer support is becoming more clearly established, papers which described informal peer support and befriending were excluded.

Research examining peer support outcomes, rather than the process of peer support, was also excluded, as were papers where the focus was not specifically on the process of peer support. For example, papers describing

the implementation of peer support projects, or papers with a broad focus on recovery, which identified peer support as one of the important factors, were also excluded. For the purposes of this review, these criteria limited the focus to studies exploring the nature of one-to-one peer support in mental health. A broader scope, which might have included carer or group peer support, as well as outcomes-focussed papers, might have lessened the likelihood of overlooking relevant research, but would also have generated an unmanageably large number of search results. Only papers written in English in peer reviewed journals were reviewed, and no date range was specified within the search.

Inclusion and exclusion criteria were defined and reviewed by the author with the support of academic supervisors to verify paper selection decisions. They were established and refined as a framework to enable the most directly relevant papers to the conceptual area to be accessed.

3.2.3 Paper retrieval

The process of identifying relevant papers is summarised in Figure 3.1. The total number of participants across the studies is 368; 248 of these were peer workers, 31 were non-peer mental health workers, and 89 were people receiving peer support. The participants were members of thirteen qualitative studies which ranged in sample size between 6 and 71 participants. Although quantitative papers were not excluded, none were found to meet the inclusion criteria, possibly because quantitative methods have been largely used to measure outcome rather than process. Three studies used data from the same population of peer workers for each of their investigations. These were included despite the possible influence it would have on the synthesis because each paper offered a distinct focus, and met the inclusion criteria. Table 1 (Appendix A) summarises the information, method and key findings for each study selected for review.

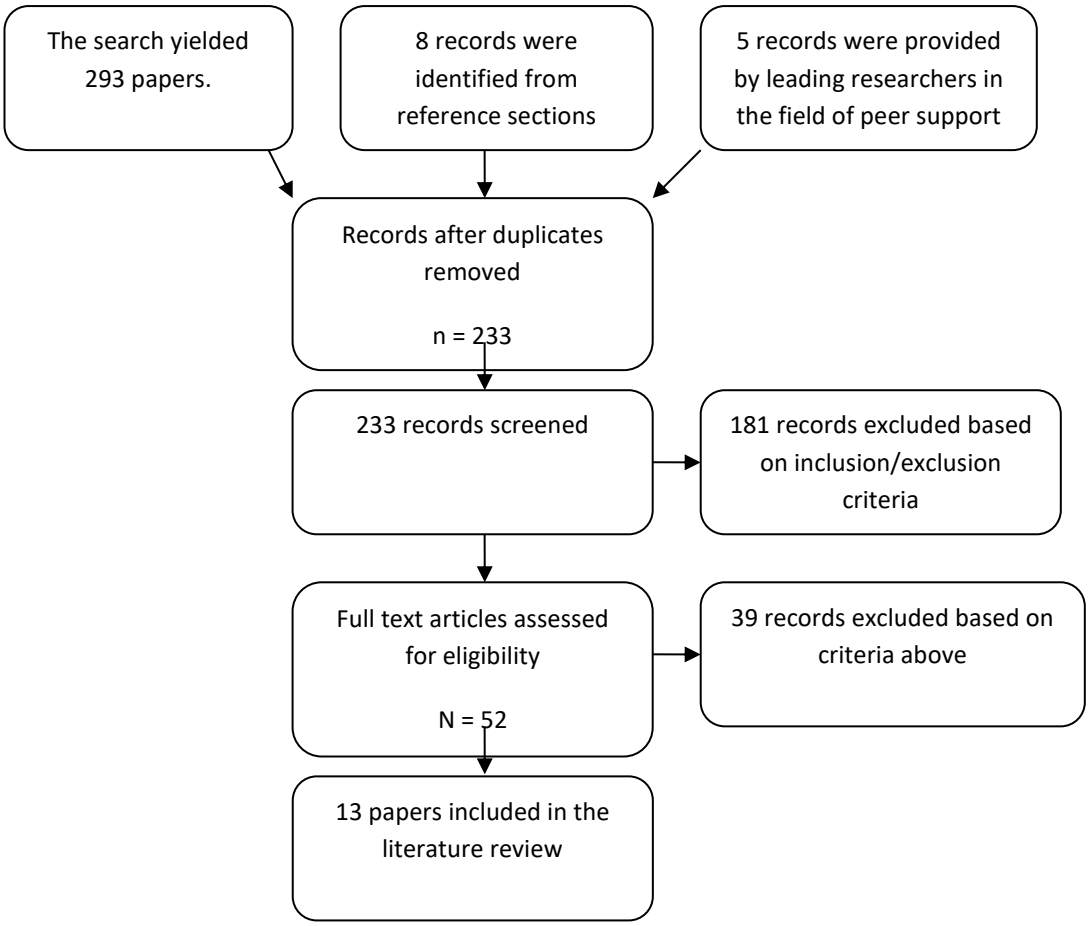


Figure 3.1. Flow diagram displaying the process of identifying relevant papers for the review

3.2.4 Synthesis of findings

Thematic synthesis of findings was used to identify mechanisms underpinning peer support across and within studies. This involves three stages: free coding of the studies' findings; creating 'descriptive' themes based on free codes; and developing 'analytical' themes (Thomas & Harden, 2008). Generating analytical themes involves 'going beyond' the original findings of each study by using the descriptive themes, in this case to infer the mechanisms which underpin peer support (Sandelowski & Barroso, 2007).

Thematic synthesis is a particularly appropriate method for this review as only four studies employed the concept of mechanisms. Where mechanisms were named, these were integrated into descriptive themes which later contributed to the identification of mechanisms involved in peer support. Themes were

identified and mechanisms were inferred by the author with the support of academic supervisors.

A variety of terms have been used in the studies to refer to the peer worker role (highlighted in Table 1). For ease of reading the term peer worker will be used to describe the peer support role, and the term ‘peer’ will be used to describe any person who received peer support.

3.3 Findings

3.3.1 Overview of the reviewed studies

The majority of peer workers within the studies were in paid roles, with seven studies using samples of paid peer workers and five studies using a combination of paid and volunteer roles (Scott, 2011; Scott et al., 2011; Scott & Doughty, 2012; Gillard et al., 2015a; Rebeiro Gruhl et al., 2016). One did not specify whether peer workers were paid or in voluntary roles (Coatsworth-Puspoky et al. 2006). Six of the studies used samples of peer workers from a mixture of settings, including statutory services and peer-run organisations, while the remaining seven recruited peer workers from a single organisational context.

Four studies did not provide information on whether peer workers had received training (Austin et al., 2014; Mancini & Lawson, 2009; Coatsworth-Puspoky et al., 2006; Gillard et al., 2015a). Four studies stated that peer workers had received training but provided no further information relating to this (Repper & Watson, 2012; Moran et al., 2011; Proudfoot et al., 2015; Rebeiro Gruhl et al., 2016. The remaining five studies provided information about training. This varied in length but generally focussed on underpinning principles including developing relationships by building on strengths and identifying needs (Scott, 2011; Scott & Doughty, 2012; Scott et al., 2011; Gidugu et al., 2015; Mourra et al., 2014).

The peer worker’s roles depended on the setting that they worked within. Within most studies, the peer worker roles were spread throughout different

organisations, so that PSWs performed various duties including managing teams, providing advocacy, crisis support and coaching (Austin et al., 2014; Gillard et al., 2015a; Mancini & Lawson, 2009; Moran et al., 2011; Rebeiro Gruhl et al., 2016; Scott, 2011; Scott & Doughty, 2012; Scott et al., 2011). Repper & Watson (2012) used a sample of PSWs who were all based within an NHS mental health service.

3.3.2 Thematic synthesis to establish mechanisms involved in peer support relationships

Table 2 illustrates the papers from which each mechanism was drawn. For clarity of presentation, numbers have been allocated to each study in Table 2. These numbers correspond to the numbers used in Table 1.

Mechanisms	**Papers**												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Use of lived experience	x	x	x	x	x		x	x	x	x	x	x	x
love labour	x	x				x	x	x	x	x	x		
a liminal position	x	x			x	x		x	x		x	x	x
strengths based social and practical support	x							x	x	x	x	x	
The helper role			x		x				x		x		x

Table 2- to illustrate which article contributed to each analytical theme

Five mechanisms relating to the process of peer support were identified during thematic synthesis. The first of these mechanisms 'the use of lived experience' contains two sub-themes.

1. The use of lived experience
2. Love labour
3. The peer worker's 'liminal' position
4. The provision of strengths focussed, social and practical support
5. The Helper role

During the process of synthesis, it became apparent that the identified mechanisms could contribute both positively and negatively to peer support relationships.

3.3.3 The use of lived experience

The defining feature of peer support is the use of lived experience. Every study in this review referred to the importance of this, and it emerged as the strongest mechanism underpinning peer support. Thematic synthesis revealed that peer workers use their lived experience in two different ways:

a. Peer workers explicitly share their experiences

Seven studies described the importance of shared experience. In particular, the honest sharing of emotions such as anger and guilt in relation to particular experiences enabled peers to build connections and to feel 'normal,' as others had experienced these too (Gidugu et al., 2015; Gillard et al., 2015a; Rebeiro Gruhl et al., 2016). Repper and Watson (2012) reported that sharing experiences ultimately promotes hope within peer support relationships.

The notion that sharing lived experiences earns peer workers credibility among peers was highlighted by Mourra et al. (2014) and Austin et al. (2014). In Austin et al. (2014), peer workers stated that establishing credibility was their main objective of sharing their experiences. Similarly, Proudfoot et al. (2012) found that the credible information given by peer workers using email support was helpful in supporting peers to gain a sense of what it feels like to live with a diagnosis of bipolar disorder.

Within the studies, there were also two instances where peers had described relationships in which their peer worker had not shared their experiences. This led peers to feel dissatisfaction with peer support because of their expectations that peer workers will openly share their experiences (Gidugu et al., 2015; Coatsworth-Puspoky et al., 2006)

b. Peer workers implicitly draw on their experiences of what works and what does not

Five studies highlighted the finding that peer workers often make an active choice to temper their approach based on their experience of what is and is not helpful (Austin et al., 2014; Coatsworth-Puspoky et al., 2006; Mourra et al., 2014; Scott, 2011; Scott & Doughty, 2012). Peer workers have experiences of being treated in ways which they experienced as unhelpful or alienating, and so they consciously develop a distinctive approach that is different to the care they received.

Mourra et al. (2014) interviewed seven peer workers to investigate their experiences of developing relationships with peers. They found that peer workers described an approach of not wanting to 'prescribe for' or 'treat' people, as they believed mutual relationships to be more helpful. Conversely, two studies found that when peers perceived their supporters as unnecessarily enforcing a power dynamic, or as being controlling, it resulted in a loss of connection and a deterioration of the peer support relationship (Coatsworth-Puspoky et al., 2006; Scott, 2011).

The use of lived experience was found to affect both the peer receiving support and the peer worker who offered their experiences, indicating that this is a mechanism which underpins outcomes for both groups. Moran et al. (2011) notes that the process of using experiences of recovery in a formal role transforms that which is most stigmatised into an asset. This allows a shift in identity from one rooted in shame to one rooted in pride. Furthermore, sharing experiences transforms that which has been most traumatic into that which is worthwhile. Four studies found that peer workers took great comfort in the knowledge that their own experiences of distress and using services had been valuable, and were being put to good use (Austin et al., 2014; Moran et al., 2011; Rebeiro Gruhl et al., 2016; Scott & Doughty, 2012).

3.3.4 Love labour

‘Love labour,’ ‘emotional labour’, or ‘emotion work’ were directly described, or alluded to, within six studies. Emotional labour is required in employment which involves face to face contact with the public, which requires an employee to maintain a particular professional boundary, while affecting the emotional state of another person (Hochschild, 1983).

Mancini and Lawson (2009) hypothesise that peer workers are required to engage in ‘deep acting’ rather than ‘surface acting’ described by Hochschild (1983), where a person experiences (rather than acts) the emotions which they display. Scott (2011) argues that while emotional labour is relevant, the idea that it involves a level of ‘acting’ is not consistent with the peer support relationships she explored, where emotional honesty appeared to be a crucial component.

In acknowledgement of this, Scott (2011) favours the concept of ‘love labour’ to more accurately describe the work which takes place within peer support relationships to ensure emotional safety for both parties. Love labour is defined as ‘‘emotionally engaged work that has as its principle goal the survival, development and/or wellbeing of the other’’ (Lynch, 2007, p.557). Within the reviewed studies, the principle goal of peer support was not simply the wellbeing of the other, but the wellbeing of both peer worker and peer, as the peer worker’s own recovery becomes fused with their role, and the recovery of the peers they support. Peer workers are more inclined than other mental health professionals to feel emotionally bound to a peer as part of the process of ‘walking alongside’ them in their recovery. Establishing this strong emotional connection was found to be a clear mechanism for peer and peer worker outcomes.

Coatsworth-Puspoky et al. (2006) found that those in receipt of peer support valued the peer workers’ approach of emotional honesty, a component of love labour. Scott (2011) and Mourra et al. (2014) identify the high level of skill which is needed to work in a role which requires love labour. The ability of the peer worker to consistently carry out positive love labour is of vital importance

to their wellbeing, and their sense of success in the role. Mancini and Lawson (2009) found that the peer worker's use of love labour (conceptualised as emotional labour) can enhance their work effectiveness, personal accomplishment, self-worth and levels of wellbeing, and this is echoed in other studies (Mourra et al., 2014; Proudfoot et al., 2015; Scott, 2011).

Alongside these beneficial outcomes, studies identified the challenging nature of love labour for peer workers. Mourra et al. (2014) found high levels of self-blame relating to 'bad outcomes' among peer workers. They concluded that peer workers are more likely to interpret the fluctuating wellbeing of those they support in relation to their own effectiveness as a peer worker. This increases the personal value and risk of the peer worker role relative to traditional professional roles. Mourra et al. (2014) hypothesised that this was due to the perception of peer workers that their lived experience and their personal identity act as their main 'qualifications'. The requirement to use their whole selves in order to role model recovery places pressure on peer workers to maintain their own wellbeing for the sake of another. This is especially likely given the emotional closeness of peer worker-peer relationships which might create difficulties in finding distance from the experiences of others (Mancini & Lawson, 2009).

3.3.5 A liminal position within mental health services

The unique position of a peer worker, both within society and within mental health services was found by eight studies to contribute to their relationships with peers. Scott et al. (2011) describe peer workers as occupying a 'liminal space' in that they exist in-between two distinct identities; the role of service user and the role of mental health worker. This liminal space also applies in the sense that peer workers exist between those who are included as within society and those who are stigmatised or marginalised. Importantly, this position offers peer workers the opportunity to role model recovery in two contexts; with mental health professionals, and with the peers they support, providing both groups with the opportunity to work with a living example of recovery with all the challenges and successes which this entails.

Rebeiro Gruhl et al. (2016) describe this as acting as ‘society’s mirror’ and Gillard et al. (2015a) use the concept of a ‘bridging function’. For peers, the peer workers embodied their own hopes for recovery by occupying a role which integrated ‘service user’ and ‘worker’ identities (Gidugu et al., 2015; Gillard et al. 2015a; Mourra et al., 2014; Proudfoot et al., 2012; Scott et al., 2011). In other studies, peer workers used their liminal position to support peers by communicating with other mental health workers (Gillard et al. 2015a; Repper & Watson, 2012).

The peer worker’s liminal position within mental health services provided them with an opportunity to revisit their experiences of service use and reconnect with these systems from a different position. Three studies mentioned the powerful process of entering mental health services as a provider and user for peer worker. Peer workers described coming to terms with the mental health system as an important part of their recovery (Austin et al., 2014; Proudfoot et al., 2015).

Mancini and Lawson (2009) uncovered some of the difficulties involved in the liminal identity of peer worker, including being reminded of previous experiences of distress relating to mental health services. One peer worker shared that he and many of his peer worker colleagues experienced high levels of anger while working due to the witnessing of others’ oppression which was reminiscent of his own experiences within mental health services. This is an added facet of the emotional connection, or love labour that underpins the peer worker role.

3.3.6 Strengths focussed social and practical support

Six studies highlighted the role of peer workers in offering social and practical support (Coatsworth-Puspoky et al., 2006; Gidugu et al., 2015; Gillard et al. 2015a; Mourra et al., 2014; Proudfoot et al., 2012; Repper & Watson, 2010). The practical support described by studies ranged from help accessing suitable benefits, attending appointments and managing medication, to support with shopping or laundry (Gidugu et al., 2015; Repper & Watson, 2010). Social support was skilfully offered through making easy, non-directive

conversation between each other (Gidugu et al., 2015; Mourra et al., 2014; Proudfoot et al., 2012; Repper & Watson, 2010). The importance of this support as a means of achieving other outcomes was described within the five papers. Both Gidugu et al. (2015) and Repper and Watson (2012) identified the provision of practical and social support as core components of the peer worker role. Gidugu et al. (2015) found that these forms of support were essential in alleviating people's anxieties about daily living tasks.

Being strengths focussed was found to be closely linked with the provision of practical and social support. Often social interests and practical tasks were used by peer workers in the studies to draw out a peer's strengths (Gidugu et al., 2015; Mourra et al., 2014; Repper & Watson, 2012).

3.3.7 The helper role

Within five studies, peer workers reported that adopting a helping role brought benefits to them in a number of ways. In Moran et al. (2011), the helping role was identified as the first of five role-related mechanisms which facilitate peer worker's recovery. Through semi-structured interviews with 31 peer workers, they attributed a range of positive effects to the adoption of a helper role, including feeling useful to others, reducing internal stigma, feeling looked up to, and the requirement to shift focus away from oneself, onto others. The sense of achievement and competence which comes from supporting others was also emphasised by Mourra et al. (2014), Austin et al. (2014) and Rebeiro Gruhl et al.

3.4 Discussion

This review synthesised literature relating to the processes that underpin formalised peer support in mental health services. The thematic synthesis of the findings from the 13 studies identified 5 mechanisms underpinning the process of peer support. Two of the mechanisms were included in Solomon's (2004) original proposal; helper therapy and social support. In the studies in this review, the helper role allowed peer workers to transform their often negative experiences into a valued asset which was of use to others. Within

the review, the helper role was only found to relate to peer workers and peers did not describe being in the helper role when supported by a peer worker. In addition, peers did not describe offering social or practical support to peer workers. This may be because the review included more accounts from peer workers than from peers (248 peer workers compared to 89 peers), providing a greater emphasis on the perspectives of peer workers within the thematic synthesis.

Definitions of peer support consistently highlight the importance of both giving and receiving support, and research has suggested that this reciprocity increases the subjective sense of supportiveness within peer support relationships (Faulkner & Kalathil, 2012). Further research into the helper role mechanism would help to identify whether this is experienced by both peers and peer workers, or whether formal peer support limits this experience to peer workers alone.

The peer worker's use of their lived experience emerged as the most represented mechanism by which it acts, being identified in all 13 studies as an important component of peer support relationships. The review demonstrated the complexity of this mechanism, as peer workers use their experiences both explicitly, and to develop an approach which they themselves would have found helpful in their recovery. That this mechanism is so powerful might partly be due to the traditional cultures of non-disclosure, and the one-sided nature of helping relationships within mental health services. These cultures increase the saliency of peer worker's sharing, and their deliberately mutual approach creates a contrast to the overt hierarchies and clinical understandings which often define mental health services (Mead & Filson, 2016). This is one example of how the powerful cultures of mental health systems contribute to the uniqueness of peer support, and of how the culture of peer support might offer alternatives to conventional practice and contribute to culture change.

The concepts of 'replicative' and 'corrective' scripts are relevant to the finding that peer workers draw on their own experience to form their approach. In relation to raising children, Byng-Hall (1998) describes how we gain our own

parenting styles from our own experiences of being parented. Using these experiences, parents seek to replicate their own positive experiences (adopting a 'replicative script'), or, if their experiences were negative, they may adopt a 'corrective script,' to offer a different approach to the one they received. In a similar vein, peer workers appear to gain a model of how to offer support based on their experiences of receiving mental health services. It seems that often, peer workers wish to correct what they felt was unhelpful about their experiences, seeking to share power and increase mutuality within relationships.

Related to this is Deegan's (2004) concept of a 'survivor mission.' Deegan herself described her motivation to "change the mental health system so no one ever gets hurt in it again" (p.16). For peer workers, the motivation to continue to work within mental health systems is in part drawn from the need to change these systems from within, to provide a purpose for lived experience, and to offer others a different experience to that of the peer workers. This is a powerful motivator, and appropriate training, and ongoing reflective practice is vital to enable peer workers become aware of their own experiences (or scripts) and how these are influencing their approaches, not only to offering support, but to relating to other professionals, and to working within potentially triggering environments.

This constant revisiting of one's own experiences, both explicitly and implicitly, within the context of offering support, is one component of 'love labour.' Shared experience contributes to a relationship where peer worker and peer become emotionally bound to one another, and where the peer workers own recovery is bound to their working role. Within the review, love labour was used as a concept to describe the deliberate and skilled work that peer workers undertake to build relationships founded on mutuality, emotional honesty, love, reciprocity and authenticity. In his seminal work on the subject of love, Erich Fromm (1956) asserted that 'the essence of love is to 'labour' for something and to 'make something grow', that love and labour are inseparable (p.22).' However, more recently, love has been understood as something of a taboo in professional helping relationships (Stickley & Freshwater, 2002).

The novelty and broadness of the concept of love labour means that it requires further investigation so that the labour that peer workers undertake to build relationships can be better understood. In an era where mental health services have become more risk focussed, the concept of love labour could be perceived as a danger to patient safety because of the boundary violations that 'love' can imply if it is not accurately described. The review demonstrated that the deep connectedness within peer support relationships acted as a mechanism for its success. This bears resemblance to Humanistic theories of human potential which argue that both giving and receiving love are central to human experience (Rogers 1957; Maslow et al., 1970). The 'core conditions' of a helping relationship identified by Carl Rogers (Rogers, 1959), empathy, congruence and unconditional positive regard, are highly relevant to peer support. Taken together, it has been argued that these core conditions amount to the provision of love within therapeutic relationships (Thorne, 1991). This review found that the peer workers' use of emotional honesty (congruence), lived experience (empathy), love labour and strengths focus (unconditional positive regard) acted as mechanisms which underpin the process of peer support.

Perhaps because of the taboo associated with giving and receiving love within supportive relationships, there is little guidance available to peer workers on how to establish and maintain relationships and boundaries which involve these processes. The close but emotionally safe boundaries that such emotional investment entails require further investigation in order to support peer workers to undertake love labour. The risks of not doing so are described as 'burnout' within the reviewed studies, however, given that peer worker's own recovery, and sense of identity, is often tied to their success in their role, burnout may be an oversimplification of the negative effects experienced by a peer worker who is poorly supported to undertake love labour.

Understanding the negative effects of peer support working for peer workers in terms of a by-product of poorly supported love labour may be helpful, as this would shift the focus away from individual failure of peer workers, onto the lack of support that they encounter in their roles. In relation to emotional labour,

Scheid (1999) identifies that when providers are unable to establish relationships which respond to the emotional needs of both themselves and the person they support, burnout is a probable outcome. In contexts where demand is too high, there is little understanding of the peer support role, or the working environment is not supportive, the demand of undertaking love labour may be unsustainable to peer workers.

The emotional closeness of peer support, coupled with the provision of social and practical support, facilitates relationships which bear many of the hallmarks of friendship. The skill of peer workers is to occupy a liminal space, between friend and worker, and between service user and service provider. The concept of liminality has been applied to the experiences of physical disability, immigration and cancer (Murphy et al., 1988; Menjivar, 2006; Little et al., 1998) and provides a means for understanding the myriad ways in which peer workers describe their in-between identity. The liminal position occupied by peer workers was found to hold the potential for positive outcomes, however, as Scott (2011) highlights, inherent in a liminal identity is an element of uncertainty. The peer worker identity defies easy categorisation being neither professional or service user.

While there is potential in this liminal space for peer workers to experience acceptance from peers and mental health professionals; to act as friend and staff member; to be accepted by society and by those marginalised within it, there is also the potential for peer workers to experience rejection from peers and mental health professionals; to be seen as neither staff member nor friend; and to be rejected by society and by those marginalised from it. The peer worker may fall between the cracks of the two identities they are attempting to bridge, and this may be a very isolating experience. If liminality is one of the components of peer support which makes it beneficial, support is needed for peer workers to navigate this dual belonging.

3.5 The importance of context

Perhaps the most important finding of this scoping review is the considerable heterogeneity of peer support. In the 13 studies under review, ‘peer support’

described advocacy, crisis support, training roles, roles in the statutory sector, volunteer roles and supervisor positions. Further research is needed to identify how each of the mechanisms is affected and expressed in different contexts and in different peer worker roles.

The review found that every factor which makes peer support beneficial, can also have negative consequences. For example, the emotional bonds that characterise love labour create powerful healing relationships, but can also lead to over involvement, burnout and unsustainable boundaries. Critical realist theory argues that explanation depends on identifying causal mechanisms as well as understanding how, and under what conditions, these may be activated (Bhaskar, 1998). It also contends that the outcome of any mechanism activation is *contextual*, in that it may produce different outcomes in different contexts, depending on the presence of other mechanisms and the manner in which they interact.

It is the context within which peer support is offered that can determine, influence and shape how each mechanism is expressed. Although it was not the intention of this review to examine the contextual factors which affect peer support, the studies consistently reported findings relating to the peer workers' working environment. Understanding how different organisational contexts affect peer support is crucial in supporting individual peer workers, and in the successful implementation of peer support within mental health services. For example, four studies investigated the complexities of formal peer worker roles, whether these were voluntary or paid, and how they can be seen as both a positive development, and practically and philosophically problematic. While some found that formal peer worker roles provided peers with hope that their experience could also be a source of value (Gillard et al., 2015a), others described the peer support that they were able to offer in paid capacities as 'watered down' (Scott, 2011). In addition, lack of support for peer workers either from fellow peer workers or other colleagues was found to lead to burnout and emotional exhaustion, difficulty maintaining boundaries as well as low job satisfaction among peer workers (Mancini & Lawson, 2009; Rebeiro Gruhl et al, 2016). Scott et al. (2011) found that other health professionals'

attitudes toward peer support was raised by almost all of the 24 peer workers they interviewed.

A growing literature exists on the challenges faced by peer workers employed within formal mental health settings, and there are concerns that when peer workers are employed within these services, peer support increasingly begins to adopt characteristics, or morph into, clinical support (Brown & Statsy, 2016). In the following chapter, I will explore this literature, which relates directly to the context that I work in. A thorough understanding of the debates surrounding the employment of peer support workers within mental health services will help to shape and refine the research questions which I present at the end of Chapter five.

Chapter 4 - Review of context of formalised peer support – History, power and politics[6]

4.1 Introduction

In this chapter, I explore the context of peer support in mental health services, describing current tensions and debates surrounding peer support, particularly relating to power and status. With the introduction of peer support workers into formalised roles in mental health services has come a growing interest in the cost saving benefits of peer support and how it may complement existing service provision.

I explore whether the role of the peer worker has been adapted to suit the needs of healthcare services and whether its autonomy is assured. Many argue that the introduction of peer support into mental health services compromises or 'co-opts' the way that peer support is offered (Russo & Sweeney, 2016). It has certainly led to a greater focus on the effectiveness of peer support, including its cost-effectiveness. This has led to arguments that peer support is being used to save mental health services money, and to calls for 'better' (quantitative) evidence for its impact within mental health services. I explore debates relating to how evidence for peer support is collected and how the epistemologies utilised, prioritise certain forms of knowledge over others. These debates will be used to construct a rationale for my study in the following chapter.

4.2 Competing forms of knowledge and power

Many of the political issues surrounding peer support have emerged, or have at least been amplified, by the introduction of peer support worker roles into mainstream mental health services. The history of peer support locates its roots within the service user/survivor movement, which challenged the power of the psychiatric system and its approach, underpinned by 'treatment' of

[6] Parts of this chapter have been published in Watson, E. (2019) The politics of peer support. In Watson, E., & Meddings, S. (Eds) (2019) *Peer Support in Mental Health*. London: Red Globe Press. (pp.25-37.)

'mental illness'. I explore this conflict further in this chapter as a means of highlighting the relationship between psychiatry and peer support, and their often competing (arguably mutually exclusive) value bases and positions within society. In doing so it is not my intention to criticise professional groups or survivors, or to polarise what is, in reality, a complex, changing social picture. My intention instead, is to highlight some of the ways in which misunderstandings flourish, about who does what, when, where and the relative value of different territories of activity in a system that encourages competition for scarce resources.

4.3 Survivor knowledge and power

Peer support is explicitly underpinned by the belief that it is the individual who themselves holds the key to understanding and living alongside their own experiences of distress. This is sometimes referred to as experiential or survivor knowledge, that is, 'specialized knowledge, grounded in an individual's lived experience' (Borkman, 1990, p. 3). In the context of peer support, this embodied experiential knowledge may include the knowledge of service use, oppression, poverty and inequality as well as mental distress. The introduction of peer workers into mental health settings has brought with it a challenge to traditional understandings of what constitutes knowledge. As Voronka (2016) writes:

> *'Suddenly, and in very new ways, those of us with experience of madness and/or the mental health system are working both within and outside of mental health fields of power to contribute, disrupt, and complicate how and what knowledge about us is produced … Yet, unlike most fields, we have yet to engage openly with the hard questions on the possibilities, limits, and conditions of relying on experiential knowledge to authorize our standing.'* (p. 191)

The service user/survivor movement was influential in amplifying the personal accounts of people who had experienced distress, as it documented peoples' recoveries from a broad spectrum of experiences, including abuse from mental

health services. Partly as a result of this and partly due to the establishment of ‘consumer power’ in health services, the service user/survivor voice has become powerful in its own right. As Crossley (2004) describes:

> *‘Survivors have been able to convert their experiences of mental distress and (mis)treatment into a form of cultural and symbolic capital. The disvalued status of the patient is reversed within the movement context. Therein it constitutes authority to speak and vouches for authenticity. The experience of both distress and treatment, stigmatized elsewhere, has become recognized as a valuable, perhaps superior knowledge base. Survivors have laid a claim, recognized at least within the movement itself, to know ‘madness’ and its ‘treatment’ with authority, on the basis that they have been there and have survived it.’* (p. 167)

It is important to note Crossley’s emphasis that the experiential authority of survivors has symbolic capital *within the movement context*. Outside of this, embodied and experiential knowledge has long been marginalised in favour of scientific, expert understandings. Survivors, service users and peer supporters have used their ‘experiential authority’ (Borkman, 1990) to demonstrate the creative and personally meaningful ways that an individual can interpret their experiences outside and often in spite of psychiatry and the medical model. Peer support is understood to be characterised by mutual (equal) relationships, reciprocity in giving and receiving support, and connection/communities built on shared experience.

The power of personal accounts of recovery has been recognised within teaching settings and healing relationships, as well as a means to change the culture of mental health systems. Even the growing use of the term survivor, with its connotations of defiance, strength and courage, to replace the term patient, with its connotations of victim, sickness and dependency, demonstrates the evolution of a more powerful discourse to constitute lived experience. However, writer and trainer Peter Campbell (2010), himself a survivor, warns of the ‘potential tyranny of personal experience that can pre-

empt disagreement and make fruitful discussion and debate … very difficult' (p. 29). Although he also testifies to the benefits of its use, this exemplifies the point that personal experience has reached in acquiring a form of symbolic power, based in experiential authority and individual accounts.

Voronka (2016) argues that lived experience is a form of 'body knowledge' and that this is how peer support is perceived as unique. Peer workers' uniqueness is premised on the fact that their knowledge is held within their bodies and is therefore different and inaccessible to other professionals, whose knowledge is cognitively acquired. Both these forms of knowledge are linked to different forms of power. In reality, it is a false line to draw between peer workers, with their body knowledge, and professionals with their acquired knowledge (Voronka, 2015). What this does is limit the ability for peer workers to draw on their own acquired embodied knowledge, but also, in systems where professional knowledge is more highly valued, it excludes peer workers from entering into conversations where they have something to offer that comes from a place of affective knowing.

4.4 Professional (psychiatric) knowledge and power

Mental health systems in the western world are underpinned by a biopsychosocial model of understanding mental distress. That is, mental health problems are caused by chemical abnormalities, alongside the experience of negative life events and environmental factors, which in turn affect psychological functioning. While professionals working within mental health services may hold alternative beliefs, structurally, these services are established to diagnose, treat and provide care using a medical paradigm. Although, for many, medical understandings of distress have lost their credibility in light of the poor evidence for the current classification systems (Bentall, 2004) and for the use of pharmaceutical treatments (Whitaker, 2010) (derived from a politically and economically powerful industry that makes profit from suffering), psychiatry continues to occupy a powerful position within society, and psychiatric understandings of distress dominate our social world.

Psychiatry has economic power, being funded by government and endorsed by the pharmaceutical industry, reinforcing the use of medication and so-called expert-based approaches. Psychiatric knowledge is also enshrined in the law. In England and Wales, the Mental Health Act (1983) affords mental health professionals power to detain a person in hospital against their will if they are deemed to be a risk to themselves or others. The 2007 revision of the Act added Community Treatment Orders (CTOs), which made it possible for people to be recalled to hospital if they did not follow certain conditions – in effect obliging people to take medication, among other interventions, once discharged from hospital.

The use of a medical classification system within the law and within mental health services affords power to mental health professionals with training in identifying and classifying behaviours. It means that professionals have a role in assessing and managing the risk of the people they support. The scientific paradigm means that scientific (quantitative) methods which focus on the effectiveness of clinical interventions, whether they are chemical or psychological, are highly prized within research and by the National Institute for Health and Care Excellence (NICE) which produces guidelines for practice. Within the context of the psychiatric discourse on mental health, there is also a strong 'risk agenda' as people experiencing mental distress may be regarded as a danger to themselves and others, justifying the need for enforced treatment. This agenda is amplified by the media who frequently portray mental distress through stigmatising, dangerous or comical images, which provide inaccurate information about the realities of trauma or mental health problems (Wahl, 1995).

The conceptualisation of distress which underpins mental health services in the western world locates expertise within professional knowledge. From an objective standpoint, a mental health professional supports and treats a patient using their training to offer guidance and advice. In contrast, peer support locates expertise within the individual who experiences distress and uses the art of experience to support this. While professional expertise can be measured by certificates and qualifications, peer support endorses a leap of

faith, in order to trust the value of lived experience. Although, in reality, the distinction is more blurred than these science–art, professional–lived, objective–subjective distinctions, in general, different forms of knowledge are valued by psychiatric services than those by the survivor movement.

The differences between psychiatric understandings and survivor understandings are clearly illustrated by looking at the language used in publications about peer support. Table 4.1 presents two such publications placed next to each other. The first is written by Shery Mead, the founder of Intentional Peer Support in the USA and a survivor who advocates for the preservation of mutuality in peer support. The second (Dark et al., 2017) is an academic publication presenting the 'case for' peer support written by a psychiatrist. While Mead and colleagues (2001) describes the primary goal of peer support as responsibly challenging assumptions about illness, Dark et al. (2017) focus on patient outcomes and service user engagement and describes peer support as a *model of service* which can enhance clinical recovery from *mental illness*. These two examples highlight the different ways that peer support is described and how these serve different agendas – Mead's using the language of the survivor movement, and Dark's the language of service delivery.

Table 4.1 *Two different conversations about peer support*

Mead et al., (2001)	*Dark et al., (2017)*
'Peer support can offer a "culture" of health and ability as opposed to a culture of illness and disability. The primary goal is to responsibly challenge the assumptions about 'mental illness' and at the same time to validate the individual for who they really are and where they have come from. Peer support should attempt to think creatively and non-	'[peer support is] an innovative model of service that has arisen from the growth of the consumer movement and research on how people with lived experience can enhance recovery from mental illness. Patient outcomes from current care are suboptimal particularly on measures of psychosocial functioning and recovery of premorbid functioning

judgmentally about the way individuals experience and make meaning of their lives in contrast to having all actions and feelings diagnosed and labeled.' (p.131)	potential. There is a need for new ways of delivering care that champion service-user engagement and evaluation of these interventions.' (p.441)

4.5 Neoliberalism and austerity within UK mental health services

Neoliberalism is a political ideology that 'values individual interaction in free markets. It argues for welfare state cutbacks and greater individual responsibility and stresses the importance of opportunity. This in turn underscores particular themes in public attitudes (deservingness, obligation and choice) and downplays others (solidarity and community).' (Taylor-Gooby & Leurth, 2018, p.1). It has been described as the 'grand narrative' of our times and as such, hard to challenge because of its very normalcy (Verhaeghe, 2012). Since the 1970's the rise of neoliberalism has brought with it an extension of market relationships which are embedded in discourses of personal responsibility and control as a means to justify economic policies including privatisation and reducing taxation, as well as a diminished role for the state, and therefore reductions in welfare spending. These economic and social discourses inform, and are reinforced by, models of human experience and mental health which focus on individual dysfunction. The neoliberal emphasis on personal autonomy has impacted on our cultural perception of mental health by rooting it more firmly as a fault (or illness) of the individual, concealing the impact of inequality, wide-scale oppression and neo-liberal policies themselves on the welfare of populations.

There is a strong focus on reduced spending within the frame of a neoliberal economic model. Although mental health services have long been considered the poor relation to physical health services, the past decade has seen underfunding in mental health services reach unprecedented levels (Cummings, 2018). In 2010, the newly formed coalition government presented austerity as the necessary response to a national emergency following the banking crisis of 2008. The austerity measures that were subsequently introduced reduced the provision of welfare across a range of services and

areas. This reduction was accompanied by a discourse of individual sacrifice (Brown, 2015); a discourse encapsulated by Tory Chancellor of Exchequer Osborne's now famous phrase that 'we are all in this together.' The coalition and Tory government's commitment to improving mental health provision has masked the extent that austerity has damaged those same services. Former Prime Minister, Theresa May described the current crisis in mental health services as one of the 'burning injustices' that her government would tackle. Despite this, there are still more cuts planned, both to public services and to welfare reforms. These are estimated to amount to a reduction in spending of £27 billion per year by 2021 (Beatty & Fothergill, 2016). As Beresford (2013) writes: 'while the rhetoric gets grander in mental health, with talk of lofty "new horizons", broader "wellbeing approaches" and "completing the revolution", we have to wonder what all of this actually means. If anything, the response to people's mental health conditions gets punier and more controlling.'

The overt goal of austerity has gone beyond cost saving and financial recovery; the steps that have been taken have permanently diminished the social state, and irreversibly altered the relationship between citizens and the state (Krugman, 2015). Austerity has been heavily criticised both in terms of its economic potential, but also its moral underpinnings, given that the poorest members of society have paid the heaviest price for a situation created by the privileged elite (Blyth, 2013). It has resulted in the UK public sector becoming one of the smallest in the world, including the United States (Taylor-Gooby, 2012).

Within mental health services, a decade of austerity has left a lasting impact in a number of ways. It has resulted in bed closures, increasing the demand on the remaining inpatient beds and leading to more out of area placements (NHS England, 2019). The demand for services has increased as welfare reforms have increased the distress experienced by those in poverty, while simultaneously reducing their options for support (Cummings, 2018). Because of the higher demand, access to services is more difficult, and people are turned away, or made to wait for the services they seek support from (NHS Providers, 2019). Short term, mechanised treatments are favoured under the

discourses of independence and ‘re-ablement.’ This has led to criticisms regarding the lack of long term support available to those who need it (Beresford, 2013). Conversely, use of the mental health act and compulsory treatment has increased (Campbell, 2018). This has been linked to a reduction of community services offering ongoing support to prevent people reaching a point of crisis (Cummings, 2018)

Staffing numbers have been cut throughout mental health services. The Institute for Fiscal Studies estimated that over 900,000 public sector roles were to be cut between 2011 and 2018 (IFS, 2012). A recent survey by NHS Providers found that only 9% of NHS Trusts in the UK reported having the right amount and distribution of staff, and nearly two thirds Trust leaders were very concerned about the future numbers and skill mix of staff in their organisation. In 2018, it was reported that two thousand mental health staff were leaving their posts every month, leaving one in eight mental health posts unfilled at the end of June 2018 (NHS Improvement, 2019).The ongoing promises of extra funding, combined with the ongoing cuts to services, has resulted in widespread dissatisfaction with NHS mental health services, both by those who use the services, and those work within them (King’s Fund & Nuffield Trust, 2019).

Austerity measures were introduced into UK mental health services at the same time that peer worker posts were first established. Peer support has competed for space and resources within an overstretched and underfunded mental health system. This context has contributed to a focus in research on peer support on its outcomes and cost saving potential.

4.6 Focus on cost saving within peer support research

> *‘Of course, as long as psychiatry maintains its power, ‘recovery’ will mean compliantly taking one’s drugs, and ‘peer support’ will mean supplying the system with cheap labor.’* (Chabasinski, 2012)

In 2013, an ImROC briefing paper written to support the introduction of peer support workers into the mental health workforce listed ten 'myths and misconceptions' relating to peer support (Repper, 2013). The first of these was that 'peer support is just a way of saving money' (p. 7). Because peer workers are usually, but not always, employed at lower pay grades than staff with professional qualifications (often at the same grade as healthcare assistants or support workers), they can be seen as a way of increasing the mental health workforce at a relatively small cost. ImROC argue that peer workers are better equipped to support people to make sense of their experiences, and that the professional domain need not be extended beyond its original remit of providing specialist expertise. They conclude: 'It is therefore clearly not simply a case of "saving money"; rather ensuring services optimise value for money, and the added value, of all staff groups' (p. 7).

Since this argument was put forth, interest in the economics of peer support has continued to grow, and its potential to reduce the costs of providing mental health services has led to the regular inclusion of peer support alongside economic arguments in reports and policy guidance. For example, while The King's Fund has consistently advocated for greater use and access to peer support, often its reports contain the implicit assumption that peer support would help relieve the financial burden that mental health services face. For example, peer support is discussed alongside online resources and the use of volunteers (Foot et al., 2014, Hibbard & Gilburt, 2014). The focus on cost-saving and cost-effectiveness is part of a wider context within mental health services which affects the whole workforce. For example, NICE explicitly looks at how many 'qualiyears' (years with good quality of life) interventions including cognitive behavioural therapy (CBT) or family therapy offer for a particular amount of money. In joining the mental health workforce, peer workers are subject to the same level of scrutiny as any other intervention, and yet the very artistry of their work defies quantification.

The cost-saving benefits of peer support (Trachtenberg et al., 2013) have been used to provide an explicit business case for the employment of more peer workers. Rethink's 'Investing in Recovery' (Knapp et al., 2014) argued that co-

designing and delivering services with people who use them is among the approaches which offers the biggest scope for cost-saving in mental health care. The economic case for peer support will undoubtedly influence how widely peer support is introduced. While cost-effectiveness may not be the sole reason for the introduction of peer support, some argue that it has taken precedence over the moral or ethical reasons (Chabasinski, 2012). Peer workers themselves have described peer support as a form of cheap labour (Manning & Suire, 1996). This issue goes beyond pay to encompass wider issues about the value of peer support. Peer workers describe feeling used as a 'dogsbody', a 'fad' and a 'phase to phase out' (Dyble, 2012, p. 135). While it is important to 'sell' peer support to those who may not understand its worth, and, while doing this, to speak in terms that will appeal to organisational needs, the focus on money overshadows the other, more inspiring, values which underpin peer support and risks eliding the many other ways that mental health services contradict and create barriers for effective peer-based approaches.

4.7 Focus on impact within a positivist paradigm

There have been calls for an understanding of the 'whole' value of peer support through research and evaluation, rather than focus on the cost-saving potential of the approach. Research into peer support is growing at a steady pace. Large organisations such as The Health Foundation and Mind have focused large research projects and provided funding streams to smaller projects, in order to understand the contribution and impact of peer support. There remains some difficulty in deciding what exactly should be measured if we are to understand the impact of peer support. Some have argued that randomised controlled trials (RCTs) have not measured outcomes which are relevant to peer support or that people report as the benefits they experience (Gillard et al., 2017).

Much of the difficulty of evaluating peer support relates to the arguments described above about different forms of knowledge: What type of knowledge matters? What sort of evidence counts? Service-level evaluations often focus on cost-saving and broad outcomes such as employment, symptom reduction and decreased service use/inpatient admissions. Quality of Life scales are

also often included in evaluations of peer workers, requiring people receiving peer support to rate themselves on validated scales. These types of evaluation increase the likelihood for further funding based on clear evidence of the need for the service. However, for some, because recovery is a personally defined human experience, the search for broad outcomes flies in the face of what peer support should be about. Large trials of peer support focusing on quantitative service outcomes mean that the personally meaningful benefits experienced by people receiving peer support are not collected. Using the protocols required to conduct RCTs, assigning participants to peer support or 'control' groups, runs the risk of altering the nature of peer support relationships by removing choice and control from the people taking part (Corrigan & Salzer, 2003), which is even more significant if choice is part of the mechanism for why peer support is helpful. Personal accounts of the experience of peer support would provide a more personal and detailed narrative of the benefits of the relationship, but these accounts will never provide evidence for the broad, replicable effectiveness of peer support which is necessary for NICE.

There is also a question about *who* should be researching peer support: Whose knowledge matters? Should research into peer support be carried out by professionals using the standards that are used to judge other interventions, or should peer support be examined using the standards which it defines for itself? For many survivors, the object of peer support is social change, and this is what should be measured in order to understand the success of peer support:

> *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.* (Mead, 2016)

The interest in the economic case for peer support, as well as its potential to improve mental health services is gradually shifting the focus of peer support away from its original intentions of social change. For the purposes of

research, and to fit in with current service provision, peer support is evolving into an intervention, rather than the originally conceived reciprocal helping relationship. As this evolution occurs, the uniqueness of peer support is removed; in order to build an evidence base for peer support, we risk eroding precisely what makes it impactful.

4.8 Peer support and the psychiatric system: Mutuality meets hierarchy

Peer support has evolved from its roots within the service user movement to become a formalised approach to offering and receiving support. The introduction of peer workers into mainstream mental health services has moved from being a rarity to a commissioning recommendation (NICE, 2014), and is understood to be a powerful way of driving forward culture change within mental health services towards 'recovery-focused' ways of working. Many (if not most) mental health Trusts in the UK now employ and provide training for peer workers in an ever-increasing range of roles and service contexts, and the role of peer support in community initiatives is well recognised (Crepaz-Keay, 2017).

However, there are ongoing risks associated with the growth of peer support. It is unsurprising, given the conflicts described above, that when peer support approaches are introduced into formal mental health services it causes controversy, disagreement and often confusion. While some have welcomed the introduction of peer workers as a sign that cultures are becoming more open to valuing lived experience, others have viewed it as 'co-option' or misuse of survivor knowledge to serve mental health systems, while they leave their controlling practices intact (Penney & Prescot, 2016). It has been argued that the re-emergence of the concept of recovery in mental health policy has been co-opted to support neoliberal agendas (Beresford, 2015; McWade, 2016). The UK activist collective, Recovery in the Bin (2019) have introduced the concept of 'neo-recovery' to describe how the concept has shifted in meaning from the original grassroots survivor campaigns toward a focus on the neoliberal values of individualism, positivism and expert led provision. In a similar vein, Howell & Voronka argue that:

> *'Whereas twenty years ago resilience and recovery were harnessed as organized frameworks for psychiatric survivors to avert the medical system through alternative means (including peer knowledge and support), they are now harnessed to incorporate psychiatric survivors into medical systems. They now work in ways that attempt to make psychiatric survivors responsible for their own adherence to prescribed ways of governing their interior lives, while at the same time leaving medical authority intact, since psychologists and psychiatrists have become experts in recovery and resilience.'* (Howell & Voronka, 2011, p. 2)

Concerns have been raised about how peer support may be misused within mental health services, so that peer workers will be expected to conform to the practices that the survivor movement continues to campaign against. Voronka (2017) questions: 'to what effect are we [peer workers] deploying our work to orient clients toward feelings and responses that actually encourage compliance and cooperation with dominant conceptual models of mental illness?' (p. 335).

Survivors have argued that when peer support becomes intentionally offered (as opposed to informal peer support) there needs to be support in place for peer workers to maintain the values of the approach (Mead et al., 2001; O'Hagan et al., 2009). Many survivors have questioned how possible it is to maintain these values within highly structured organisations such as the NHS (Faulkner & Kalathil, 2012).

Mead and Filson (2016) argue:

> *'By default, mental health organisations contradict the principles of peer support through the following: Mandatory reporting; Policies regarding diagnosis and treatment; Contractual/funding constraints around who I can see; Agreements about how long we can have a relationship for;*

and, Policies directing boundaries around peer relationships.' (p.114)

Within the first few years of peer workers being employed within mental health Trusts, their roles were loosely defined and this gave rise to a number of 'critical debates' about what peer workers should and should not do. The ImROC programme hosted annual conferences where these debates would be discussed. A regular topic at these debates was the role of peer workers in the use of physical restraint within inpatient settings (ImROC, 2016). The use of chemical and physical restraint has also become a highly contentious area in peer support. Some argue that the presence of peer workers will lead to reduced restraint, that no staff member wishes to be, or enjoys being, part of restraining a person in distress, and that peers may be able to 'de-escalate' situations by building trusting relationships with people. Others believe that the use of peer workers in physical restraint is a stark example of how the mutuality of peer support in mental health services becomes compromised.

Scott and Doughty (2012) and Scott et al. (2011) explore similar arguments relating to record-keeping procedures and risk assessments. They describe how peer workers may be drawn in two directions, having to report and manage risk using clinical frameworks, while drawing on their own understandings to support another person to feel in control of their own 'risk'. The mutuality of peer support is inevitably compromised when one person is employed, and their role involves risk assessment and note-keeping. Peer support is gradually transformed from a relationship between two people with shared experience to an intervention provided by one person to support the other:

> *'By becoming part of mental health services, which continue to use practices which are at odds with its philosophy, peer support walks a delicate tightrope between being part of the solution and becoming part of the problem.'* (Watson, 2017, p. 130)

4.9 Impact of politics on peer workers

The conflicts and critical issues in peer support impact on peer workers to different degrees in different contexts. For some, the presence of other peers, a supportive working environment where they feel able to reflect and develop their own approach, and the opportunity for training may minimise negative impacts. Penney and Prescot (2016) note that peer workers and the mental health systems they work in (including statutory mental health services) may uncritically welcome the introduction of peer support if they are unaware of the history of the survivor movement, or have a sincere belief in the validity and value of the medical model. For peer workers who are not familiar that the roots of peer support lie in the survivor movement, it may be easier for them to work within medical systems, as they may feel less conflicted about how these contexts align with the original intentions of peer support.

Despite this, there is a large amount of research which testifies to the difficulty experienced by peer workers working within mental health systems. Research consistently emphasises themes of feeling stigmatised by other staff, being viewed through a diagnostic lens, experiencing poor support structures, a lack of credibility in peer support and unclear working roles (e.g. Vandewalle et al., 2016; Walker & Bryant, 2013). One large-scale survey of almost 600 peer workers in the USA found that 64.3 per cent had experienced or witnessed stigmatisation or discrimination from their co-workers (Cronise et al., 2016).

These working environments, coupled with the pressure to maintain personal well-being, have been linked to burnout in peer workers (Mancini & Lawson, 2009). Whitmore (2017; p.191) describes feeling like the 'token mad woman' in her role as a peer support worker in a crisis house. She describes keeping her approach simple and ultimately 'blending in' with the staff team.

In contrast, Irwin (2017) describes her reasons for leaving her peer role on an inpatient ward:

> *'I asked myself many times whether I would be able to, or even whether my conscience would allow me to, work within an*

> *existing system of psychiatric care that had essentially left me feeling disempowered, utterly hopeless, re-traumatised, passive beyond recognition and a great deal 'sicker' than when I first entered the system. If I worked within it, would I feel that I was condoning a system that had essentially harmed me? … I left because I had reached a point where I felt I could no longer work in an environment which compromised my own values, and the values of peer support.'* (p. 153)

She goes on to describe other factors which influenced her decision to leave, including the difficulty of working in an underfunded system:

> *During my time as a PSW, I witnessed a system that was over stretched and jaded by constant funding cuts. I witnessed compassionate staff with too little time to spend building relationships, and I witnessed frustrated and distressed people, who entered with hope that somebody would listen and left with so much less than they deserved'* (p. 155).

There are other problems facing peer workers relating to the concept of lived experience. For some, this phrase is meaningless as all experience is 'lived' (Penney & Prescot, 2016). For others, grouping people together by describing them as having lived experience removes the individuality of their experiences. This grouping is sometimes referred to as 'strategic essentialism' and has been used by other social change movements, including feminism, as a means of uniting under a shared identity to bring about social change. Strategic essentialism can be a powerful tactic for collective change, but defining a person using only their experiences of mental distress may serve to reinforce the stigma associated with this identity, by failing to take into account the other, equally important, elements of a person's being. Some research has found that peer workers found that their 'peer' identity might impede their future progression in recovery and in their working roles (Dyble, 2012; Moran et al., 2013).

Career progression is another critical issue in peer support, with few opportunities being provided for peer workers to access further relevant training or move into more senior roles. This is illustrated by Tessa Rodgers, (Watson, 2019) a peer worker who describes the lack of career progression within her peer role, and how her previous experiences as a Drug Support Worker were not taken into account.

> *'There is no question at all that this job, in all its myriad locations, teams, restructures and all that follows in the slipstream of constant change, has helped me to positively redefine who I am. Here comes the BUT, I have been on the same pay grade for well over five years now, and I use not only my lived experience, but my employment experience too. It's very interesting and I am never bored at work, but I do feel exploited and I can feel resentful too.'* (p.35)

There are some exceptions; in other NHS Trusts that employ peer workers, their management and leadership experience and responsibilities are taken into account, and there are posts at the same pay scale as team leaders or service managers.

4.10 Conclusions

This chapter has provided an overview of some of the current debates in peer support, highlighting the sometimes conflicting approaches to working, measuring and understanding peer support relationships. The growing popularity of peer support within mental health services has meant that the values of mutuality and personal choice which lie at the heart of peer support have met with systems which favour expert-based approaches and are required to demonstrate clinical effectiveness.

The debates in peer support include a diverse range of people who believe in bringing about change. Conflicts arise in how people believe change should come about: Should peer support be introduced into mental health services as a means of evolving the culture, or should mental health services be

abandoned in favour of peer-led approaches? Or, to put it another way, do we believe that mental health services can change (or even if they need to change) their philosophy, or should peer support remain outside of them?

Peer workers are being introduced in greater numbers into mental health services across the world. Pertinent questions relate to how we protect the identity of peer support as it is introduced, how services can support peer workers to cope and to progress within psychiatric institutions, and how they might measure the impact of peer support in a way which does justice to peer relationships, rather than solely to build the economic case.

Chapter 5 - Rationale for the current study

5.1 Introduction

The past decade has seen a huge rise in popularity for peer support within mental health. The introduction of peer support workers in a range of mental health settings across the Western World has increased the demand for evidence regarding the impact of peer worker roles and in particular, their potential to improve mental health services and save them money. The current literature within peer support outlines how peer workers bring positive benefits to the people they support and to the teams and organisations they are employed within. While reviews conclude that peer workers produce the same or slightly better outcomes than traditional mental health services, the methods and foci of research have been criticised.

There is a small amount of research that has focussed on the mechanisms and processes that underpin peer support. This focus facilitates a better understanding of how peer support operates and why it might bring about the outcomes that it has been found to. The literature review presented in Chapter three identified five mechanisms which may be causal to positive outcomes in peer support. This literature review also highlighted the varying definitions and contexts of peer support across the world. What was understood to be peer support varied between studies depending on the context in which the peer support took place. The exploration of peer support within mental health services undertaken in Chapter four has highlighted the criticisms of introducing peer support working within statutory mental health services in the UK and US.

5.2 Gaps in the current literature within peer support

It is a surprise that so much energy has been afforded to introducing peer support into UK mental health services given that it is still so little understood. The evidence base that suggests that peer support benefits mental health services comes from the US, Canada, New Zealand, as well as the UK. All of these countries have very different healthcare systems, and it cannot be said

that what works within one system directly translates to another. Not only does the current literature come from different countries, it also explores peer support within very different settings, including housing services, advocacy organisations, peer run services, and statutory settings. While the findings are likely to be at least partly unique to the context they were found in, all of these studies have become homogenised to constitute one evidence base for all peer support.

The literature that explores the mechanisms that underpin peer support is minimal. The literature review in Chapter three found only 13 studies that explored this. Of these, only two studies came from a UK context, highlighting how little research examines how peer support is offered within NHS mental health services. Some first person accounts of peer support have described the challenge of working in this setting (e.g. Irwin, 2017). Health Education England (2019) have committed to significantly increasing the numbers of peer workers over the next five years, and more NHS Trusts are securing funding to include peer workers into their workforce numbers. Because of this, it is vital that we understand the impact that these contexts have on the experiences of peer workers within these settings, including what supports them and the specific challenges of working in these roles.

There have been criticisms of introducing peer workers into mental health services both within the UK (Recovery in the Bin, 2018) and across the Western world (e.g. Brown & Statsy, 2016). These critics argue that when peer workers are added to systems that are underpinned by medical models, they are forced to compromise the values of peer support. It is important to establish if and how this is the case, and what can be done to prevent this. Moreover, in the past decade, the NHS has been heavily affected by austerity which has included the closure or restructuring of services, the increase in demand for services, and the decrease in inpatient beds, as well as in staffing numbers across the board. There has been no research into how this context has shaped peer working, and whether and in what ways this has compromised their ability to offer peer support.

Finally, there is a clear absence in the peer support literature of a methodology that is aligned to the values of peer support. The search for 'high quality' quantitative evidence about the benefits of peer support has led to a positivist paradigm dominating the peer support literature. The development of a research methodology which emulates the values of peer support would recognise the value of lived experience both within peer support and within research and honour the unique contribution that a peer support research approach can offer in these arenas.

5.3 Study purpose and objectives

The current research aims to develop an understanding of the process of peer support within a UK NHS mental health Trust in order to understand how this specific setting influences peer support working. The context of an NHS mental health service is multi-layered. The system is made up of people, employed in a hierarchical arrangement, who have social and collegial relationships with one another. They are influenced by their training and their service setting, and governed by policies and protocols. The mental health system is also influenced by broader political and systemic factors. The personal, embodied context of peer support workers must be explored alongside an examination of the broader contexts they are employed within.

It is proposed that describing and exploring the experiences of peer support workers within an NHS mental health service setting will provide a rich understanding of the experience of offering peer support, rooted in the context of NHS mental health services.

5.3.1 Purpose

To explore the role that this specific setting plays in influencing how peer support is undertaken in an NHS mental health service

5.3.2 Primary objective

- To develop an understanding of how the context of an NHS mental health service effects the experience of working as a peer worker using

the narratives of peer workers, as well as my own experiences of working in a peer support role in this setting

5.3.3 Secondary objectives

- To capture the perspectives of peer support workers in relation to their role and what, in their perspective, enables/inhibits its success.
- To identify facilitating and inhibiting aspects of the environments that peer workers are employed within.
- To develop a methodology and method that is aligned to the values of peer support

The following chapter introduces my methodology and describes my reasons for the philosophical underpinnings to this research.

Chapter 6 - Methodology

6.1 The cave

In *Republic*, Plato presents his allegory of the cave to describe the effect that a lack of education has on human nature. The allegory describes a group of prisoners who have lived in a cave, chained up and facing a wall, all their lives. They observe the shadows which are cast on the cave wall and these become meaningful to them; they believe that the cave is the limit of reality. When one prisoner escapes the cave, he is at first blinded by the sun outside and then becomes aware of the world in all its colours and sensations. He returns to the cave and, his eyes having adjusted to the light outside, is now blind in the darkness. The other prisoners, seeing his blindness, refuse to believe his experiences of the outside world, assuming that the experience has harmed him.

This symbol of the cave keeps coming back to me. There is something about the contrast of the cave and the technicolour world which chimes with my own experiences. First, it chimes with my experiences of recovery and finding my way out of personal caves:

> *And sometimes, like yesterday, this joy just comes from nowhere really and fills me with gold, like I become carbonated and the world just sings and I realise how beautiful life is and how lucky I am. Nobody told me before that joy is a fuel, it has an energy, it is self-perpetuating. Probably if somebody had said that to me, when I felt so far from life, and so cold, I would have told them where they could cram that joy.* (my diary)

Second, it chimes with my understanding of research, what science is and what it does not have to be. I was raised in a positivist cave. In my psychology degree, I was taught that empirical data and statistical analysis were the only reliable forms of evidence. In relation to mental health, psychology taught me 'objectively' what a mental illness is; the symptoms, the neurochemical imbalances, the treatment pathways. Every semester we would undertake

modules which taught us how to condense human experience into ‘p’ values and determine whether they were statistically significant. We were taught to be detached from our data to ensure that our results were not biased by our own perspectives, after all, ‘a biased scientific result is no different from a useless one’ (Sarewitz, 2012 p. 149). I was raised by engineers; I was schooled in psychology; deep in my cells are ideas about science which are hard to shake. Ideas about causation, what proof is, what counts as evidence, truth, reality, and indeed, what counts as science. I had no reason to question these ideas until their limitations began to profoundly impact my life.

When I was first taken into mental health services, I was given a diagnosis, and then another. At first, I greeted the diagnoses with relief, because they legitimised my distress. Science could provide the explanation and the pathway out, I thought. It was a way for everybody around me to hear, from qualified professionals, that this was serious, that I was experiencing something scientifically valid that they should pay attention to. But bit by bit, the novelty and the helpfulness of the diagnosis wore off and it evolved into something sticky, toxic and shameful. It took away my credibility, it set up a dynamic between me and others where they thought they had the authority to tell me what I should be doing and how I should recover. It stole the other parts of my identity, it made me a risk object, it made me ashamed of myself. So ashamed.

In place of the evidence based treatment pathway that I thought might be my escape route, there was instead a dynamic between me and ‘science’ that cast me as the fool. Where my experiences did not fit with the evidence, I was told I was mistaken, and where they did, I was told that I was a certain way because of my diagnosis; that everyone with my diagnosis behaves the I way was behaving. And rather than finding this reassuring, I found myself lost to a label, floundering because I could not recover. Reality and knowledge began to have multiple meanings. There was the reality of diagnosis and medicine and there was my reality. And I began to see that both ‘realities’ were a bit mad, and neither one particularly helpful, but that the medical reality had power. It had

power because it was rooted in science, in expertise and in the law, and all I was rooted in was my own experience.

The science I had put my trust in began to hold a power over me by imposing a language onto my experience which I did not choose and I no longer wanted. And with the language came judgements about who I was and why I was that. I was imprisoned by a narrative of mental illness, of hopelessness and failure because, from my powerless position as service user, as mental patient, I had no authority to question what science was saying about me.

It was only after I started working as a peer worker that I encountered people who rejected their diagnoses, who defiantly declared that they were never ill. I began to leave this particular biomedical cave, and look back and see how damaging and false it was. It was from this vantage point, that I could clearly begin to see that what had held me hostage was not actually science at all, but profoundly limited shadows masquerading as something real.

Despite these experiences, or maybe because of them, I began this PhD with the concern that I may not be objective or detached enough to do good science. For a long time, the importance of objectivity and neutrality have been hard-wired into me and the process of this PhD enquiry has entailed a gradual unpicking of what I believed science must be, and what I understand to count as knowledge and truth. In particular, I believed that a systematic literature review was the best form, the only form with any status, and so that is what I did. In Chapter 3, I wrote it up, in a dry, academic voice which felt unsatisfying. I feared that qualitative research had to conform to positivist ideals. I believed that my own experiences and job role would be looked upon as a source of bias, I thought I would have to hide them. I felt the injustice, the sadness of once again having to conceal the parts of myself that would mark me out as less than others. I believed that this PhD would evoke the same feelings of stigma and judgement that I feel in relation to my mental health. I believed all of this; and then I met the feminists, and the critical realists. I met the insider and survivor researchers. Perhaps most importantly, I met the ethnographers who blended the line between ethnography and autoethnography. I left the cave, and it was glorious.

6.2 Life outside the cave

Perhaps it is a little presumptuous to say that I left the cave, given that, in Plato's allegory, the slaves couldn't see the cave they were in. It is probably more accurate to say that, for the most part, I no longer live in a positivist cave, but that I am probably inhabiting several others without knowing it, as we all are, all the time. And now, having stepped away from the cave, I am developing my own tentative standpoint, with some backward glances to where I have travelled from. I am wary of 'science' which can seemingly wield evidence to suit any means, and yet, a part of me knows that in science lies power, and power is tempting. I would like my findings to have power and maybe I have to grieve still for the fact that they will not be statistically significant.

I feel the low status that qualitative research has in some circles; I feel it in the same way I feel stigma. And, while in some circles, when I describe my research ideals it is met with knowing smiles and satisfied nods, in others I am drawn into a debate with people who are trying to 'help me see' how wrong I am, as if I have signed up to a cult and they are trying to save me. And it still hurts when I explain (as best as I can) that there are other, equally (if not more) valid ways of understanding science than positivism, and I am met with derision.

Within this methodology chapter, I describe the process of thinking that I have undertaken during my study. From falling out of love with positivist science, I began my search for a methodology which is aligned to the values of peer support, discovering situated knowledge, survivor research and feminist standpoint theory. I also describe my emerging ontological and epistemological stance, rooted, for now, in critical realism.

6.3 Moving away (far away) from positivist science

The concept of 'scientism' is often used to refer to the infiltration of the practices of positivist science into all aspects of our social world (Lather, 2009). Positivism assumes that reality is stable and exists independently of our

perception of it. Although our current understanding of it may be imperfect, there is a potential universally correct explanation of reality and this can be achieved through empirical methods (Green & Thorogood, 2004). Empirical methods focus on observable phenomena and aim to emulate the methods used within physical sciences. Although there is some disagreement about the definitions of positivist science, causation is largely understood to be determined by observing patterns of regularity between intervention and outcome (e.g. Marchal et al., 2013).

In mental health research there has been a growing emphasis on evidence based practice and the use of Randomised Controlled Trials to establish this. There is understood to be a 'hierarchy of evidence' which positions systematic reviews and RCTs as the gold standard of research, and expert opinion and observational studies as the least robust or reliable forms. Alongside this growing emphasis on quantitative evidence, critiques of the use of positivism within social sciences and in particular mental health research have also mounted. The positivist ideals of neutrality, logic and detachment have been questioned on several grounds. Most notably, positivism offers a misleading depiction of causality, and of how we are situated within our social world, within our own bodies, and within culture (Johnstone et al., 2018). Rather than removing these 'variables' for the purpose of scientific enquiry, it is argued that our knowledge, the things we deem 'true' or 'real,' are always represented within and mediated by socially constructed modes of engagement (e.g. Habermas, 1972, 1974; Foucault, 1977; Bhaskar, 1978). Far from being the pinnacle of objectivity, positivism is rooted in colonial and sexist bias (Harding, 1987)

Although such critique may prevent the possibility of discovering objective truth, it does not mean that the concept of truth must be rejected entirely. Instead, critical realists, feminist standpoint theorists and survivor researchers contend that the social positions occupied by certain (oppressed) identities can provide less distorted views of reality by penetrating ideological views that are maintained by those in privileged (oppressor) social positions. In the

following sections, I will explore these philosophies and how they are relevant to my research.

6.4 Epistemology

6.4.1 Critical realism

Critical realism offers a middle ground between the poor fit of positivism and the nihilism of post-modern relativist approaches (Mussell, 2016; Pilgrim, 2018), and its key assumptions compliment the situated, values based approach of peer support. Critical realism presupposes a reality which exists independently of our senses (ontological realism) but that is not readily accessible to us, and is mediated through the theories and discourses (the 'real') which shape what we see and therefore can be said to 'know' (epistemological relativism; Bhaskar, 1986). Because our experience of the world is always mediated through our personal, political, cultural worldviews, critical realism argues that all knowledge is partial, incomplete and open to being reconstructed in light of new information. This means that peer support must be explored cautiously, and findings must be understood to be contingent and context bound rather than universal. Yet patterns will be found, and causal mechanisms may be suggested.

Critical realists argue that surface appearances are potentially misleading and inquiry must take us beyond and behind shallow understandings. In the open systems of the social worlds we live in, it is not possible or desirable to isolate particular variables from the context they occur within. Instead, it is understood that mechanisms act together, and that how they act is dependent on, and rooted within their specific context (Edgley et al., 2014). Mechanisms also combine to form more complex entities, which have properties that are qualitatively distinct from the original elements but remain likely to be causal. For example, Archer (2000) describes identity as one such 'emergent' entity, formed from interwoven personal, social and political processes. These processes mean that identity is not solely the property of an individual and cannot be fully understood in individual terms. Similarly, the concept of peer

support cannot be understood without also understanding the contexts and cultures within which it unfolds.

Critical realism is described as an emancipatory philosophy, emphasising the importance of developing knowledge of ourselves and society for the purposes of human emancipation. Explanatory critiques (Bhaskar, 1986) involve uncovering hidden structures which are causal to surface (empirical) appearances. They rest on the assumption that, in general, it is preferable to hold a true belief than a false one, and that the striving toward true beliefs, in turn uncovers the falsity of others, by exposing hidden processes. Exposure of these allows us to transform or remove barriers to greater emancipation. This is consistent with the aspirations of peer support, which in part emerged out of a civil rights movement and has as one of its goals, social and system change (see Chapter 4).

Critical realism is well suited to my enquiry because it is an emancipatory approach, with a focus on the context bound, value laden nature of science. It holds onto the notion that some accounts are more 'real' than others, which is also consistent with feminist and survivor voices. All of these approaches argue that some standpoints have a vantage point from which to 'see,' and so can make knowledge claims closer to the truth than those whose position of privilege makes them ignorant to the full picture of human suffering within a system driven by profit maximisation, patriarchy and postcolonial aspirations of acquisition.

6.4.2 Objectivity and situated knowledge

Through a feminist lens, my experiences of using mental health services, described at the beginning of this chapter are an example of hermeneutical and testimonial injustice. Miranda Fricker (2007) describes these forms of injustice as the wrongs done to a person or groups of people specifically in their capacity as knower(s): 'testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretative resources puts someone at an unfair disadvantage when it

comes to making sense of their social experiences' (p.1). Some have referred to this as a form of epistemic violence; the imposing of a particular discourse (in this case, the discourse of mental illness) on a silenced group of people ensuring their submission and oppression while generating barriers to emancipation for the group. Summerfield argues that 'The political and economic order benefits when distress or dysfunction that may connect with its policies and practices is relocated from socio-political space, a public and collective problem, to mental space, a private and individual problem' (2008, p.3).

Feminist scholars argue that traditional scientific epistemologies have systematically excluded women from occupying the position of the 'knower' or from being the agents of knowledge. Instead the agents of knowledge have consistently been (white, western, bourgeois) males, communicating a male voice of science and establishing an historical narrative from a singularly male perspective (MacKinnon, 1982). They argue that despite claims of objectivity, traditional science is inherently biased toward the views and issues of males, disempowering subaltern groups, and offering solutions to the problems of males in a manner that suggests that the whole population will benefit (Flax, 1983).

Developing Marxist ideas, feminist standpoint theory suggests that an oppressed group has access to knowledge in a way that other groups do not. Within this frame, feminist theorists argue that all knowledge is situated within a particular socio-political context and is therefore partial, but that some standpoints are closer, or more able to elucidate, the truth than others (Harding, 1987, 1990). In their arguments, standpo;int feminists have constructed a distinct scientific approach characterised by an appreciation of qualitative differences and complexities, broad understandings which are sensitive to the inter-relatedness of things and a bi-directional relationship between scientific knowledge and shared lived experience (Keller, 1982; Rose, 1983). Rather than striving for neutral, objective stance, they argue that 'the pot carries its maker's thoughts, feelings, and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story, or science.' (Krieger, 1991,

p.89). Further to this, several authors have highlighted how most scientific research studies are flawed because of a number of factors contributing to bias across a range of academic disciplines. These include the reliance on, and reduction of data into single alpha levels to determine statistical significance, the publishing of studies which cannot be replicated, the manipulation of scientific/statistical analysis to foreground positive results, selective reporting and a failure to acknowledge the conflicting political interests within particular studies/academic disciplines (e.g. Ioannidis, 2005). This is compounded by publication bias, which leads to an under-reporting of negative results or results that fail to conform to the prevailing scientific prejudice (Young et al., 2008).

6.4.3 What counts as knowledge and whose knowledge counts?

A key question in feminist and mental health survivor movements is who is able to speak about individual experiences? Who decides what is meaningful about experiences, and using what criteria? Feminist scholars have provided examples of how knowledge has been generated about women in a way that has oppressed and supressed their own forms of knowledge about themselves:

> *'The classic texts of Western history, philosophy, literature, religion, and science, riddled with misinformation about women, are handed down as sacred truths. When individual women attempt to challenge the adequacy of such misogynist accounts, they are frequently informed that their innate inabilities preclude their comprehension of these classic insights.'* (Hawkesworth, 1989 p.538)

This misuse of concepts of reason and logic has further been described as functioning as 'a kind of gang rape of women's minds, […] in masculine hands, logic is often a form of violence, a sly kind of tyranny.' (De Beauvoir, 1960, p.201). Epistemological claims that profess to be neutral, replicable, universalising and therefore scientific actually occupy political and ethical realms. In mental health, feminist theory has criticised current medical

approaches for pathologising what they argue are reasonable responses to various forms of oppression. They emphasise the long-standing approach within psychiatry of labelling women as irrational, unstable, immature and unintelligent, while the economic and political system systematically denies them equality, justice and fair treatment, so that such labels serve to obscure the causal relationship between injustice, oppression, and madness (Brown, 2000)

There is huge overlap between feminist arguments and the survivor movement in mental health, which argues that: ‘mad voices have been – and continue to be – not heard, overwritten, silenced or even erased in the course of psychiatric treatment. We often find ourselves giving not just our story but also the knowledge that has emerged from our experiences only to have it re-framed, serving various purposes and different agendas, and ultimately alienated from us’ (Russo & Beresford, 2015, p.153). The survivor movement began in the 1970s and created an influx of narratives relating to personal recovery and the experience of abuse at the hands of psychiatric systems. This movement challenged the basic assumptions which underpin medical understandings of distress and positioned survivors as the knowers of mental distress, of mental health services, and of the stigma associated with these experiences. Just as feminist scholars have argued that their experiences are misinterpreted and misused within dominant patriarchal discourses, so too do survivor researchers in relation to the psychiatric paradigm:

> *"Mental health service users have traditionally been excluded from creating the knowledge that is used to treat us, and many of us have suffered from the misunderstanding of our needs by people who have been taught to see us as by definition incapable of rational thought."* (Wallcraft, 2009 p.133)

For feminists and survivor researchers, women (feminists) and survivors occupy social positions which afford them the ability to identify and understand social concepts on a far more authentic and embodied level. Using their situated perspectives transforms the context of justification but also the context of inquiry, as the questions posed by feminists and survivor researchers are

proposed to be radically different (Harding, 1987). Narratives from people who have used mental health services unearth recurrent themes of oppression (Chamberlin, 1990), stigma (Connor & Wilson, 2006) and an experience of a system constructed to serve those in control (Eastman, 1999). As such, consistent with critical realism, the outcome and overarching goal of both feminist and survivor research is of emancipation rather than of control or manipulation, as in traditional science (MacKinnon, 1982; Campbell, 2001).

6.5 Applying a standpoint to research

Both Feminist standpoint theorists and survivor researchers argue that the issues that they raise cannot be remedied simply by adding women, or adding lived experience, into existing scientific processes (Harding, 1987; Horrocks, Lyons & Hopley, 2010). Even if this inclusion is based in equality, their addition would leave the androcentric oppressive standards, which have been identified and fought against, largely intact. Keller (1985) and others have suggested that the ideal of objective detachment can disadvantage research, as it leaves scientists unable to develop intimacy and sensitivity toward the objects of their study. Feminists argue that increasing our awareness of the values that inform research through an ongoing reflexive process, increases objectivity by avoiding the confusion of personal perspectives with universal views (Harding, 1993). The inclusion of marginalised groups within the reflexive process produces what Harding (1990) refers to as 'strong objectivity;' the ideal form of objectivity which acknowledges the importance of valuable oppressed standpoints over value neutrality.

However, critics of standpoint theories have argued that the assumption of an 'epistemological chasm' between the standpoints of dominant and subaltern groups is outdated, while others have discredited the notion of separateness of different standpoints (Walby, 2001; Haraway 1988, 1989). The argument that women or survivors are able to generate more accurate knowledge simply because they are female or have lived experience risks an oversimplification of females/survivors into monolithic groups, imbuing them with almost mystical ability to perceive oppression. Such arguments risk intimidating

women/service users who do not identify as feminists/survivors, and alienating males/mental health professionals (Haack, 1993).

These criticisms of standpoint theory and the arguments from intersectional perspectives have led to the broadening of standpoint theory to acknowledge that there is no single feminist standpoint that is able to claim superiority over others. Instead, it has been recognised that a diverse range of standpoints exist, and each is able to be epistemologically informative (Collins 1990). The expansion of standpoint theory has encompassed the standpoints of other marginalised populations, accepting that the experience of marginalisation, regardless of gender can offer richer insights than the experiences of privilege (Harding, 1993, 1998).

Feminist standpoint theory has also moved beyond a reliance on a 'unique perspective' to the use of a unique values base as well. The combination of a unique standpoint, with a values base rooted in connection, collaboration and awareness of power has led to the development of a distinctive scientific approach. This approach is further characterised by an appreciation of qualitative differences and complexities, context based understandings which are sensitive to the inter-relatedness of different processes, and a bi-directional relationship between scientific knowledge and embodied lived experience (Keller, 1982; Rose, 1983).

The mixing of unique standpoint and specific values is valuable to research in peer support where lived experience (or a unique perspective) is combined with a set of core principles, both being essential within peer support relationships. The values of peer support (described in Chapter 2) include reciprocity, relational safety and mutuality. Feminist standpoint theory and critical realism provide a suitable underpinning for research in peer support in five key ways:

- The awareness of power and the importance of equality within peer support relationships is complimented by feminist approaches.
- A strong emancipatory motivation is inherent in critical realism, feminist standpoint theory and peer support

- Critical realism and feminist standpoint theory make clear the importance of context. A number of authors have argued that the introduction of peer support into the context of large mental health systems fundamentally alters the support that is offered (e.g. Gillard, 2017; Russo & Sweeney, 2016)
- The concepts of embodied lived experience, authenticity, voice and empathy which are central to peer support are also the foundation for feminist standpoint theory. Peer support relationships locate the expertise within the individual whose experience it is, and the aim is to help a person to claim their identity and value their experiences.
- The use of transparency and reflexivity as a means of demonstrating rigour, by acknowledging one's own positioning and the possibility of its impact on data collection and analysis (see 6.10 below)

6.6 Methodology

Although Critical Realism and feminist epistemologies offer a philosophical foundation to me, neither advocates for the use of specific methods. In fact, critical realism has been described as 'a philosophy in search of a method' (Yeung, 1997, p. 51) because of its openness to any and all research practices. Critical Realists argue that inquiry should remain a pragmatic process, so as to preserve the process as one directed by the phenomena under study (Danermark et al., 2002).

Given the epistemological underpinnings described above, my method should:

- Value the lived, situated experiences of peer support workers as central to our understanding of peer support.
- Involve my own voice as well; as a 'knower' of peer support, the mental health system and of madness, I should be prepared to search myself as well as the experiences of others
- Explore both peer support and the context which it takes place within, in the understanding that peer support is inseparable from its cultural, political, social and material context

- Be reflexive, aware and honest about my own experiences, thoughts and emotional responses. I should be prepared to challenge myself and be challenged by the perspectives of others, especially where these are different to my own
- Reported in a way that acknowledges the limits of representing voice (discussed in the section 6.8)

Based on the epistemologies I describe above, and the values of peer support, I have developed a method which combines interviews and auto-ethnography.

6.7 Interviews as a source of knowledge

Given that feminist standpoint theory and peer support locate expertise within the individuals whose experience it is, interviewing peer support workers will be the most suitable method for my research. Although widely used within qualitative research, interviews may take different forms depending on the interviewer, their research topic and their epistemological stance. Survivor and feminist researchers have articulated an approach to interviewing which is based on empathic understanding, closeness and reciprocity between interviewer and interviewee. As an early advocate for such an approach, Oakley (1981) argued against the aim of objectivity and mechanistic techniques within interviews. Instead she and others have embraced the use of interviews as a means of two-way sharing of lived experience and of deepening relationships.

This approach will underpin my research; If research interviews are to be consistent with the values of peer support, and where possible, mirror peer support relationships, they must be characterised in these ways:

- They must be loosely structured given that peer support is a non-directive approach, the interviewer should not adhere to a strict structure, instead allowing room for the interviewee to express their ideas and for these to be explored
- They must be rooted in flexible and close relationships rather than distant and controlled. There should be an element of reciprocity where

both interviewer and interviewee are willing to share something of their experiences. This is not merely to access richer data, as some have suggested (Harrison et al., 2001) but a moral and ethical decision based on an awareness of power and the desire to share it.

- They must be reflexively undertaken, with an awareness of what impact the relationship, context and content, might have on interviewer and interviewee. Because reflexivity is not limited to research interviews but must run alongside every stage of research, it is discussed in greater detail below (section 6.10).
- They must be characterised by empathy, defined as 'entering the private world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person….It means temporarily living in his/her life, moving about in it delicately without making judgements … as you look with fresh and un-frightened eyes.' (Rogers, 1975, p. 3). This skill is central to peer support and empathic listening is a cornerstone of peer support training across the country (Watson et al., 2016). In recent years, the concept of empathy has been criticised (Lather, 2009). This is explored further in the section below.

6.8 The voice of the peer support worker

In attempting to emulate feminist approaches which seek to 'give voice' to the voiceless lies the potential to betray those voices, and to misunderstand and oversimplify the concept of voice entirely. Qualitative researchers are encouraged to privilege voice as a form of knowledge under the assumption that voice speaks the truth of a person's experience. Within these paradigms, voice has the ability to show what is 'true' or 'real.' Qualitative researchers often use methods which attempt to 'give voice' or 'make voices heard,' often by using direct quotes from multiple participants as an effort to allow readers to directly witness the multiple conflicting voices within a given context (Guba & Lincoln, 2005). Jackson and Mazzei (2009) argue that these practices are underpinned by an understanding of voice as something that is waiting to be

liberated or retrieved. This understanding ignores the process of research which shapes, privileges, selects and filters certain voices:

> *'Qualitative researchers have for some time begun to question the ethics of representing the voices of others, interpreting narrative accounts, and the privileging that occurs in the decisions that we make in the questions we ask (or fail to ask), interpretations that we map onto (or miss), and the ways in which participant voices are portrayed and represented'* (p.2)

They argue for straining the notion of voice, resisting 'too easy' ideas about voice and rejecting the idea that presenting quotes as a means of letting participants speak for themselves is a sufficient solution. Others have criticised the feminist values of empathy and authenticity in research. The act of empathy entails linking the experiences of another person, to something familiar within ourselves, in order to root them within a contact we have felt and understand. Some argue that this process of identification is a form of violence; a failure to acknowledge the limits of our own understanding, and an imposition of our view upon experiences we cannot comprehend (Lather, 2009, p.19)

Behar (2014) describes her efforts to develop an approach to her anthropology that is neither cold nor averse to exploring the relationship between connection and otherness. It is this balance, between empathy and an awareness of the limits of it, which is the intention I hold for my research.

6.9 Including myself – autoethnography

Liggins, Kearns and Adams (2013) argue that combining researcher and participant roles enables the researcher to be as close as possible to the experience that is being researched. They note the particular benefits of this approach for mental health research where issues of stigma and privacy may affect participant disclosure. In Autoethnography, the researcher offers an analytical account of experiences that they themselves have been central to. It demands that the researcher "scrutinize, publicize, and reflexively rework

their own self-understandings as a way to shape the understandings of and in the wider world" (Butz & Besio, 2009, p. 1660). It is part of a feminist tradition of using auto-biography to consider our own embodied subjectivity and how this is affected by particular experiences (Radstone, 2000). Fusing the roles of researcher and participant rejects the idea that a detached, objective researcher is necessary in constructing meaning and endorses the roles of subjectivity and emotion within research (Ellis, Adams & Bochner, 2010).

The choice of Autoethnography is taken as a means of combining voice, experience and theory. This has the joint outcome of sharing personal understanding in an academic context, and continuing the process of personal development for the author (Nye, 1997). The success of this method rests on developing the appropriate balance between an inward focus on personal identity and vulnerability, and an outward focus on the social and political aspects of embodied lived experience (Ellis & Bochner, 1999).

Critics of autoethnography have questioned its reliance on memory and interpretations where these may lack detail or be factually inaccurate (Burnard, 2007). It is also frequently criticised for being self-indulgent and narcissistic (Coffey, 1999). In some auto-ethnographies, letters, photographs and other sources are included to add 'factual' details, however, others have questioned the relevance of a concern with 'facts' given the importance placed on personal reality (Ceglowski, 1997). Others note that involving the author within the dialogue of the research helps position them as a more mutual learner, removing some of their assumed authority (Sparkes, 2002). Although Finlay (2002) argues that it also creates a paradox which gives them more credibility and thus authority.

What is clear is that Autoethnography demands honesty and reflexivity on behalf of the researcher, which enables them to identify and reflect on the choices they make as to what to include and exclude from their accounts. In her Auto-ethnographic account of a long-term illness, Ettorre (2005, p. 536) questions 'am I willing to include details that might reflect badly on me? That might show me as an intransigent patient as well as stubborn?' Her concerns reflect my own apprehension of adopting this approach; in writing honestly

about my own experiences, I risk the judgement of others and their potential criticism both on an academic and personal level. Autoethnography requires a level of skill from the researcher, as they negotiate the many 'balancing acts' involved with this style of writing. These include balancing between the personal and the political (Holman-Jones, 2005); art and science (Ellis, 1991); and the roles of witness and the role of doer (Chawla, 2003).

6.10 Staying close and reflexive

Given that I have undertaken research in the area that I work, and am using my own diary as a source of data, I am aware of the need for committed reflexivity to underpin my work. Within this chapter I hope that it is clear that I have practised reflexivity before beginning my research, through being introspective, assessing my own biases and motivations, and asking whether I am suited to examine peer support given my involvement in it.

Finlay (2002) defines reflexivity as 'being thoughtfully and critically self-aware of personal and relational dynamics and how these affect the research.' (p. 210). It is a means of examining decisions, motivations and relationships between researcher and the researched and enables research to be placed within its socio-political context. It also affords research greater transparency by showing the context bound partial nature of the researcher (Geertz, 1998).

It is only through reflexivity that I may be able to challenge any beliefs about my research presenting a copy of reality and puncture any fantasies that I hold about absolute truth and objectivity (Foley, 2002). I will use supervision, as well as maintaining a research journal, to explore my own judgements and assumptions throughout the research process. It will be particularly important for me to spend time doing so, as my judgements may not always be obvious to me, having worked for such a long time in the area I am researching. It is my hope that this research is marked by transparency of my own relationship with the area of study, as well as my own relationships with the peer support workers. I will endeavour to be honest about the successes and mistakes which will inevitably form a part of my enquiry, and to question myself about the conclusions I arrive at.

This will be important throughout the research process, but in particular during interviews. The reflexive interviewer looks critically at the process, context, and outcomes of interviews and explores how knowledge is being constructed. Again, I will support this reflexively through journaling and supervision, enabling me to frame the interviews with an open and self-aware approach. I will also examine the impact of my role in the Trust on this research, in particular, I will try to be aware of how this influences what people share with me and how I conduct interviews. Within interviews, Bickford (1993) has described a framework for 'political' listening which requires the listener to challenge their need for control, instead being open to difference and curious about standpoints that are different to one's own. This style of listening is aligned to the non-judgemental listening required within peer support relationships. I have explored reflexivity further in the following method chapter.

6.11 Quality in qualitative research

Reflexivity is widely understood to be a marker of quality in qualitative research. Tracy (2010) argues that reflexivity is a component of 'sincerity,' one of the eight criteria she lists as essential for excellent qualitative research. In addition, she lists a worthy topic, rich rigor, credibility, resonance, significant contribution, ethics, and meaningful coherence as the markers of quality in qualitative research. These eight criteria have guided me to be self-critical about my methodological choices, and transparent about the origins of these. In particular, the concept of credibility will be helpful in analysing and reporting my findings. I will endeavour to provide in depth illustration or depiction of what I have found, rooting this in the context of the mental health systems that peer workers describe. These in-depth illustrations require researchers to *show*, rather than tell, providing enough information so that the audience may reach their own understanding about the subject. In my findings chapter, I will use creative approaches as a means of achieving this.

Related to credibility is the concept of multivocality. As Tracy (2010, p.844) describes:

> *'In addition to providing an empathic understanding, attending to multivocality provides space for a variety of opinions. Qualitative researchers do not put words in members' mouths, but rather attend to viewpoints that diverge with those of the majority or with the author. Multivocality also suggests that authors are aware of cultural differences between themselves and participants.'*

This concept is particularly helpful to me, coming to this research as I am, as a white, middle class female, with my own preconceptions about peer support. Paying attention to what my preconceptions are, and how these are challenged or confirmed, will be an important part of maintaining transparency and authenticity which are essential to all qualitative research.

6.12 Conclusion

In this chapter, I have described the development of my emerging standpoint, which is rooted in survivor, feminist and critical realist epistemologies. I have described an approach to research which is congruent with my own values, as well as the values of peer support. In the following chapter, I will describe my method using a reflexive approach where I am conscious of my 'insider' identity within my research, given that I work within the Trust that I am studying. I will explore how this, and other factors, influence the power dynamics between myself and the people I interview.

Chapter 7 - Method

7.1 Introduction

In the previous chapter I drew on feminist standpoint theory as well as critical realism to develop an approach to research which is aligned to the values of survivor research and peer support. This is important for me personally as, largely, the values of peer support are also my values as a human being. But it is also important politically; research within mental health has a legacy of 'doing to' people, researching about them, rather than with them, and certainly not trusting them to research themselves. In recent years, survivors and activists have sought to balance 'the overwhelming majority of material written about those who are labelled mad by those who do the labelling and those who study them' (Crepaz-Keay & Kalathil, 2013, p.23).

They have positioned experiential knowledge – the knowledge gained through embodied, lived experience within a situation - as central to understanding, and thus survivors as the knowers of mental distress. Within this chapter, I describe the method I used to undertake my research which consisted of 18 interviews with peer support workers, alongside my own diarised experiences in the role of peer support development lead over the period of 14 months (February 2017-April 2018). This method enabled me to incorporate both my own experiential knowledge of peer support and the organisational context, and the experiences of other peer workers.

7.2 The language of qualitative research

Having described in the previous chapter, my shift in thinking away from positivist science, I have become aware of the use of language within qualitative research which continues to retain some of the features of positivism and the scientific method. Use of words such as 'data', 'analysis' and 'sample' have come to feel restrictive to me, and not helpful in accurately describing the concepts they refer to. Despite this, I have continued to use such terms within my method section. I have done this because the search for alternatives would likely result in a more confusing and difficult to follow text, given that any new terms I select would not be anchored within the shared

understanding of the already understood terms of qualitative analysis. In addition, Spivak (1974) wrote that ‘to make a new word is to run the risk of forgetting the problem or believing it solved’ (p. xv). I am aware that the issue of analysis in qualitative research goes beyond the words we use for it, but is often underpinned by a privileging of scientific, quantitative knowledge above other forms.

So, although I have continued to adopt the language of ‘analysis’ and ‘data’ I have endeavoured to undertake the analysis in a reflective and reflexive style which is more congruent with the values of feminist science, survivor research and peer support.

7.3 Research setting

I undertook my research within Nottinghamshire Healthcare NHS Foundation Trust (Nottshc). Nottshc was among the first NHS Trusts in the country to employ peer workers in 2010 and has communicated an ongoing commitment to developing peer support within the organisation. At the time of writing (2019), it employs approximately fifty-five paid peer workers, alongside a number of volunteer peer workers. These peer workers are mostly based within Adult Mental Health, Primary Care Services, Child and Adolescent Mental Health Services, Perinatal Mental Health Services, Mental Health Services for Older People, and the Recovery College, which is a resource for people over 18. The Trust offers a training course twice a year for people wishing to work or volunteer in peer support roles. This is co-produced and co-facilitated by my team, the Peer Support Development Team.

To co-ordinate the peer support developments across the Trust and to support current peer workers, the Peer Support Development Team sits centrally in the Learning and Development Department at the Trust headquarters. At the beginning of my PhD studies, I was employed within this team as a Peer Support Development Worker. During the course of my studies, my manager left the team and I moved into the role of Peer Support Development Lead, the role I currently hold. My role involves offering supervision to peer workers in addition to their management supervision. I am the training lead for the peer worker training offered by the Trust and I co-facilitate this with peer trainers

within the development team. I supervise and manage peer support development workers as part of the peer support development team. I work with teams who want to employ peer workers or develop peer roles to support them with this, and I co-ordinate regular development days for any person who has completed the peer support training. My role also involves responsibilities which are not strictly related to peer support but are linked to a wider agenda of recovery within mental health services. For example, I co-chair the Trust Wide Recovery Steering Group and am involved in projects relating to trauma informed care and staff wellbeing. My position as peer support development lead puts me in a more powerful position than the peer workers I interviewed in terms of pay and influence within the organisation. I have reflected on this in later sections.

In terms of the wider context of Nottshc, at the time the research was carried out (between February 2017 and April 2018) the Trust had been undergoing 'cost improvement' programmes, including cuts to staffing, service redesigns and service closures for a number of years. Subjectively, there was a sense among the peer workers and staff I spoke to that these had begun to reach unprecedented levels, such that some services felt unsafe due to low staff numbers and high levels of risk. In Adult Mental Health, the community teams had very recently been restructured; the specialist teams that once existed, including Early Intervention and Assertive Outreach had been merged and made into locality based teams. This had left the staff I was in contact with feeling de-skilled having lost their specialism, and unsupported, having lost their existing colleagues and supervisors. The results of the 2018 survey confirmed that Nottshc had amongst the lowest levels of staff morale in the country, as well as the lowest levels of staff engagement. The survey also showed a marked decrease in levels of self-rated wellbeing, perception of equality and diversity, quality of care and safety, as well as an increase in bullying, harassment and violence experienced by staff.

Between June 2017 and May 2018, while I was undertaking my research interviews, 23,686 mental health staff left the NHS across the UK, equating to one eighth of the total mental health workforce (House of Commons, 2018a). This led to one in ten posts being vacant at the end of June 2018. In July 2017,

the government published a mental health workforce plan for England which outlined the creation of 19,000 new posts within NHS mental health services (Health Education England, 2017). Despite this, in the year that followed, the workforce increased by only 915 people. Between 2009, when Nottshc first secured funding for peer worker positions, and 2017 when I began my research interviews, there was a 13% reduction in mental health nurses, and a 25% reduction in mental health nurses in inpatient settings across the country (House of Commons, 2018b). Within Nottshc, staffing levels consistently failed to reach the targets laid out for 'safe' staffing (Nottshc, 2018, 2019)

At the time of writing my journal for the purposes of my PhD, my manager (an Occupational Therapist by background) was leaving our team and I moved into her role. Although I took up the responsibilities of the role, my pay remained the same and this was the source of much distress, cynicism and sadness for me. I also felt conflicted in my role, having read so many critiques of peer support within mental health services, and I felt sharply aware that I may be contributing to the co-option of peer support (see Chapter four). In the months that I kept the diary, I often felt that I wanted to leave the Trust, and that my job was draining me of my passion for peer support.

7.4 The participants

The eighteen participants were all peer workers within Nottshc and this was the recruitment criteria for the study. Other criteria were that participants must be aged 18 years and above, with no maximum age limit. They needed to be able to give informed consent and understand written and verbal English. There was no limit on the duration that a person must have been a peer support worker for them to be included in the study, meaning their length of service varied between 1 and 8 years, and some had worked for the Trust in different roles prior to being employed as peer support workers. All the peer support workers were based within mental health teams, which involved working alongside professional staff in multi-disciplinary teams. This included support within inpatient and community settings (11 peer workers were based in community teams and 7 on inpatient wards) with

people of varying ages using different Nottshc services. Peer support roles at Nottshc include the responsibilities inherent in any support worker roles, including attending meetings and handovers, holding a caseload (if working in the community), writing clinical records and one to one support. Peer workers who worked within inpatient and community settings were included in the study to offer a more comprehensive understanding of the culture of mental health services, and because this represents the spread of peer workers within Nottshc.

Twelve of the interviewees were female and six were male. Eleven worked in community mental health teams and seven worked on inpatient wards. Because the research took place within Nottshc, interviewees were drawn from a limited pool of peer workers. Extra efforts were taken to protect the anonymity of participants. During transcription, their places of work and names of colleagues were removed, including the service that they worked within. Within the findings section, creative processes have been used to present themes in a way that distances them from the individual peer workers. These are described in more detail below. I had a relationship with each interviewee before they were interviewed. I had known them through training them, or training with them, managing and/or supervising them and working alongside them as a peer worker myself. I have reflected on these dynamics below, as well as within my findings and discussion chapters.

7.5 Ethical Governance

Before beginning data collection, ethical approval for the study was sought by the University of Nottingham Research Ethics Committee. The application for ethical approval was supported by Nottshc who reviewed the submission which included the participant information sheet, consent form and interview topic guide (Appendices B, C & D). As the study was a student study, taking place at a single centre, involving NHS staff only, the Trust Research and Development Department confirmed that they did not expect an IRAS form to be completed for submission to the HRA for their assessment. Ethical Approval was received in writing on the 31st May 2017 from the University of

Nottingham Research Ethics Committee (Appendix E). Permission was granted by Nottshc Research and Development Department for the Trust to be named within the research. Further details relating to confidentiality, risk to participants, as well as reflective ethics are provided below.

7.6 Recruitment

Following receipt of ethical approval from the University of Nottingham Research Ethics Committee and Nottshc Research and Development Team, I met with the team leader of the peer support development team, my then manager. I provided an information sheet about the study (Appendix B) which described the study aims, expectations and ethical approval. I also explained these verbally. As the organisation's gatekeeper, the peer support development team leader identified and emailed the peer workers within the Trust to invite them to take part in an interview. This email included a participant information sheet and my contact details. Potential participants were provided with the opportunity to ask further questions and discuss the study in person prior to giving consent (or not) to take part in interviews. The email was sent by the peer support development team leader rather than by me to ensure a degree of distance between myself and the peer workers, and peer workers who were interested in taking part contacted me directly via email. I was aware that some peer workers may have felt obliged to be involved in my research because of my position in the peer support development team. The email made clear that my research study is separate from my working role and that participation, or choosing not to participate, would not have any consequences for their working role or our relationship.

Because of my existing relationship with the peer workers in Nottshc, many of them knew about my PhD study and offered to be interviewed. It is likely that I would not have recruited eighteen participants had I not already had a relationship with them. I have reflected on the benefits and challenges of these existing relationships, as well as my position of 'authority' in later sections of this chapter.

7.7 Consent

All participants provided written informed consent after I had explained the details of the study to them and provided them with a participant information sheet. I allowed time for them to consider the information and ask questions about the study. I also stressed that I would not discuss the research interviews within my working role and no Trust staff, including the peer support development team, would be made aware of who took part in the research.

After signing two consent forms (Appendix C), one copy was kept by myself and another was kept by the participant. Study information sheets made it explicit that participants were free to withdraw from the study at any time and that participation, or declining to participate, had no consequence for their working roles. Participants could be withdrawn from the study either at their own request or at the discretion of the investigator, and could also request that their data be removed from the study. Although no participants chose to withdraw, if this were to happen another participant would have been recruited to replace them.

7.8 Sample size

A sample size of 18 was determined using the concept of rigour in relation to qualitative research. Tracey (2010) argues that sample sizes should be determined according to the number that will provide enough data to support significant claims, and the goals of the study. A total of 18 interviews was considered sufficient after considering the complexity of the research questions and of the interview topic guide, and the diversity of the sample. An interview sample of twelve or more is suggested to provide a sufficiently rich data set for qualitative research (Guest, Bunce & Johnson, 2006). As there are approximately fifty-five paid peer workers in Nottshc, eighteen is a significant proportion of the total number.

7.9 Interview process and method

The semi-structured interviews were face-to-face, taking place in a setting that was private and mutually convenient. Each interview lasted up to 90 minutes and each participant was interviewed once. The topics discussed

related to the participants experience and perception of peer support within the organisation. Each interview began by asking the participant how they defined peer support. This was the only question that was asked to each participant. Although a topic guide was used (Appendix D), the structure of the interviews was based on the responses that were given. The focus of each interview remained on areas relating to working environment, their experience of the peer support role, their relationships within peer support and with staff, their use of lived experience and the emotions involved in their work. The notion of reciprocity is central to peer support (Repper, 2013) and feminist research (DeVault, 1996). Because of this, I sometimes shared my own experiences or reflections within interviews. I shared these when I thought it would facilitate more discussion, either by contrasting with or agreeing with the experience of the interviewee. Although I was careful not to rely too heavily on this technique, I was inspired by researchers who argue that reciprocity between interviewee and interviewer shows interest, builds relationships and trust, and contributes to meaning making (Ellis & Berger, 2003; Oakley, 2016). Below is an anonymised example of a time that I chose to share my perspective within an interview:

> ***Aurora:*** *I always just think that they [staff who supported me] know all my history but they've long forgotten now I'm sure, because I know now, when I'm working with people, you know, you can't remember every detail of everything can you?*
>
> ***Me:*** *I think that's my reluctance of ever going back to the service I was supported by because they know such personal stuff, they know the darkest points in my life, they've been there and they've seen…the person that I am not now, it didn't feel like that was me at the time, and I don't want them to be defining me by that*
>
> ***Aurora:*** *That's what I mean, I don't want to be defined by that, I want to be defined by who I am, but they don't really know me outside of that do they*

7.10 Transcription

With the consent of the participants, all the interviews were audio-recorded, transcribed and saved on a password protected computer. Characteristics identifying participants were removed during transcription and participants were given a fictitious name to protect their identity. All the participants received a copy of their interview transcripts as a matter of courtesy, and not as a form of member checking. Although member checking is believed, by some, to increase the trustworthiness of qualitative research, others argue that the process often results in censoring, corrections and expanding on points, and fails to acknowledge that the perspective of any interviewee changes over time, context and depending on the perceived audience (Drever, 1995). Silverman (2013) describes interviews as contextually-embedded narratives, and the process of member checking cannot validate the data, but only serves to increase it. Audio recordings were stored and archived in accordance with University policy and all data were handled and archived in accordance with the University of Nottingham Code of Research Conduct and Research Ethics (2010). All the interviews took place in Nottshc buildings in private meeting rooms.

7.11 Journaling as data

In addition to the 18 interviews, I kept a journal of my own working experiences within the Trust. This was separate to a research journal I kept to reflect on my experience of undertaking interviews. As I described in the previous chapter, I did this in order to undertake research in a way which honours the values of peer support, and because, ‘As those educated and practiced in gathering, analyzing, interpreting, and writing about the experiences of others, I think it is important—when relevant—that we be prepared to take an informed risk and expose our own’ (Vickers, 2002, p.611).

I wrote this journal of my working experiences as I have written every other journal in my life; sporadically, and with fewer entries than I had hoped to write. I did not structure my reflections using particular models, or focus on particular questions. I wrote what felt pertinent to me about my experience of the working

week. In particular, I wrote about experiences which evoked strong emotional reactions within me. This regularly included the internal conflicts and anger I felt within my changing role in the peer support development team. I wrote without censoring my own experience or the details of others' experiences that they had shared with me. Prior to using my journal in data analysis, I removed any details that would identify individuals that I worked alongside. The emails used within my results section are fictionalised, however, they have been developed from the types of communication that were sent to me in my position as peer support development lead over the period that I was collecting data.

I found the process of undertaking interviews, and of keeping a journal more difficult than I had anticipated. In the following sections, I have reflected on my position within the research, the ethics of my research choices and the risks to the participants and to myself.

7.12 Reflexivity: My position within the research

Researching within the organisation that I work within has been my intention from the beginning of my PhD enquiry. To have chosen another setting would have been to overlook the voices of the peer workers I know and respect from within Nottingham, and to some extent, to silence myself as well. I was aware at the beginning, and became more aware throughout my study, that my role in the organisation would make certain elements of research more difficult, and others easier. The value of 'insider' research within health and social care settings has been described by several authors. Similar to feminist standpoint theory, it has been argued that insider researchers have a superior understanding of the context they are studying; that their presence is less likely to change the nature of social exchanges; and that their established relationships can provide greater connection and a foundation for both the telling and perceiving of the truth (Bonner & Tolhurst, 2002; Oakley, 1981). Smyth and Holian (2008) also suggest that insider researchers are more aware of both the formal and informal politics of their social contexts, and are able to use previous knowledge for the purposes of research which would be difficult for an outsider to acquire. However, it has been argued that the implicit

nature of insider knowledge can lead to unconscious assumptions going unchecked (DeLyser, 2001). It is only the outsider who is able to observe with appropriate distance and detachment without being influenced by the customs of the group. They may also be better placed to ask naïve questions, and notice subtle rituals that are taken as normative (Simmel, 1950; Merton, 1972).

The importance of insider research has been applied in the context of race, where it has been argued that a white researcher cannot possibly be as sensitive to the realities of black communities as a black researcher. At the most extreme end of this debate, Wilson (1974, p.324) argues that 'whites are basically incapable of grasping black realities.'

Others have rejected the insider/outsider dichotomy entirely, arguing that people cannot be easily labelled as either, and that 'individuals have not a single status but a status set' (Merton, 1972, p.22). Therefore, being an employee of Nottshc, and a peer worker, as well as a friend to many of the people I interviewed represented some dimensions of the insider/outsider continuum. Other dimensions, including power, race, gender and class may shift my perceived position to that of an outsider depending on who I am interviewing and what I am asking them about (Mercer, 2007). Less has been published on the specific ethical, methodological and political dilemmas involved in insider research and little guidance is offered in how to work through the 'hidden ethical and methodological dilemmas of insiderness' (Labaree, 2002, p. 109).

The concepts of an insider or an outsider identity are particularly pertinent to peer support, where relationships are built on shared experience, often the shared experience of being an outsider. The peer relationship involves both a sense of being an outsider, in terms of ones relationship to society and healthcare professionals, and an insider, in terms of the peer to peer bond. As described in Chapter three, Scott (2011) describes this simultaneous insider/outsider position in terms of liminality.

My position as peer support development worker, and then as development lead was something to which I paid close attention at all stages of the research process. I was aware that my identity might impact on my research and on the

perceptions of the peer workers I would interview. I believe this impacted in two key ways:

1. My existing relationships, including friendships with peer workers

I had existing relationships with all the peer support workers I interviewed. These ranged from working relationships, to long and close friendships. Drever (1995) notes that 'people's willingness to talk to you, and what people say to you, is influenced by who they think you are' (p.31). Many of the peer workers told me that they felt more comfortable being interviewed because they knew me and said that they had shared more because of this. My existing relationships enabled me to help people feel at ease and to break down some of the assumed formality of a recorded research interview. However, it also required careful reflection so that the interviews were more than an extension of our friendships. In my research journal I reflected on three issues in particular relating to my existing relationships. First, in an interview with Pete, while walking to the interview room we began talking about how work was going. This conversation continued into the research interview:

> *"I noticed with Pete, we began as friends on the way to the interview room, sharing how difficult work had been recently, and the interview evolved out of that conversation. And I think I got that wrong. But how else could I have been? When he asked me how things were should I have lied? Or give him a version of the truth because of the context of interviewing?*
>
> *I don't know if it is just the positivist in me that is singing songs about bias and influencing the interviewee, but I regret how that interview unfolded. But maybe it is the perfect snapshot of this messy boundary between researcher, peer worker and broken human. That I was too much of the broken human that day and not enough of the researcher. And that Pete knew me too much as a peer worker, and I him, to step into new skin and have different conversations."* (From my research diary)

Before the interview, I took Pete through the information sheet and consent forms. With other peer workers, this had the effect of setting a different tone to

supervision, enabling us to step into a slightly different relationship where both of us expected slightly different things to the conversations we have in supervision. However, with Pete, when I began recording, he asked me a question relating to a work issue I had been talking to him about on the way to the interview room. During the interview he asked me a lot of questions about how I viewed peer support in the organisation. These questions created a conflict in me; answering them might mean that he changes his responses to fit in with my opinion, but not answering them would feel rude. As the interview unfolded, I shared my opinion with Pete more than I intended to, and more than I did with any other interviewee.

Second, my existing relationships meant that I had some sense of what interviewees might talk about, and some power to direct them to speak about certain topics. This was a power I was aware of, and wary of:

> *"I am interviewing Lana tomorrow. Last night I found myself thinking about work, and how much it is crushing me, and then I thought about this interview with Lana, and I thought, 'Lana will back me up.'*
>
> *I was looking for Lana to confirm things that I want to be true. I wanted to be vindicated. I wanted her to point to the monsters and say, 'look, they're real, I see them too.' I almost used this interview as fuel for my own witch hunt, used Lana as a puppet to confirm my theory that there is a persecutor and it is the NHS. And because Lana is my friend, and she wants to help me, she would have said those things I'm sure. And I could have painted a picture of peer support as the victim in the hands of psychiatry and I would have felt satisfied with this one dimensional representation because all I really want is for people to see the evil of psychiatry with its total absence of redeeming features. I was looking for peer support, not a research interview."* (From my research diary)

This experience with Lana was helpful in waking me up to the possibility that I could direct participants to agree with my own point of view. Because of this, I

made time to prepare before each interview, and to journal afterwards so that I could increase my own self-awareness and offer a reflective interview style.

Finally, I had been a peer support worker to one participant prior to them being employed. I had not expected her to talk about this in the interview and I found it difficult to hold onto my identity as researcher:

> *"And then Lizzy started talking about the peer support she had received, the peer support she had received from me. And I found it so difficult to stay as interviewer, because she was saying nice things about me, and creeping up from inside me was this feeling of, 'please, just stop saying that, Lizzy, just stop being nice' and I couldn't reflect things back to her about this amazing peer support because doing that would have felt so narcissistic.… I found myself drawing a blank. When she finished talking, I had nowhere to go, other than, 'wow, that's profound.'"* (From my research diary)

2. My dual role as researcher and peer development lead

During the interviews, I found it particularly difficult when peer workers discussed their difficulties within work. After Faith said that she dreaded coming into work, I reflected in my research diary that:

> *"I worried a heck of a lot about what she said, I wanted to rescue her, felt like I'd failed her, I wanted to tell her she's wonderful. I felt guilty that supervision isn't enough. And those are not the thoughts of a researcher, that is the peer support development lead. I can't just take off one hat and put on another."* (From my research diary)

I also felt defensive when peer support workers commented on the progress of peer support in the organisation, or passed judgement on how this could have been done better:

> *"…when people have criticised, like when Max criticised peer support, I took it so personally. I felt a flare of anger and injustice as he said it, and I had to notice that and stay with*

Max, and honour his experience of being left out and left behind, even though I felt like it was me he was describing."
(From my research diary)

During the research I became more aware that that the identities of insider and outsider are not mutually exclusive and, consistent with feminist authors, identified these as existing on a continuum (Mercer, 2007). The borders separating both identities are 'permeable' (Merton, 1972, p. 37) and 'highly unstable' (Mullings, 1999, p. 338), so that I occupied manifold insider and outsider identities 'as situations involving different values arise, different statuses are activated and the lines of separation shift' (Merton, 1972, p. 28). In particular, the power I held as a researcher and as peer support development lead meant that I was not equal to the peer workers I interviewed. I have continued to reflect on this below.

7.13 Relational ethics

In practice ethical practice requires constant revisiting and reflection. As Ellis (2007) notes, "relational ethics requires researchers to act from our hearts and minds, to acknowledge our interpersonal bonds to others, and initiate and maintain conversations" (p. 4). Each interview raised context-specific, relational ethical challenges (Finlay, 2002).

In particular, the power dynamics between me and the interviewees was something about which I was acutely aware:

"I could feel people wanting to answer in the way they thought I wanted them to. I could feel them, and sometimes they asked at the end, 'was that OK?' 'Did you get what you needed?' After the first couple of times it happened, I made sure to tell people at the beginning that I wasn't looking for them to say anything in particular, it wasn't a test of their peer support knowledge and I wasn't checking up on their practice.

And yet, I could feel the same urge in myself, to please them, to be a good interviewer, to ask insightful questions, to not miss anything that they said or misinterpret or interrupt their

flow. And I think I felt this more so because of our existing relationships, because I liked very much the people I interviewed, for the most part, and I wanted them to like me. I didn't want them to think that the peer support development lead, that Emma, is a bit weird and pushy and imposes her understanding on people. I would hate that." (From my research diary)

While at times I was aware of my power as interviewer, I was also aware of the power of the interviewees, to tell me what they chose to and to ask me questions too:

"At the end of the last interview, Aurora asked me, 'what's your diagnosis and what happened to you?' What a chasm of a question. I had no choice but to pick my way through an answer. I had been questioning her for just over an hour and now, for me to refuse to answer her question, it would have felt cruel, or at least would have shone a light on the power imbalance between us; she has to answer my questions, I don't have to answer hers, and that would have made me squirm more than answering the question. So I told her, and I felt the familiar scrubbing away at my insides that I experience whenever I have to mash together a narrative that makes sense." (From my research diary)

7.14 The ethics of keeping a journal

While individual auto-ethnographers have written about their desire to be accountable to ethical principles of how to write about others in their research (Ettore, 2005) there is little guidance on the ethical considerations of keeping a journal

There is nothing unethical about keeping a journal; many people (myself included) keep journals over their whole life span, and these offer a place for unfiltered honesty, judgement and reflection. The ethical dilemma in this context relates to the use of my personal diary as data. In one sense, because

the entries are my own reflections, written by me, there should be no ethical issues in using these provided I am comfortable to do so. However, because the entries contain details about other people, my relationships with them, and their experiences of work, some consideration needs to be given to the use of this information.

Whilst writing my journal, I acted as a participant within my research, with no filters relating to names of places or people, or to my own opinions and emotions. Whilst analysing my journal however, I did so with care to remove identifying details of services or people. There were also entries where I had written about experiences that peer workers had shared with me about their work, and about the burnt-out environments in which they were working. Using these entries could be seen as a betrayal of trust and an abuse of access (Griffiths, 1985). However, others argue that the use of 'incidental data' is an acceptable part of insider research (Mercer, 2007). It was largely unnecessary for me to use these extracts, given that the interviewees spoke about similar experiences during interviews and consented for these to be used in my research.

7.15 Risk to participants

As described above, although the focus of the interviews was not of a sensitive or embarrassing nature, interviewees sometimes chose to share issues which caused them distress. Before beginning, I explored with each participant what would feel safe for them during the interview. I drew on my own experience of offering peer support relationships in order to offer a sense of shared exploration and mutuality. During interviews, I was sensitive to the verbal and non-verbal communication that I witnessed and conveyed. Participants were aware that they could pause or terminate the interview at any time. I ensured that the voice recorder was placed between us and that they knew how to stop this from recording if they wished to do so. If anyone had become distressed during the interview, I was prepared to pause or terminate the conversation in order to prioritise their wellbeing. I would have offered support and, where appropriate, asked if there is anybody that they would like to be contacted for further support.

As described above, extra efforts were taken to protect the anonymity of participants because of the relatively small number of peer workers the sample was drawn from. This included removing names of people, services and buildings during the process of transcription, and using creative ways of presenting findings (described below).

7.16 Risk to me

Ellis (2007) notes that 'situations arise in the field that make our heads spin and hearts ache.' (p.3) Hearing the experiences of peer workers, my colleagues and friends, was sometimes difficult. Although much of it I was already aware of through supervision relationships, it was difficult to hear peer workers sharing their frustrations, their bad experiences, and their wishes to leave the organisation. At these times, it was more difficult to remain curious and focussed on better understanding the interviewees' experiences rather than on how to fix it, how to defend myself, or how to help them progress in their role. As a researcher, I could not help also listening with the ears of the peer support development lead and I followed things up with interviewees in supervision or informally in confidential spaces when I felt it would be ethical to do so. The interviews gave me a much greater appreciation of the pain, and the strength of the peer workforce, and I made a commitment to the people I spoke to, to try and help them. For example, when Faith (not her real name) told me:

> *"I dread Wednesdays. And then, I never want to say that but I do. Like this morning I was just like I don't want to get up. I literally don't. It's really impacting on my mental health now"*

I felt a commitment to her as peer support development lead to help change her working environment to one she did not dread. I did this after, rather than during, interviews so that I could maintain the reflective listening required for my research, rather than discussing possible solutions or exploring specific dynamics which I would do as a supervisor. Apart from the interview with Pete, described above, I am satisfied that I was able to adopt a curious, reflective

approach within interviews while also being aware of times when this was more difficult.

The process of journaling my experiences of work also posed some 'risks' to me. Smith (1999) detailed the dangers of Autoethnography which include being ostracised from one's peers, restricting career opportunities, and becoming 'emotionally naked' to friends and colleagues. Some auto-ethnographers have reflected that the process of reliving their experiences leaves them feeling vulnerable and alone (Ettorre, 2005). Vickers (2002) refers to authentic writing as writing 'without a safety net.' Authentic writing, she states, 'is risky. However, we should not be enemies of new knowledge because danger lurks' (Vickers, 2002, pp.608).

I found it more difficult than I had expected to record my personal thoughts and experiences in the knowledge that the journal would not remain private. I had concerns about how I would be judged based on snapshots of experiences:

> *"My other fear for auto-ethnography is that it won't be poetic enough. What if I write in a boring, conventional way? What if I can't find the right words and I slip into stale academic language? What will people think, that have told me I can write, when they read something boring or unsatisfying?*
>
> *And really, my biggest fear is, what if I can't find a way to write as if no one will read it? Even now as I write, I am imagining an audience and selecting words and tone to suit them. But this is my diary, its mine, and when I open this document, I want it to feel like I am reuniting with an old friend who will hear me, and keep what I say in compassionate confidence."* (From my research diary)

At times, I also felt that the journal was a burden and something I did not have the time or the energy to complete:

> *"I am struggling with this journal. I feel like it is rushed and cold and dry. I feel resentful that I have to write down things and*

> *explain things that I already know. And to who? Who am I explaining it to? It feels like a cold collection of facts that I am mashing together as quickly as possible so that I can close the document and feel like my work is done. I am angry at this diary. I am angry at the world. The world that misses me and takes from me and expects things and leaves me empty. That is why I haven't written, that is the crux of it. Silence is my only defence. A passive way of politely saying fuck you, you may take no more from me."* (From my research diary)

However, over time, I also used the journal as a source of support. I became less aware of an imagined audience and more in need of a space for my own self-expression.

7.17 Data analysis

For some months I sat with my interview transcripts, and my own journal, feeling their importance as they entered my everyday experience. I was aware of the huge undertaking that analysis presented, and aware of the impossibility of doing this in one day per week, the study time I was allotted. As time passed, I became more sure of how I wanted to work with the data. I knew that I wanted to read and read again all of the transcripts. I knew that I wanted to begin to sort through, to group together complimentary sentences, to get lost in it, to experience the 'stumbles' (Brinkman, 2014) and the contradictions; the ideas that were both familiar and unfamiliar to me and then to find some sense of coherence. In my research journal I wrote:

> *I am waiting to welcome madness. I am amassing this swarm. I want to descend into it. I want it to pile through my mind and out the other side.*
>
> *Like floss.*
>
> *Like a freight train.*
>
> *Like a swarm of bees.*

I want it to sting me. I want it to teach me things, and for those things to be painful, because the best lessons always rob you of something you thought was a given, and that should hurt.

I want it to be exciting and unpredictable and to descend without knowing the way out, or what the journey will look like. I want it to swarm around me. I want to lose myself in it, for it to be so thick, there is no knowing how to make sense of it. I am not even sure I want to order it or compartmentalise it into themes. Because that would rob some beauty from it. To take its wildness would be to take a part of what it is. To pretend it's neat would be a lie.

I want to rub the reader's face in it. I want to get my hands dirty in it and then hold them up and show the world; 'it's this'

I want to be bruised by it. I want to fight with it. I want to disagree and shout at it, and watch it contradict itself.

I want to crawl out of it, breathless and weary and changed, and see it from the other side. And maybe then, jump back in, one more time.

And when the time came, that is what I did. I began with the transcripts, reading each one and adding notes in the margins which I believed summarised the subject of each sentence. After reading each transcript, I made a list of all the words/codes I had written in the margins before moving onto the next one. I tried to keep the labels as true to the text as possible, so a peer worker describing feeling unwelcomed by the team would be coded 'feeling unwelcome by team.' Having done this for all 18 transcripts, I returned to the first transcript and checked that the codes I had chosen to describe the sentences made sense to me with fresh eyes. It transpired that some did not, and so I altered some of the codes, to offer more information that would be helpful to me in the next stage.

The next stage involved mixing together and separating out the lists I had made for each transcript. I did this in a physical way, by printing out each list,

cutting up each individual code and creating a pile, contained in a biscuit tin, of every small word or sentence I had used to describe the chunks of text. I began to sort these into groups based on similarity of topic, for example, ‘time with people,’ ‘not pushing people,’ ‘sharing lived experience with staff’, ‘sharing lived experience with peers’, ‘listening’, ‘personal wellbeing’, ‘reasons for becoming a peer support worker’, ‘opinions about the organisation.’

I then grouped these based on similarities, for example, ‘sharing lived experience with peers’, ‘listening’, ‘time with people’ and ‘not pushing’ were all grouped into ‘peer support relationships.’ Although it would be tempting to reference Braun and Clarke (2006), it would be a lie to say that I consulted any textbooks before doing this.

The process resulted in three broad categories, which I have used to structure my findings:

1. ‘The soup we swim in’: the institutional context and peer workers’ perceptions of power
2. The institutional construction of the peer support role and the peer identity: an empowerment paradox
3. The emotional labour of offering peer support, and working in an institution: Apportioning emotion

After analysing the interview transcripts, I turned to my own diary. I chose to keep this separate from the interviews because of its different style and length, and because my perspective is no longer one of a peer support worker, but of peer support development lead and researcher. Because I had already established the three categories above from analysing the interview transcripts, I used extracts from my diary to further contribute to these. I selected entries which told of my perspective, and because the categories were sufficiently broad, they offered space to structure my diary entries without feeling that I was limited by a presupposed order.

I resisted the desire to remove the negativity I felt within my role at the time I was writing my diary, although, when I returned to it for the data analysis, the negativity was something to which I no longer connected strongly. Apart from some experiences from my personal life, entries that would betray the trust of

others, I have not intentionally withheld any of the reflections that I wrote in my diary. I was struck much more than I had anticipated by the honesty and courage of the peer workers I had interviewed and felt uncomfortable with the idea that I could censor and protect myself, while using all and any of their interviews. At times, I have felt that my diary and its addition within my thesis has been overindulgent and that I have foregrounded myself at the expense of others' experiences. I have strived to reflect on the balance of voices throughout my PhD in the hope that this is not the case.

7.18 Presenting my findings

My findings are a combination of auto-ethnography and the results of analysis of my interview transcripts. This combination mirrors the values of peer support, because my own and others' voices are represented. The possibility of faithfully representing the embodied experiences of individual participants in qualitative research by offering their undisturbed voices in the form of quotes has been seriously questioned by qualitative researchers (St. Pierre, 2009). Indeed, Grant (2013) argues that 'the idea of the possibility of a direct transmission from experience to thinking, to describing, to receiving, in a neat linear, unproblematic, undistorted, unmediated way by coherent, clear headed, fully conscious folk is a bit of a paradigmatic fairy tale by now' (p.34).

Moving beyond the description of themes 'emerging' from analysis, the approach to presenting findings requires an awareness of the contested concept of voice (Jackson & Mazzei, 2009) and the dilemmas raised in attempts to represent the 'voices' of others. Texts written with this in mind use 'de-authorising devices' (Lather, 2009) including conflicting voices, running commentaries and constructed conversations that break apart singular narratives and enable readers to experience the messiness, partiality and irreducibility of the research subject (Lather & Smithies, 1997). Though my research is not an ethnographic study, I have taken inspiration from postmodern ethnographies which consist of fragments of discourse, including creative writing, parody and quotation intended to evoke rather than map or explain the embodied reality of others (Foley, 2002).

In presenting my findings, my intention is to avoid describing what I found, but rather to evoke for the reader some sense of the experience of peer support and of the mental health system within which it is situated. To do this, I have used the transcripts from the interviews creatively, combining them into single narratives, or breaking one person's experience into several different voices. Hence quotes from transcripts have been taken out of context and merged with other people's voices for the purposes of theme development, dramatic flow and to protect confidentiality. Sommer (1994) notes that the use of people's voices in creative ways, removing them from their context is a double faced issue, both epistemological and ethical. Epistemological in the sense that removing voice from context may alter what we can know, and what that voice is able to tell us; ethical in the sense that by doing so we may presume to know more than the people whose voices we are presenting. Here I am in agreement with Jackson & Mazzei (2009, p.3) who 'reject the notion that presenting data as if it speaks for itself is an answer to the problem of voice, and instead seek practices that confront and twist voice.' I have worked reflexively, with a desire to honour the individuals who shared their experiences with me, while also honouring the identity of peer support, which is messy, emergent and unresolved.

7.19 Findings

My findings chapter is structured using the three categories which I created while analysing the data:

1. 'The soup we swim in': The institutional context and peer workers' perceptions of power
2. The institutional construction of the peer support role and the peer identity: an empowerment paradox
3. The emotional labour of offering peer support, and working in an institution: Apportioning emotion

Within each of these categories, I have layered a number of different methods of representing my data to present and evoke the experiences of peer workers and myself:

- *Constructed conversations* – conversations that are made up of direct quotes from the transcripts of interviewees. Conversations include between 2 and 4 people depending on the complexity of the topic being discussed. These take the form of a transcript which is constructed using quotes from interviewees. Each person within the conversation represents a different viewpoint or element of the debate. One speaker within the transcript contains the views of several different peer workers, and the views of single peer workers have been spread between speakers. This is partly to protect the anonymity of individuals, and partly to enable a 'conversation' between different elements of the debates within peer support
- *Single narratives* – taken from the transcripts of different peer workers and built into a single narrative on a particular issue. These were used when peer workers were in agreement about an issue and the use of a single voice represents this
- *Longer quotes* – taken from transcripts, spoken by one person, sharing an experience which illustrates an aspect of peer working
- *My journal* – extracts from my journal lifted directly with the date included.
- *Fantasy/fiction* – including one poem and one 'quiz.' Richardson (2000) argues that creative devices, including literary and fictional prose allow researchers to more effectively portray real events. The use of fiction, which is different to falsehood, facilitates presenting findings in a dramatic way (Grant, 2010)
- *Emails* – fictitious emails which are comparable to email exchanges that took place between peer workers and myself

Taken together, these methods represent an experiment in the presentation of qualitative data using a critical feminist/survivor perspective and the intention to reflexively incorporate the voices of the interviewees and the researcher with a sense of the context we work within.

Chapter 8 - Findings

8.1 Introduction

This chapter presents my analysis of 18 interviews with peer workers, and my own diary. It is presented in a way that will evoke for the reader a sense of the experience of different peer workers. The chapter is divided into three sub-chapters, each of which represents a category which I used within data analysis:

1. ‘The soup we swim in’: The institutional context and peer workers’ perceptions of power
2. The institutional construction of the peer support role and the peer identity: an empowerment paradox
3. The emotional labour of offering peer support, and working in an institution: Apportioning emotion

As described above, a variety of methods including constructed conversations between peer workers and my own experiences in the form of diary extracts are interwoven to evoke each theme for the reader. Before presenting these findings, I have provided an overview of the peer worker roles within Nottingham including their responsibilities and pay grade in order to contextualise the findings.

8.2 The contextual picture: Peer support roles and working environments at Nottshc

Within Nottshc, peer support workers are employed across a range of services including older people’s services, adult mental health, perinatal mental health and child and adolescent mental health services. Peer support workers are paid at a ‘Band 3’ salary which begins at £16,968 per year and increases in increments for each year of service to £19,852 after 7 years. This is the same wage as most support workers and healthcare assistants, although some healthcare assistants are paid at ‘Band 2’; something which created tension between the peer workers and some healthcare assistants when they were first introduced onto the wards in 2012.

All peer workers in Nottshc are a part of a multi-disciplinary clinical team, working alongside mental health nurses (Band 5 or 6), psychologists (Band 7, 8a or above), psychiatrists (paid on a different scale, but more highly than nurses), occupational therapists (Band 5 or 6) and support workers or healthcare assistants (HCAs). The peer worker is expected to offer support alongside nurses and psychiatrists, but have more time in their roles to see people more often and for longer than other workers. This is seen as a key part of the peer worker role.

There are overlaps between HCA/support worker roles and peer worker roles in some situations. All of these roles are paid at the same level (with some exceptions mentioned earlier) and are the only 'unqualified' roles within mental health teams, meaning that their training does not result in a professional registration. The distinction is often drawn by highlighting the skill sets and key responsibilities of each role, with support workers and HCAs undertaking more clinical responsibilities. For example, while a support worker would administer medication, a peer support worker would be unlikely to do so because of the clinical nature of the activity. Peer support is underpinned by a values base which is not paralleled by HCA or support worker roles. The use of lived experience and 'recovery focussed' values make the peer support role distinct from other HCA or support worker roles.

On acute mental health wards, peer workers differ from HCAs in that they are 'supernumerary' to the core number of staff required to safely manage a ward. This means that peer workers are not expected to be involved in HCA duties such as serving meals, making beds or undertaking observations, although many peer workers do undertake these activities in order to support the team. Historically within Nottshc, there has been some confusion about the peer worker role in inpatient settings, which has sometimes resulted in peers being 'in the numbers' or expected to undertake the same duties as an HCA. While there is no published evidence to support this, it was a common feature of supervision with inpatient peer workers and is true of other organisations employing peer workers (e.g. Rebeiro Gruhl et al., 2016). Peer workers are also not expected to be involved in physically restraining people within inpatient settings, a responsibility which is understood to be at odds with the

values of peer support. An exception to this is the ‘peer HCA’ role – a role that was briefly trialled as a hybrid role within inpatient settings. This involved a trained peer worker being employed in an HCA position, included in the staffing numbers and expected to undertake all the duties of an HCA. This role was controversial when it was introduced and added to the confusion about the distinctiveness of the peer support role. There is currently only one peer HCA employed in Nottshc.

Peer support roles differ between services in terms of the activities which peer workers undertake. When peer workers are first introduced into teams, the teams are given time to discuss how the role could be used and how people using the service would most benefit from it. There are some common components of all peer worker roles. In community roles, regardless of what service a peer worker is employed in, they are expected to manage a caseload and make visits to people in the community. They are also expected to write patient records and share information with the wider team. In inpatient areas, peer workers do not hold a caseload. Instead they build relationships with people who are admitted to the ward and support them with the goals they identify. This might include helping them to make use of their leave, preparing for weekly meetings with their psychiatrist or working toward being discharged.

8.2.1 The organisational culture

In 2017, Nottshc released its first ‘people and culture’ strategy which emphasised a strategic priority to ensure that the Trust was considered a ‘great place to work.’ The strategy focused on staff wellbeing, retention and recruitment, as well as equality and diversity within the workforce. This was described as serving the ultimate aim of organisational effectiveness. The 2017 inspection by the Care Quality Commission (CQC) resulted in the Trust being rated as ‘good’ over all for its service provision (CQC, 2018). In the subsequent 2019 inspection, the Trust was rated as ‘requires improvement,’ with a particular emphasis on the need to improve leadership, safety and responsiveness across the Trust (CQC, 2019) The adult mental health inpatient wards were rated as ‘required improvement’ primarily because of reduced staffing, available beds and supervision for the workforce. Across the

report, the inadequate staffing levels were emphasised, alongside a lack of engagement and clarity within the Trust's leadership teams. Staff morale was generally low, as described by the staff survey (2018) and staff did not feel able to raise concerns or trust that these would be handled well if they did (CQC, 2019). There were also concerns that where cost improvements were being made, these would impact on patient safety and care.

Nottshc uses the achronym 'positive' to describe its values: People, Openness, Safety, Involvement, Trust, Innovation, Value and Excellence. In addition to this, the Trust Recovery Strategy (2016) states that Nottshc has:

> *'embraced the concept of Recovery over the past 7 years and Recovery principles have offered a sound guide for developing the culture and practices within the service[…]Recovery now informs the approach underpinning all of our services'* (p.5-6)

The Recovery Strategy (2016) acknowledges the need to change the culture of the organisation and positions peer workers as one means that this may be achieved.

8.2.2 The expectation of culture change

Unlike any other member of staff paid at band 3, it is explicitly written into the job descriptions of peer workers that they are expected to act as 'recovery champions' and to take a lead role in embedding recovery values within the service setting that they work in. The Nottshc peer worker job description states that peer workers should 'raise awareness of recovery language among Trust staff by modelling positive, strengths based, non-discriminatory, non-jargon, non-medicalised language in all areas of work.' In addition, they should be prepared to 'support the team in promoting a recovery orientated environment by identifying recovery focused activities and imparting information and education as required.' (p.2)

Part of the training that peer workers receives includes how to work within staff teams who may not be familiar with the peer worker role, and how to challenge stigmatising or unhelpful attitudes of colleagues. Peer workers are expected to role model recovery not only to the people that they support, but also to

those they work alongside within clinical teams. The peer support worker job description is provided in Appendix F for further reference.

8.3 Theme 1 – 'The soup we swim in': The institutional context and peer workers' perceptions of power

8.3.1 *Diary entry* 16.02.17

There is a new digilock on the door separating the café from the rest of the building and now everyone has to stop to put in the code. Every time I reach this door I feel a blade of anger push upwards inside me. These are the Trust headquarters and they used to be a place where everybody was free to move, free to go to the library or the café or the college. And now this arbitrary locked door which all of a sudden draws a distinction between those who know the code and those who don't. Those who have power and those who don't. If there are concerns about security, why not lock the offices? Why not lock the doors after 5pm when the building is more empty? Why not do something more sensible and less excluding than locking the doors between the café and the rest of the building. It is symbolic of the arbitrary risk-averse decisions the Trust is making constantly.

I have let through countless visitors who have found themselves stuck in the café. Each time I tell them the code. I email the code round to peers; I feel like scratching the code into the door. There is also a sign telling people not to ask the café staff for the code because they can't give it out. I feel like writing the code on the bottom of that sign. Or scratching it into the door. The code is 2145. When you make it through the locked door, all that's there is a corridor with no heating and a bucket in the middle of it that collects drips from the ceiling. It's a good job we're protecting that.

8.3.2 *Constructed conversation*: Having a relationship where there's more autonomy, is kind of alien to what services users are used to

Izzy: I do think it depends on the service user's experience or perhaps what experience they've had of using services. Because I think some people, particularly if they've been in services a long time, they don't have much hope, they do tend to feel quite negative about things. They might have had a number of different workers and I think some people have had quite poor experiences within the mental health services and they've had a lot of control taken away from them and things have been done…apparently to them. So I think that's meant that the idea of **having a relationship where there's more autonomy, is kind of alien to what services users are used to** in those particular circumstances

Gemma: With younger people, their whole perception of why they're getting support is to change. Even if I'm honest and talk about my lived experience, I feel like with children they still see me as another clinician. And things like my ID badge are a barrier. I think it's quite difficult for them to understand because all they've ever really known is somebody that's a clinician, someone there to help you, someone there to tell you what to do, to do this and do that, and for someone else to come in and work in a completely different way, I don't think it quite computes with them really. I think once they get to know it a bit better, what it is, then they kind of understand.

Anthony: I think people definitely have barriers up…things like 'I've been through the system so many times, nothing's ever changed, they don't believe me, what I'm saying, they just think I'm this label, psychotic.' So they put a barrier straight up. I mean just walking on a ward, initially and you've got new people in, or you'll hear, 'they won't engage' you hear that all the time, 'they're not engaging with any of the staff, they're not engaging' so you're writing them off before they've even started. I've heard people say they have been let down so many times and they just start to open all this stuff that they need help with and support with, but then it's closed down again and shut, and then they're

left with it, and then they're sent home. But then…peer support I feel, if it's done right, can break that down

Izzy: I think people feel let down by the services, by the NHS for example, or social services or county council, they feel let down by the bigger organisations, and it's, you know, it's all about the tick boxes.

Gemma: And people expect to be assessed or be told what to do. It's a bit different with younger people. Because of…the power imbalance…I feel like they do want a bit more…answers from you…like 'How do you get rid of…' I don't know, 'how do I stop feeling this way?' That kind of thing. Rather than just talking about how they're feeling and why they might be feeling that way. You do feel like sometimes I've felt at times like I was trying to treat somebody, but then I don't know anything about like…treatment. You're backed into a corner sometimes and you want to give an answer but I'm not really the person that should be saying that

Anthony: I think in adults...on the wards…there's nowhere where people can just talk about their experiences. There's the spirituality room, the spirituality services, but that is largely about having services put on and practicing from your religious background or beliefs. There's nowhere else. So I think peers have a unique position where they can support in that way

8.3.3 *Diary entry* 03.04.17

Today I had a debate with a clinical team leader and a nurse about the word illness. They were was saying that they preferred the term illness or ill health and I was saying that peer support would favour distress or trauma. They were trying to convince me that it really is an illness.

They said that they understood trauma was probably the cause of most illnesses, but that it is still an illness, and that is still a helpful way of describing it. They said that there actually are chemical imbalances. They said that sometimes there is no trauma, so in those cases, it is just an illness that can afflict anyone. I said that there are forms of trauma that we don't see and that it is self-defined. For example, having a child means losing control of your body and your identity, and isn't that an everyday sort of trauma that we don't talk about? They said yes, but….there is no abuse. And anyway, in mothers, the illness is often triggered by the expression of milk so the chemical process is clear.

It isn't my role as peer support development lead to shout in peoples' faces, 'YOU'RE NOT RIGHT!' So I refrained. I said it was interesting, their different perspective, I could appreciate how you could think that, I can see how your experiences and your training tell you that this is right.

It's astounding how many people, especially mental health professionals, still hold onto this illness model. In the week when the United Nations issued a statement that included the sentence: 'the longstanding biomedical tradition of medicalizing various forms of psychosocial distress and human suffering has cast a long shadow over the importance of addressing the social and underlying determinants of health. This not only undermines the right to health, it also ignores a rapidly growing evidence base.' (Puras, 2017)

But I suppose that most mental health professionals don't actually read that kind of thing, at least it appears that they don't, if they can still argue passionately that it is an illness that doesn't discriminate. Like a panther, just waiting to strike anyone at any time.

8.3.4 *Single narrative*: Your main motive, is to do your best for the person, and sometimes that's with the constraints of the system

Anthony

All the things that you do on the peer support training, you bring in to play over time. But I think the first bit is the empathy. Empathy means you can appreciate when someone's getting frustrated at the ward door because the member of staff has said, 'sorry you're not going out at the moment.' Or 'you went out four hours ago, why are you asking now?'

I used to challenge restrictive practice you know, situations like, let's call him Bill…has unescorted leave and comes back and he's over his time limits, he's done things he shouldn't have done, you get there on Friday and they'd go, 'Bill's restricted now, for his leave.' And you'd ask why, and then I would then be looking to say, 'well, I can understand why you want to restrict his unescorted leave but all the history of this admission and previous admissions is when he goes out with staff there aren't any problems, so why aren't we giving him that in the interim?' I think that sort of challenge is in the best interest of the person. And maybe that's not a peer role, maybe that's just someone properly advocating for the person. And if I see that someone is always lethargic on the ward and really sedated, I'd be saying can we go into review and talk about his medication? Because this person's only awake for three hours during a shift. It's just that navigation sometimes of the system but I'm still trying to work to the best interests of the person.

Another example…I met 'Joe', his name wasn't Joe, but I met Joe when I was called into a de-escalation room and one of his gripes was that he'd been there and he'd never had his speciality tea. So, on my break I went to get his speciality tea. And then I built up a relationship with him over three weeks, four weeks, five weeks. And then I came on the ward to say hello, and they said Joe needs to have an injection and he's saying no. And they were getting a massive team together. And I went to speak to Joe, and Joe said, 'well I had a 10 minute review and they doubled my dose, and they didn't answer any of my queries, I had no chance to talk about why they were doubling the dose, and I believe the dose is unsafe.' And I said, 'well I can't change the dose at

the moment, it wouldn't be unsafe because they can't prescribe it if it's unsafe, but I understand that you haven't had sufficient time in your review to discuss this.' I said, 'You have to have it today, but I will come into your next review with you and we'll get them to explain why they're going for this and the rationale.' And instead of then…what everybody thought was going to be a massive interjection to facilitate a depot…Joe with myself walked into the clinic room and allowed the nurse to give out the injection.

Some visitors once asked me, 'are you just pill police as a peer?' and it's…somethings you can't change regarding the system, you can't sometimes change the fact that the doctor has said that 'I'm going to prescribe you a depot.' Or 'you need to take this medication' but it's how you then pass on that to the individual.

If I hadn't have been on the shift, Joe would have had to take his medication either way. And…it is sometimes horrible choices, you know…with that particular case that we talked about…instead of something would have ensued with flailing arms, possibly getting injured, you know…As opposed to what happened, where the person just walked in…that to me is the best possible outcome of that situation. And as a peer, I left that day thinking I've done a good job, because I was going to go to his review, no one had got hurt, he's had something that he was unfortunately going to have anyway, and there was no…it just made it a smoother process.

So sometimes those are the compromises that, as a true peer, you're failing in a way, but…I do sometimes struggle with…if we are wanting people to have meaningful lives and stuff, putting a level of medication in them at night so they can't function until two o' clock in the afternoon is not brilliant. And it's likely that the person who wants to function and do stuff will go 'I'll perhaps not take this tonight because my day's gone until three o' clock in the afternoon.'

It's a very difficult one with…the system trying to keep things safe and then the rights of the individual, it's…tough. But that's when you try and do your best for the person, that's **your main motive, is to do your best for the person, and sometimes that's…with the constraints of the system.**

8.3.5 *Diary entry* 27.10.17

I went to an eating disorders team meeting this morning. Wow, there was some language. They read out referrals full of 'john admits that he fears gaining weight' 'sarah denies having phobias of certain foods.' Why are we using the language of the law? They are not suspects.

They want a peer support worker to tell people what it's like to be well. They want the peer worker to sort of convince a young person that eating is awesome, that any crazy food rules they have are simply unhealthy and look, this amazing peer worker who is fully recovered from her 'illness' is living such a happy life that you should just eat and you can join her.

It feels like peer support is being set up to fail. We are so small as to be powerless, tasked with co-producing a culture change, an impossible venture. How can an ant coproduce anything with a killer whale? They don't even live in the same reality. The ants would just fucking drown.

8.3.6 *Constructed conversation*: Some of the physicality of it, I struggled with

Simone: Personally I don't think peer workers should be involved in restraining people. And I think the main reason why I think it's not a good idea is that it's immediately going to chuck that wall up, it's bound to. Not saying you couldn't knock it down again, but it's going to make life much, much harder for that peer worker to do a lot of the things they're supposed to be doing. And it's going to waste that opportunity. Having a peer worker in a team, to me is a great opportunity, and to dismiss that to basically make them another Healthcare Assistant, that's a waste I think.

Anthony: When I came into my peer role I was expected to be involved in the management of violence and aggression, that was part of my job description. I had no experience of aggression. I had the training that the Trust had offered and when I was first involved in managing aggression I was still very good at the talking but **some of the physicality of it, I struggled with**, I froze on one occasion…and it took me time, not to get used to it, but just to understand what I was expected to do and how it was. And so I had a period of time where I questioned whether I could do the job.

Simone: I haven't done the MVA training, managing violent patients or whatever it's called, I haven't done that training, and I haven't chosen to do that training for a particular reason, so I don't get involved in restraint. If I had that training, there'd be a… a view or an understanding that I should get involved in restraint. So I haven't done the training so I can't do it. But purposefully not done the training

Sally: If I needed to be involved in a restraint on the ward I would have had to just step up to it, but so far I've not had to do that. I feel like my strengths aren't going in there when it's chaos and having to restrain and medicate and all that. It does unsettle me when the alarms go off and I have shared that with people. We had an incident a few weeks ago and I felt a kind of…some of the people that weren't involved, kind of actually physically drawing towards me because I was just, I wasn't there rushing into what was happening but I tend to stay with people in the communal areas. I thought this feels like they're

almost…comforted that I was just there. And then once this person had had some medication…she'd calmed, and she was just sat on the floor and someone asked if I'd sit with her…I asked her permission, you know, considering her feelings and giving her that control, and then we chatted, must have been at least 45 minutes and she was just talking, talking, just continuously, and I just thought, it just made me think that I've used things that are my strengths.

Anthony: In my role I feel like nine times out of ten I can invariably stop things ending up like a mess on the floor, you know, where….the person is really really restricted in terms of…I found that my peer skills in terms of my empathy and my ability to go into rooms where people were moved because of their distress and stuff. As a peer it was quite a privilege to be asked to lead on the 'No Force First', so if I came onto shift and I found somebody had been restrained, to actually work with the individual to actually try and minimise and prevent that scenario from happening again. I just think it's the way that you do it and the way that you interact with someone. And it can…change outcomes…it can change, and it can also change…because it can also change the length of stay that somebody has on a ward depending on the interactions they have regarding things, you know. So although…there is a conflict regarding the peer role, it's trying to do your best in those situations.

8.3.7 *Diary entry* 31.05.17

Group supervision today. Sally has just come back from sick leave and she was trying to describe how she had lost her confidence. She felt like staff are just waiting for her to go off sick again. She feels scared to speak in meetings and she reads straight from her notes. She said that she believes that in time she'll get there but its hard work.

Lewis used the phrase 'mission creep' for what he thinks is happening to peer workers. If they are expected to do HCA tasks, their focus will gradually shift and they will lose their identity. Mostly, I don't think it's about the menial tasks that peer workers do or don't do. But the tasks of risk assessing, note writing, restraining do compromise peer support I think. The tasks of the institution which revolve around surveillance and control. Maybe it is true that a peer worker would do these tasks in a different way than other workers, maybe they would write collaboratively or with a 'recovery' focus. But it doesn't make these practises OK, just because they can be done in a less harmful way. It's just putting a wolf in sheep's clothing, we are still restraining and writing notes. If the culture is unwilling to change or to think about these practises then ultimately peer support will be lost to the institution. In my opinion.

8.3.8 *Single narrative*: Patch people up and hoof them out

Victoria

In the community team I work in there seems to be very much an emphasis on, you know, drugs and medication, and you know the word compliance keeps coming back again. It seems to be very much more medicalised. The understanding of recovery is still quite patchy. I feel like the agenda of the team has become very different because resources have been strapped and we've been restructured. There is an emphasis on having meetings on people that are in immediate crisis and sorting out the crisis and then moving them on. There is a lot of moving people, moving people on quickly. And a lot of emphasis on medication and things like that.

There is a lot of pressure for people to keep a large number of people on caseloads and manage risks. All that kind of thing seems to take precedence over anything else really. And teams tend to have people now I think who are…have got much higher level needs and higher level risks as well, and I think that's quite challenging if you don't get enough back up and support with that.

So I think that is an issue at the moment for peers.

I'm not saying that there's no focus on recovery goals or anything like that. I suppose because the resources have been strapped, there's been a move from talking about long term rehabilitation and helping people recover a meaningful life. That was, to the majority of the team workers, obviously not all of them, but that's how it felt to me you know when they first started having these meetings I felt, gosh, you know, what have I walked into? Because they are very…they're very kind of…very medical, very kind of 'this is the crisis, this is what needs to happen.' That's very, very different to the way that I've approached things in other teams. Obviously we had meetings there, but they weren't like that. It's just the way that the service is being funded at the moment.

Now I know that there are non-medically trained people who are in high positions in the Trust but at the core of it is the medical model. Because it still

is tablets, tablets, tablets. I know that with me, and I'm sure it's happened to so many of my colleagues, people have felt safe to make disclosures that they've never made to anyone.

But then it's where do you go with that when you've actually opened up a really deep wound? And what I would want for somebody would be a psychologist, and we've hardly got any psychologists, and what do you then do with that psychic wound?

Recently somebody made a huge disclosure to me which involved safeguarding so I had to take it further. And I explained all this and I did all this kind of stuff and…it just unleashed this absolutely damaging response. It was motivated by caring I think but it was a really damaging and exposing response. So you are really caught between the devil and the deep blue sea. So you build that trust and it is an absolutely genuine trust, so somebody feels they can tell you something, and then they tell you something and then you've got to go tell somebody else and you listen to it being handled in a well-meaning, but utterly crass way. And not in a way that I would handle it at all, but are you going to challenge a psychiatrist and a CPN who are kind of barking things at you?

And these professionals were very well meaning, I'm not blaming any workers at all because they're constrained by policy and procedure and their job role and so, so much around throughputs and outcomes and the commissioning process. And I wonder about the emotional strain on other staff, because they do an awful lot of just gritting their teeth and holding it together, and they're so target driven, and so they're juggling people and endless paperwork. I see so many people who are employed by the NHS under stress, struggling, beaten down and under-valued by the system and I think they deserve to be valued. Everybody deserves to be valued and I don't think the NHS are good at supporting their own.

Not even investing in training or development. The suicide prevention training the Trust does is online! Of all the things to do online. I just think, in my dream world, everybody would be trained in trauma. And again, there isn't the money and there isn't that level of understanding, it's just we'll give you some

medication that will make you sleep or it will lessen the hallucinations or it will lessen the voices. I think it's worse on the wards, they have a really tight turn around. **But it is really sort of patch people up and hoof them out.**

One lady I've been seeing since for a few months now and she needs that time, she needs more time. Her goals are to be able to exercise, lose weight, get out the house. She's now exercising but I haven't managed to get her past the front door yet, so until she's confident enough to do that, I'm working with her.

I think there's always the pressure there, it's not something I think about very often until there's meetings or supervision where they talk about caseload and how much time you're spending with people and that's when it becomes a bit of an issue. It's like 'why are you still working with this person?' or 'you're spending too long a time with this person, why aren't you seeing more people?' and certainly as the demand is rising with the referrals that have been coming in, that is becoming more of an issue. I'm hoping to really sort of bring home to them that this is what peer support is, I'm not another clinician, please don't box me in because peer support works a lot better if you let me go…and do these things.

And I'm thinking how many more people can we take on physically within the hours that we work? But I think that's the same for any team, I think the Trust as a whole expects a hell of a lot from their employees, for very little reward. And you can't consolidate and you can't embed. Things are tried for a year or tried for two years and then there's yet another re-organisation.

8.3.9 *Diary entry* 02.05.17

An update on the locked door. There are now two posters above the digilock. The first one reads:

> *'Please do not ask the catering staff for the digilock code as they have been instructed NOT to give the code to anyone. There is a phone you can use to contact the department you are visiting, or your meeting host, so they can collect you.'*

The second one reads:

> *'Have your say! Learn about and contribute to developing our people and culture together. Drop in sessions [dates]. Working together to increase excellence in compassion, equality and staff engagement to improve patient care.'*

The juxtaposition just encapsulates this crazy contradictory culture.

8.3.10 Diary entry 21.09.17

I went to this ImROC demonstration day today, and could barely make it through two hours. One of the clinical directors asked me if I'd heard of Recovery in the Bin and told me that he didn't really buy into their manifesto. I told him I did, and I thought it was important to listen and understand the counter-narratives. I said I agree with much of what they have to say. And then when he went up to speak, he started off by telling us about his lived experience and his childhood. What I find funny is that professionals have started more and more to stand on stages and casually mention their lived experience. It's curious because I wonder what the purpose of that is. In peer support the purpose of it is to say 'I have this experience, I am equal to you, not more, not less.' But it seems like lived experience is being used by people like this clinical director as a way of saying 'look how credible I am, look how much status I have as a knower of things.' Rather than flatten the hierarchy, it increases it.

And then he spoke about recovery, and his view of it. He had this slide that said why recovery was important. These were the things that were on it:

- Recovery is a paradigm that can be adapted across care spectrums

- Recovery has the potential to create service efficiencies

- Recovery focusses on individual outcomes

Last time I checked, recovery was a social change movement that has the potential to change cultures and focusses on social outcomes. But this is how it is taken into services. And this clinical director is seen as someone who champions it and drives it forward, and he is saying these things. The thing is, I know I was listening with a filter of venom by that point because there were two other points on that slide which were probably more balanced but I didn't write them down because they didn't piss me off.

But the thing that got under my skin the most, the thing that blew my mind as I sat there watching him, was that he told the audience all about Recovery in

the Bin and how worthwhile it is to listen to counter-narratives and how they should check the website out.

I felt myself resisting my flight response. I was sat right in front of him and I could feel my body telling me to get up and walk out, or to scream, or to tear my own skin off. But I couldn't. And I knew that in a few hours' time it would be my turn and I would have to talk about peer support in the NHS, even though I trust the system less and less.

8.3.11 *Constructed conversation*: I think we're valued because we're cheap

Simone: I still don't believe now that the Trust are loyal to their promises of peers. Because the evidence, although there are more peers around, there's a hell of a lot more trained peers that could be employed and teams, budgets, for whatever reason, aren't able to utilise it or are unwilling to utilise it. I don't feel, or don't see the evidence that they're really doing it. I hear more talk than I do seeing of actions I guess.

Lewis: I think peer support is an afterthought in service design, like an added extra. For a lot of people in the Trust it's a box to tick, they're not actually buying into it. It's such a shame, such a wasted opportunity

Lucy: I think that is the Trust is…it feels like the Trust is very good at saying what they think needs to be heard, but they're also very good at actually not doing a lot, doing the minimum to show that they're backing up what they're saying, and I can't help feeling that recovery is sliding into that a bit.

Simone: And you know….and the business of doing, you know that you're doing something that somebody two or three bands higher than you is doing, it does get you down. I like to think that I'm not money orientated but you don't want to be taken for a ride. I feel…at my lowest points, I feel really exploited by the Trust.

Lewis: I don't think the NHS completely values peers or necessarily understands the work that peers can do

Simone: I think we are valued, but we're not valued. **I think we're valued because we're cheap**. People say peer support…you know we're equal, we're equally important as all these other things, but actually if you were to look at peoples' salaries we're not.

Lucy: I'd also like staff to take on the peer values. Because I think they're transferable. We'd still have our lived experience as the core of what peer support is, to be able to share those skills, the active listening and the paraphrasing and the values

Lewis: and for staff to be more involved in the things peers do. Like, I don't think it's fair just to let peers lead groups left, right and centre. Because I feel like they're saying 'we don't have time for this' but let peers run them but actually I feel they need the mixture of other staff

Simone: but more peers wouldn't hurt either. I'd like to see more peers employed and a variety of roles for them.

Lewis: but we need to protect the peer role too, not blur it, it's a role in itself. I totally agree you can be a peer in whatever you do like more clinical roles, but I think if the role can be really protected, it can have so much more strength and time

Lucy: But I think it is difficult because there's no head count and no budget for peer workers. Like there's no quota to fill like there is for nurses

Lewis: I don't know who it was but someone high up said they wanted to have two peers in every team, and there's nearly 500 teams in the Trust, so that's 1000 peers isn't it? I've worked it out and we're nowhere near that, so there must be more jobs coming up because the Trust wouldn't spend all this money training peers up and then not using them.

Lucy: And it would be great to see more peers, but if we saw more peers, we'd have to make sure we could support those peers. I think for me, it's not about numbers, its supporting what's already there, because I think there's a lot of peers that are just hanging in there. Love to see more peers, but are we ready and can we support them?

Simone: You can see from the track record…where are all the peer support workers? Where's the knowledge in the team gone? Evaporated. You know, peer support has been around within this Trust for quite some time. But then when they have a new cohort, it's like it's a new thing, it's not. Some…peer support workers told me, I speak with, feel like cannon fodder. The most important thing is if you….build on peer support workers in mental health, you need to properly resource it. It's all good and well to come up with inspiring new policies but if you then try to implement your new policy and you don't find that it's working, don't blame the people on the ground floor

8.3.12 *Diary entry* 21.04.17

I feel like everything I see and hear is just more evidence that things can't work. I have run out of steam on my survivor mission, I am not surviving it. There are some organisations where everybody identifies as a peer. It must be so nice that there is no part of peer support that is about changing an internal culture or contending with decades of psychiatry's bullshit.

Maybe it would be more helpful to say things like 'peer support is a compliment to other professional roles'? But my views aren't that peer support is a compliment. The subtext of peer support is a compliment is 'peer support is at the bottom of the hierarchy.'

That's not what I believe. I actually really don't see the point of mental health nurses. At all. I think if every nurse was replaced with peer workers the world would be a happy place. If every psychiatrist had to do the open dialogue or peer support training, the world would be a bit less closed and a bit more mutual. Maybe it's because I don't understand the system well enough, but I just don't see the point. What does a nurse do or have that a peer doesn't? They have this clinical training? So what?

I think this whole journal will just be one long rant, and at the end of this PhD I'll just have to try and convince people I'm ranting because its love labour. Does love labour involve this much anger?

8.3.13 *Single narrative*: We're all just hamsters on a wheel, the staff and the patients

Izzy

The culture on the ward is just one of underfunding and so called cost improvement programmes. And the feeling I'm left with is frustration that people perhaps don't get the help that they need. There is a culture of feed, medication, off you go. Most of the time, they want people out because they need the beds. And generally people don't get the chance to talk about their experiences, or how they're feeling, in their reviews. I find that really frustrating. And I try best to make sure somebody doesn't feel like they haven't been heard but then a lot of the time, we've got no staff, and we've got sixteen to twenty patients.

I see the pressures of the ward staff particularly. They haven't got enough staff, it's as simple as that. They're just, I think because of all the pressures, they're made to feel that they can't ask for more either. And that's wrong, because you're there to do a job but if you're stretched to that limit, the patients go out the window.

There's no thought behind what they're doing. **We're all just hamsters on a wheel, the staff and the patients.** People are being stretched so much that they get frustrated with the patients, and that's not through lack of caring, it's their pressures of having to deal with a huge ward full. You'll see some not engage with patients at all but some of them will go way above what they need to do. I've seen, this year, two or three nurses crying.

And people are desperate to come into hospital, who need to come and stay, and then there's a lot of firefighting, and juggling of people and beds. It doesn't feel fair and it makes me really annoyed that this is kind of where we're at. There seems to be no concern for the welfare of others, whether it be patients or the staff.

We've had people that other people didn't want to be around put on the same ward. And you think, knowing that there was a problem between those two people, why have you done this? It's like 'well we've got no beds anywhere

else so they're going to have to go there.' And that's going to cause them more distress, and then we end up with more problems because then there is that level of stress that weaves through all the other patients, and then you end up with this really heightened situation and you think, that could have been avoided.

It's not easy, I'm not going to lie. It's not something you get up in the morning and think, today I am going to totally change everything, but there are days where I go in and I think if I can just do something. I spent half an hour last week talking with somebody because he didn't want to come back to the ward he wanted to go home. I spent half an hour sitting with him, talking to him and I really tried everything that I knew I could do and then he still ended up having to get people to take him back to the ward because he wouldn't go. And then that's really hard because I get where he was coming from, he wanted to go. But the doctor had changed his mind almost and thought he should stay for a bit longer.

That's what it's like, you're in this situation where people are either promised something or they want something and their needs aren't being met to the degree that perhaps I wish we could. Like we've had problems this morning because somebody wanted to go out on escort but there are not enough staff currently with all the jobs that need doing. And then he's become incredible angry, incredibly upset, and has been quite abusive towards staff members and then that kind of ends up with him not being able to go out because nobody is going to take him out because he's screaming and shouting at everybody. And then he's had to have medication because to try and calm him down because he's trying to trash his room. And then it starts to come out that he feels that we're ignoring him, but then it's like well we've done everything we can, we took you out first thing this morning, we've taken you out and we can't currently do it.

I'll often offer to take people out in that situation, I'll do it when other people won't. When they're like, 'well this person's being abusive to us, I don't feel comfortable taking him out,' and I'll often step in because I feel really bad that their needs aren't being met, I think well maybe I should do it. And sometimes

that's probably not the right thing for me to do, but I get quite…I just get this overwhelming feeling of empathy that I really need to help them as much as I can.

I don't know what would make things easier, I really couldn't tell you. I think if there was suddenly something that did make it easier, I'm fairly sure that the goal posts would move, because it's such an evolving place. Since I've started, it's evolved, you know, the speed at which people are coming in and out, the amount of people that we get coming in, and the amount of people that are really, really in a not great place. Instead of getting people coming in who perhaps need a bit of respite or a bit of help before they get into a real crisis point, we're getting people who have been in a real crisis point for a long time, and are very distressed. It's almost evolved, it's got worse in that respect, over time and it's like, this isn't what I started off doing.

And I'm fairly sure it's still evolving in one way or another. They're always coming up with new policies or plans from the management and stuff. And even though those changes might not directly be for the patients, the way that they affect staff, it filters down. And I think it's extremely saddening that the personal has been taken out of the Trust, it is business now and that saddens me because I think the NHS is amazing.

And I know that a lot of our staff have left recently and the shortage has caused a lot more of a, not unsafe environment but, it's just a bit unstable for people, it just feels a bit wobbly. On both sides. Because you've got sixteen lads in, four staff. That's four people to one staff member in ratio wise. And If you look at absenteeism in acute environments it's quite high, and some people don't call it stress, they have other reasons why they're off in inverted commas. And I think that's the soul destroying bit, you've got an amazing amount of people who just want the best for the people they care for but they can't do it because of the system

I don't see things getting any better either, with the current climate, economic climate. It feels like…somethings about to give…that's how it's felt like for me for quite a while. Like it's unsustainable, the system that's operating on the wards

8.3.14 *Diary entry* 28.03.17

This week was the recovery steering group. One of the members was saying that there have been so many recovery focussed changes but because there have been so many cuts he can see staff reverting to risk averse ways, and he said that it was like a veneer of change that is peeled off when things get really pressured. It makes me wonder how much hope there is for services because I know that the cuts have reached unprecedented levels and I know that there is more to come. So what is to become of recovery and peer support?

At the conference yesterday, one of the speakers said that if peer workers are introduced in to 'non-recovery-focussed' teams, one of two things happens: either peer workers become 'mini clinicians' absorbed in the culture of the medical institution, or they become 'martyrs for recovery' on a futile mission, the only ones who have lived experience among a team of monsters who don't get it. It was wonderful for me to think about these reactions as being the result of the context and not the person. I've seen so many mini-clinicians and I've just felt a bit frustrated that that was their approach, but actually it's so clear now that it's the environment. I also think there's something about power and how people respond to feeling powerless, either by adopting a powerful language (mini-clinicians) or by demonising others (martyrs for recovery). It takes a very self-aware, contented person to see a chance for status and turn it down for the sake of mutuality.

8.3.15 *Constructed conversation*: People that've been in the role for quite some time should be able to progress

Izzy: I think there's a sense of, that you can't advance within yourself as a peer, that you're always forever a peer. And I know that's something I've brought up before, but I think…I'm interested to know how you…progress within yourself. I don't think it should be a static role

Lewis: I think the organisation needs to offer peer support workers…a pathway. Like actually every company offers their workers when they come, you start at the bottom and then you work your way up. You experience, they give you training, but there's a way of reaching…financial stability and that is a concern for me. It's on my mind, how do we work to that? So in the end I would like to be free from PIP [benefit payments]

Izzy: **People that've been in the role for quite some time should be able to progress**. It feels like you're just stifled. I know that's the whole…the way things are in the NHS that everybody feels a bit stifled, but that's been happening for quite some time

Anthony: that resilience should say a lot if you've been in a role for so long. I've done the job for six years but I do feel that I need a rest. It is quite a stressful environment. And that's why I think after a length of time that you perhaps would want then to look at doing something different.

Izzy: I think and that's when people more tend to go into policy and development. And I suppose I'd like to do a bit of both. That's how I would balance the emotional cost

Lewis: You can only…without support….of counselling and extensive supervision, you don't last very long on the ward. Maybe a year or two and that's it. Then peer workers look for greener pastures.

Anthony: I don't find it draining, I don't know whether it's because I've got a good balance of days…so I'm in on day, off, in one day, off. I don't know how it would feel to work full time, like some peers do

Izzy: I've always balanced it by not working full time, and being very careful with what I do with the days I'm not at work. I couldn't do it 5 days a week, I could not.

Sally: If I was full time I think I wouldn't be able to do it because it's too much sharing.

Anthony: I think there must be more opportunities…so like even though I'm doing this now, I feel like there's going to be more opportunities, or…something else along the lines with peer support, I don't know what, I just go with the flow [laughs] something, I don't know

Sally: I feel like for me this is fine, I can have just as impact however I'm paid. But I think, I wouldn't do anything different if I was paid more…well I might spend more! [both laugh] but I feel I wouldn't be able to…I give my all now! I'm not holding this bit back, and when I'm band four I'll let that go!

8.3.16 *Diary entry* 27.04.18

It struck me as I skimmed through this diary just now that the door I walk through every day, the one with the digilock on it that I have ranted about, that I used to feel so much anger about, it is nothing to me now. It is just a code I input, without much thought, before taking a deep breath and heading to the office. I see staff holding it open for people, I make sure I check behind me for others who might not know the code, I still let stranded people through and email it to people I am meeting in the café to make sure they don't get trapped. But I feel no anger or outrage about it anymore. It just is what it is, it is part of the wallpaper so to speak. I have just accepted it, like so many others. And maybe it took me a year but I don't even really see it anymore.

Isn't that curious and slightly sinister? The things that filled me with rage, eventually I become desensitised to? It just becomes the soup we swim in. In the interviews, peers are talking about how services have reached a level of austerity and staff cuts that is completely unsustainable, that they're not sure how it can continue and the amount that is being asked of people is outrageous. What if, this time next year, we look back on what is happening now and see it as preferable to the reality of 2019? What if we have just grown accustomed to the shortage and the crummy level of service we can offer, and the almost burnt-out workforce who aren't being offered any empathy and so have none to give?

You can't stay angry at a door code for a year can you? At some point, you have to re-direct your energies and just get on with things. Or would an activist do something different? I just don't have the energy to be angry at every small thing that these services do, there isn't enough emotional space, it is as much as I can do to manage my workload and manage the team and manage my own emotions, to fight every small fight would be too many battles.

8.3.17 Summary of Theme 1

In the context of the mental health system, many peer workers described feeling powerless in their roles, like ‘hamsters on a wheel.’ Working in mental health services was described by peer workers as being highly stressful for all staff. Peer workers explained how the culture of cost improvement, alongside the need to improve the quality of services was disempowering.

Peer workers also discussed the low pay and limited opportunities for progression within their roles. While some peer workers were content with their current roles, others were frustrated that there were no opportunities to progress after years of service. They perceived this as a message that peer support is not valued within the organisation, or at least it is only valued because of its cost effectiveness. Some peer workers described how they felt valued within their teams and had contributed positively to the culture. Beyond their teams, peer workers felt that the wider potential for peer support to influence culture is not being harnessed.

Working in a clinical environment also meant that some peer workers were required to be involved in restrictive practices. Peer workers described their various opinions about this, with some seeing it as an opportunity to build closer relationships, and others seeing it as a violation of peer support practice and an abuse of power.

Peer workers described their awareness of power within peer to peer relationships and the methods they used to foster more equal feeling connections with the people they supported. This included sharing their own lived experience, using empathy and changing the focus from ‘doing to’ to ‘being with’ people. Some peer workers found that they received respect from the people they supported which was different to the respect that other professionals received, because it was based in shared lived experience. Some peer workers described the difficulty they experienced in sharing power within peer to peer relationships, as the people they supported were used to being told what to do.

8.4 Theme 2 – The institutional construction of the peer support role and the peer identity: an empowerment paradox

8.4.1 *Constructed conversation*: It felt like I was coming home to something

Lucy: I remember someone coming into Recovery College to talk about peer support when I was a student there. When she described what it was, I knew that it was something I wanted to do. I didn't do anything about it straight away, it's not like I had this whole master plan of a peer support career…but I did know that it just completely fitted with my values.

Kate: At the recovery college and on the peer support training there are so many people who had this…such a positive outlook on mental health and that was such a contrast to my experiences as a service user. I never had anyone tell me that what I'd gone through was valuable, it was just all about, have you done this, have you done that, have you got an allotment, have you got a boyfriend, all the stuff I hadn't done and didn't, sort of…didn't want to do either!

Lucy: It was like getting a message that your experiences were valuable

Kate: A big part of it for me was making it up to that little girl who was told she wouldn't make anything of her life. I remember…when I was…about 11, I made a promise to myself that I would use my negative experiences to help other people. So that idea of peer support has always just fitted for me, for who I am

Lucy: For me peer support is about the whole of who I am, not just a job. It's a way of living and a way of being. So even if I wasn't in this role I would still be working in this way. When I saw these peer worker roles, **it felt like I was coming home to something**, like it was meant to be. And when I first started, I felt like, oh god am I even working? This is just wonderful!

Sally: [laughs] yeh, like it's not about the money really is it? I mean if it was you wouldn't be in this job! When I was on the ward I met a peer support worker, and I remember her saying, 'you can do this too' and at the time I didn't believe her at all. Umm but the fact that you know, she said you'd had your

own struggles but were working, that gave me a little bit of hope and…it was just the right person at the right time, because…she was just like a breath of fresh air on the ward. She told me…about her experiences and they were very, very similar to mine, and…the fact that she was working was so inspiring to me. So it was just meeting other peers and seeing how inspiring they were to me, and I literally think that if I hadn't had that peer worker that I wouldn't be here

Kate: I wonder what it would have been like if I'd have had a peer support worker, like someone who didn't have any secondary motives for supporting me. I had such a crap time in services, well on the ward specifically…that I wanted to be a peer worker to make that different for other people. Because I just felt really isolated, I know there were people in the ward with me but no one had like any recovery…stories. Everyone was in it together in a kind of bad way, so we all felt horrible. I took a big pay drop to become a peer worker, I was an assistant manager before but it's something I really wanted to do, and life's not all about the money is it?

Lewis: Well for me it was a bit about the money I'll be honest, when I started I just wanted a permanent contract because I had loads of financial pressure coming off benefits and it was a bit of a surprise, well a fluke I guess, to get the job. I mean I always wanted to help people fulfil their potential and be in…like in a nurturing role but I did need financial stability too.

8.4.2 *Constructed conversation*: There's a certain respect for doctors, but there's a certain respect for peer support workers because they know we've been there

Victoria: I do think though, another confusion with it all is that obviously some members of staff have got lived experience, so I've heard it said that…you know staff have got lived experience, everybody's got lived experience, so I think that's also where some of the confusion comes in as well

Lucy: I mean, some other staff would say about peer support, 'well that's no different to me working with them.' There is a difference. Staff may have lived experience no different to me, but they may not choose to use that for the benefit of your role. Whereas in peer support we do. Yes, you need professionals, you need that. Even patients would say they need professionals to work with, to understand different concepts of them, to support them, in a bigger picture. But peer support is different to that.

Adrian: We don't go in like medically qualified staff with…you know, in the file or generally in your head, going to do this, going to do an assessment, going to prescribe, going to come back in two weeks' time and check if those tablets are doing whatever it is they're supposed to be doing. And sometimes the…staff have lived experience, but they're in a culture where they shouldn't be telling people their lived experience, they haven't had any training on disclosing their lived experience, you know? They're not…as fortunate to have had some of the training that you've perhaps had as a peer for your role. Because I think there's lots of staff that come with lots of lived experience.

Lucy: from the beginning of conversations I always explain that I'm not medically trained, I'm not…I can only bring my own experiences, I come in knowing that they know more about themselves than I do, certainly when we first meet, and I want to learn from them.

Victoria: with professional support you have the dichotomy of, you have the professional and you have the patient. The professional has the knowledge and expertise, and the patient is there to be helped…but peer support

deconstructs that and flips around the importance so, what would traditionally be the patient is now the person with the expertise

Adrian: We're not the experts…and we're not qualified to do their assessments. The questions you ask are kind of different, like you know, clinicians obviously have got specific questions that they've got to ask and you would be more on a time constraint, because you would have some specific things that you've got to get through. Most of the time everybody's on a bit of a time constraint so if we were doing that it just seems a bit…yeh you would be…it would change the role.

Lucy: Yeh and I think like I still try and understand and….like the risk side and try and get some of that stuff…because it's important as well. But that's not, you know, essential in my role to just be asking questions like that.

Adrian: I think actually, I don't think it's the people I think it's the…dynamic and the actual nursing role. And them not having enough time and the pressure that they're under actually. But I think if all that pressure was removed, I would say any member of staff could go on that journey. Maybe different personalities would vary how they choose to do that, or whether they feel it's part of their role. They might not feel it's part of their role to really connect with that person. They might just see it as more I'm here to care for you, I'm here to keep you safe, I'm here to stop you from taking your life or harming yourself, or…

Victoria: I think, if someone really watched me…day to day what I do, they'd see that it is different and how it is of benefit from people that I work with and that. **There's a certain respect for doctors, but there's a certain respect for peer support workers because they know we've been there**…people tend to engage with me a lot quicker because of that

8.4.3 *Constructed conversation*: You have the title but you have to define the role

Adrian: I think that here I have quite an autonomous role, so I have the freedom here to build my role as well. I kind of felt a bit left to get on with it at the beginning but I don't mind that. And I think because of the job I did before, I was always left to it, so…and I like it in a way, being left to it, because…not completely left to it…obviously I meet all my key responsibilities but you know branching off into other areas like organising groups or activities just to sort of boost morale, not only for the service users but for staff as well.

Hannah: when I started on the ward, there was just no structure to the role, so it was kind of like left for you to develop yourself, which I get that. Like a new role, you can develop it yourself, but I don't get how you can develop something when you've got no idea, when you're completely new to the role yourself how you can just develop something within a team that's already set up

Victoria: When I started…I got asked so many times, what is a peer support worker? So many times. I used to feel, for me…to start with it was just so annoying to try and explain the role. It's just hard to put in to words because it's so unique individually, that it's difficult to put into words. Not good, doesn't make you feel particularly good

Adrian: And I think it's, I think our team have really…not been quite sure of peer support so…I don't actually think they know what to expect in a way. But it's really hard to explain that all in a sentence isn't it?

Hannah: Yeh I think if I'd have known myself a bit more and you know…I'd have just known a bit more about what you're able to do and you're not just like completely lost, I think I'd have been able to push a bit more. But I think because of how it started, that just knocked my confidence and I couldn't do it then, if that makes sense. I just kind of just lost myself a bit in the role. Which I think had a big impact on how motivated I was then. I know we were told this on training, we were given an idea of peer support, but there's no book, there's

no handbook that can tell you how to be a peer support worker. It's almost like **you have the title but you have to define the role**

Victoria: I mean it was easier for me in the other team, the first team I was in before our teams were restructured because there were four peers, so we were able to have much more of a presence and also support each other, and also… you know…discuss ways of working and…all those things that are quite…very very useful when you're starting out. But the problem then, when we were all split up, it did feel quite isolating at times. And…because of the uncertainty of…what the role was to start with I think that also meant that, you know, I found that referrals were quite thin on the ground to start with and it was looking at how to generate referrals as well.

Hannah: I think…starting with something that's got no structure and you're like a deer in the headlights yourself…I kind of just lost motivation to…push it then. And also not knowing what you're pushing for. I was told I wasn't allowed to answer the phones. But then other people…then when the phones were ringing constantly, I'd feel really bad and I'd say should I answer the phones. Some people were telling me not to and then I got told to answer the phones. And then I picked up the phone and one nurse said 'you shouldn't be answering the phones.' And then an email got sent round saying that everybody should be answering the phones, even…from peer support to nurses, so obviously from the bottom to the top [laughs] and I was thinking well I felt that was really unfair. And then if you don't answer the phones you're sort of sat there thinking, 'crap, what do I do?' I look like I'm not helping out, but people have told me not to, people are telling me to…what do you do? But now I answer the phones [laughs]

Victoria: I didn't think there would be such a…a battle really sometimes, just to feel that I'd got a role and feel that I'd got…because that's the hardest thing I think, feeling that I didn't have a role in the team and I really wasn't prepared for that kind of feeling. But…you know I think, yeh, I didn't want to just walk away. I've actually moved into an OT support role now because I wanted to have some chance to work with clients through a longer period and actually look at recovery goals and actually building relationships and that kind of thing.

I mean I would still like to be a peer support worker, it's not saying that I don't want to do that role, but I just felt so unsupported, and so…kind of…that really the role was being diluted so much that I felt…I needed some structure, I needed to…be working in that kind of way.

Adrian: I've always been massively supported by my manager. I think that makes a huge difference. And I knew there were people to ask if I needed…I don't know …I suppose I was left to it, but then, the team, they see that value, they can see why working in that way is good. So I felt like I'm OK doing that on my own.

8.4.4 *Constructed conversation*: It's just what you're classified as

Lewis The peer label foregrounds your lived experience, it's out there straight away

Izzy: I like that, I think it's important that people aren't afraid of who they are, or the experiences they've had.

Lucy: It's quite transformative isn't it? Like these things that we've always hidden are out there now. Like it's turning a negative into a positive. All that pain and sadness hasn't been in vain because I'm using it to help someone

Izzy: All the other jobs I've had where you just keep quiet about it, peer support is totally different. It's kind of brilliant to be able to use it without worrying about what the consequences might be or who knows what. And it's helped me to see myself a bit more clearly…like to work on understanding my own stuff…own experiences.

Lewis: Yeh but what I'm saying is you've got no control over that now, do you know what I mean? I think I expected myself to feel great about being able to use my lived experience because that's what I've wanted to do in all my other jobs, and I think…I don't know. I feel like for me personally, it's hard to have that as my title. Because I feel like I don't have as much control over when I can and can't use it. I feel like it's just out there. And if people ask I feel like I have to give them something, whether that's detail or just vague, but you have to give them something

Hannah: I don't really understand…it actually frustrates me when I hear lived experience all the time, like **it's just what you're classified as**. There's more to you than lived experience, everybody's got lived experience of something, it just isn't exactly what you're about surely?

Lucy: I think it depends on how you look at your lived experience, because for me, I don't know, I feel un-easy about my own lived experience and about being defined by that, but it was quite a defining time in my life. So at the moment, I'm alright with defining myself by it but I wonder if as time goes on it

might feel I want to move away from that identity to something more based on what I have been doing if that makes sense, not who I was.

Lewis: I think if you make lived experience central it just leaves you a little bit vulnerable, because…like people in the street don't need to know that I've ever had a mental health difficulty, but because I'm a peer everybody in Nottshc already knows that of me. But they don't know what exactly, and you do get people that are clearly thinking 'I wonder what…?'

Hannah: it's everything the team knows about you, I've experienced something but they don't know what. So you've got this big question mark over your head and I don't really like that. And do I want that to be the first thing that people know about me? I'm more than my struggles, I want to be defined by who I am, but they don't know me outside of that do they?

Lewis: I thought it would be more empowering that it has been. I've thought about it and I think I'm not sure I like it. I'd rather be a support worker and then use it when it's right to use it and when I need to use it. Because when you say peer support people then want to go straight into lived experience, how you explain your role is by saying you've had a lived experience, that's the first thing you say to people, people want to know about that.

Hannah: It tells you what you're defined by. It's not like, I'm this, this and this and I have a lived experience. Which is what like…people try to be like I am all these things as well as whatever condition or…experience you've had. But it kind of says you are this condition or experience.

Izzy: One thing I wonder is how long do you call yourself a peer? I keep wrestling with the idea that, you know, ten, fifteen years on, how valid will my experience be? I mean it's been four years since I was last in hospital, and in many respects I have to put on this peer hat. I'm always having to think back, but as time goes on, how far will I have to go back? Does that make sense?

Lewis: yeh and do you always really want to be searching this kind of information? When it's not even been a thought for a while?

Izzy: like I say, I'm happy in what I'm doing right now but it's just something I wrestle with, how long do you stay a peer? And isn't everyone a peer?

Lucy: I think that everyone should be able to use their lived experience, like have peer nurses and that, but I don't think we're the same as support workers. Being a peer is about more than just lived experience

Lewis: that's not how staff see it. If you were a support worker they wouldn't worry as much about you being vulnerable

8.4.5 *Diary entry* 09.06.17

One of my fears working as a peer is that my lived experience is not enough. What if everybody found out what I'd actually gone through and they realised that I was never a peer? So sometimes I find myself choosing language that hides my experiences in vagueness, because I'm afraid that what they are is not enough.

And yet, when I look at my own experiences, when it's just me and them, I know that I literally had as much as I could take without dying. I know that I did nearly die. I know that this 'recovery' is my goddam life's work and that it killed me and created me. I know that. But in the face of other people's seemingly more legitimate stuff, I cower.

For example, I don't take medication. I haven't taken any pills for years and I haven't been prescribed mad cocktails of different anti-psychotics. I didn't have trouble withdrawing, I just started reading Anatomy of an Epidemic (Whitaker, 2010) and stopped taking the pills. In all honesty, it wasn't difficult. But the narrative I hear around medication is that peers take loads of it, that medication somehow legitimises distress, that withdrawal is a virtuous and difficult path, that being medication free is only a sign of legitimate struggle and 'peerness' if you have fought tooth and nail to get there.

I wouldn't countenance taking medication now, even if I woke up tomorrow and wanted to die, even if I saw rats crawling up the walls, even if the sky turned red.

Wait. Maybe if there were rats I would.

But short-term, alongside other things.

Another thing, I have only had one admission. And it was only for one night and then I discharged myself. I didn't experience the complete loss of liberty, I didn't feel the full weight of psychiatry crushing my spine and my hopes. I was poised on the precipice, I stared down into the void with my eyes wide open and while the chance was still there, I discharged myself.

Medication and admissions are the markers of lived experience aren't they? I don't have scars either. Should I have scars? I sometimes feel like I would like one, just one big one that says, I have suffered too. How warped is that? Are there any other professions where I would find myself typing this? Wishing I'd had one more admission? One more scar?

The crushing irony is that outside of peer support I feel the opposite. I feel too mad. I would never speak of the ins and outs of admissions and medication and scars.

8.4.6 *Constructed conversation*: I'm meant to be the success story, and I can't be failing

Sally: A lot of people just see it [peer support] as someone who's got a lived experience who…is a bit flaky, who may become unwell. So you're really conscious, like for me, I was very conscious that as a peer, I don't want to be off unwell, I don't want to be off if I'm sick, because then that could be viewed as being, well you're not up to the role, that's why you're a peer because you're sick, you're ill, you have a mental health issue. I think that can be the view of a lot of teams and that is my experience of other peers that I've spoken to but luckily for me not, or not in my team.

Izzy: It's like you've got to prove you can be well and recover, especially if they have been on a ward, but why? I had this conversation, actually on the ward, where somebody said we've got to be careful with peer support workers because they may become unwell. But anyone can become unwell! It's like if you're a peer and you're unwell you're just confirming what people already expected. So I try to point out my strengths too so they don't just think I'm vulnerable

Sally: The other thing is, in some ways, as a peer support worker **I'm meant to be the success story, and I can't be failing**, because if I'm failing then what hope do they have? It's a lot to take on

Izzy: Yeh I think there is that pressure because if you burn out or go off sick you'll damage the peer role. And at the end of the day, it's not just about your role, it's about peer support in general, if you go off sick then it's the reputation of peer support isn't it? I often get stuck in this, am I doing right as a peer? Am I honouring the peer name that I've been honoured to be labelled as peer? So I feel like I have a lot to live up for. I almost feel like I'm representing peer support on the ward so I feel like I have not just my own integrity to…be trying to do the best I can as a peer, but also feel like I'm representing the Trust and people that have trained me and other peers that are working in the Trust and I feel like I want to…try and….give peer support the best name that I can by what I do.

Sally: Like if we can really demonstrate it well and show the benefits and the positive outcomes of what we do, then more people can get on board

Izzy: And the opposite too, if you're off sick or are struggling, then it's everything that people know about peer support

8.4.7 *Quiz*: How peer are you?

Take this short questionnaire to find out…

1. Are you grateful for your job?
    a) It pays the bills
    b) It doesn't really pay the bills
    c) So grateful

2. Have you ever taken psychiatric medication?
    a) I know people who have…
    b) Some anti-depressants
    c) I take all the medication, but you couldn't tell from looking at me

3. What are your thoughts on psychiatry?
    a) Makes sense to me
    b) It's helped me understand myself and my condition
    c) I actively campaign against it whilst being respectful to individual psychiatrists

4. Have you ever completed a wellness plan?
    a) A what?
    b) Sort of half-done one
    c) My wellness plan is my bible, all my friends have a copy

5. In the past year, how much activism/campaigning have you been part of?
    a) Does complaining about my incorrect Ocado order count?
    b) Between one and five events
    c) I have my local MP on speed dial

6. How many hospital admissions have you had related to your mental health?
    a) I've booked myself into a spa a couple of times

b) They were going to admit me a couple of times but couldn't get a bed

c) Plenty

7. Which of these groups of people do you most easily fit in with?

a) Amanda Holden, The Pope, Freud

b) Stephen Fry, Ruby Wax, Meg Griffin from Family Guy

c) Carl Rogers, the Buddha, Rosa Parks

8. How much of your personal information are you prepared to share in supportive relationships?

a) Why are you asking that question?

b) I have some things I keep to myself that are private

c) I'm an open book; if it helps, I'll share appropriately after asking if it would be OK

9. What intentions do you bring to supportive relationships?

a) To help people self-manage and discharge them in good time

b) To support people achieve their goals for recovery and inspire hope

c) To offer a deeply empathic space where two people can learn together and be profoundly changed in the process of shared growth

10. What boundaries do you try and maintain in supportive relationships?

a) Professional and caring

b) Achieving that balance between being friendly but not a friend

c) Emotionally intimate and attuned but respectful and clear

11. What does a bad day look like for you?

a) I shout at the traffic, don't smile much and drink a lot of coffee

b) I can't get out of bed and when I do people tell me to go home and look worried

c) I tell people calmly that I'm struggling before doing something kind for myself or meditating

12. The hardest thing about this job is…

a) Managing risk

b) The crappy pay

c) Feeling so profoundly connected to people and wishing the world was kinder

13. People describe me as…

a) Efficient and capable

b) A bit unstable

c) Kooky and creative

14. Which statement best describes your career pathway

a) I studied hard to get this job

b) I'm well educated and had a successful career before this one

c) I work permitted hours and being a peer is all I want

15. My lived experience is…

a) Private, thank you.

b) Pretty much in my face all the time

c) Enough in the past so that it doesn't affect me, not so much in the past that it's not a part of me

16. When I make a mistake I…

a) Apologise and move on

b) Hate myself for at least a week. Hand in my notice.

c) Reflect with self-compassion and use it to inform my practice

How did you do? Count up the total number of a's, b's and c's you scored.

Mostly A's: Sub-clinical peer levels

Sorry, you're not a peer. Much as you might like to think you are, your childhood was probably too normal and your lived experience just isn't enough to qualify you. It's unlikely you've ever been on benefits or that you take

medication, so what makes you think you have lived experience? You are also a little too reluctant to talk about your own personal experiences, as if these are somehow private. You probably buy into the medical model a little too much and your motivation is about helping people rather than something more existential and peer-y.

Mostly B's: mild to moderate peer

Well done, you definitely have some lived experience, maybe even a little too much. The ways you use it, and how you manage your wellbeing are a little shaky which means you sometimes come across as a bit unstable, and this jeopardises the peer identity. Although you try hard in your peer relationships, you don't always feel a connection and sometimes your experiences don't feel relevant. Equally, you might try and be respectful toward staff members but sometimes this ends up as overly angry or placating because you're not always sure about how to be authentic all the time. At some point, you have probably wholeheartedly agreed with a psychiatrist about a course of treatment, a clear indicator that you're not quite enlightened enough to make it into fully fledged peer-dom

Mostly C's: severe and enduring, text book peer

Congratulations, you are a true, gold standard peer. You have lived experience in bundles, meaning you can relate to pretty much everyone. The great thing about your experience though is that it doesn't affect your self-esteem or your day to day functioning, so you come across as pretty normal which is a relief for the people you work with. You might have dabbled in person centred counselling in the past, and are probably into Buddhism. You believe peer support is part of a spiritual path of connection and deep emotion, and this makes your peer relationships profoundly meaningful. Luckily, you are able to communicate this so psychiatrists can see the value of what you do, and begin to change their own practice without feeling threatened. While you actively campaign against the medicalisation of human suffering, you have empathy for individual doctors and nurses. Namaste.

8.4.8 *Diary entry* 18.05.17

I have spent another week in my hopeless head. I have stopped sleeping. In the night I turn, like a dried up leaf in the wind, from my side, to my back, to my front and then to my side. And random work issues hook into my mind. Ridiculous thoughts to think at 3am

I saw my old CPN (was she a CPN? She would never tell me her qualifications, as if I would use them as proof she was inadequate…maybe I would have too) today. I was opening the digi-locked door to the café to let some stranded visitor out and waiting on the other side, there she was. As we opened the door onto her she giggled with surprise and when I saw her, this anxiety charged through me like cavalry across a battlefield; like hooves against my ribcage. I doubt she even recognised me, that woman who wounded me, who told me I was sick. Who said I wasn't living. I wonder if she is still using the same approach with others. I felt simultaneously angry and frightened, and so completely paralysed.

How peer workers go back into the service that supported them I don't know. Even if they had a good experience, they would be surrounded by people who knew everything about them, every embarrassing facet of an admission, every mad belief.

8.4.9 *Single narrative*: Try to stay as the bridge, and see it from both sides

Adrian

There's been a couple of situations where I've intervened before between a service user and a member of staff and spoke to both of them separately and put the service user's point across and put the staff members point of view across and they're both like 'oh actually yeh' and that's nice when that happens. I think it's, I don't know I'm probably not explaining myself very well but I **just try to stay as the bridge, and see it from both sides**. I'm a bridge in the sense that it's not just about me talking to staff about how they approach things, but on the flip side, sometimes I speak to service users as well and say you know what, you might think that they're doing this to upset you, but they're not, they're actually doing it to support you, these decisions that they're making are in your best interest you know?

But if you stay in the middle there are loads of times where you can be that go-between type person. Like my manager will say, Adrian, go and weave your magic. Because there are often some people who will just not engage with the staff team, won't engage with any of the staff, and then I'll go, and they'll engage with me. And I think that's largely because I can say, I've had a lived experience of mental health issues, I can empathise with how you're feeling right now. It's a bit of a friendship in a sort of safe and contained environment I guess.

I've worked with service users where the doctor has said, can you continue to work with that person because they're not telling us everything in the review? So that, in a sense…not puts pressure on you but, I've had to work with some really difficult…in some really challenging situations with people who are not speaking to anybody else and are only speaking to me.

It's helpful for the staff, that you're one of them but you have a foot in both camps. I think they really value being able to say to a service user, we've got a peer worker. And sometimes things come up and the staff might ask me what my experience of using the crisis team would be or something like that. I

know they have a lot of experience of seeing people but having someone in the team that can actually relate, it's nice that they will ask me things.

And I guess that's probably a little bit of pressure in itself because you've got to be close enough to your experiences that they are relevant and they're part of your identity, but far enough away that they aren't still affecting you. I think if peers are given the opportunities to re-connect with their peers and to keep updated on the opportunities and what's going on in peer support, it's not too difficult to keep that peer-ness but if peers are isolated from other peers, even if not intentionally so but are just not given the opportunities to reach out to other peers, it becomes easier for that spark of peer to die out.

8.4.10 *Constructed conversation*: I'm not saying people aren't recovery focussed but…

Sally: I find it quite painful listening to how some psychiatrists talk to the staff and I think 'ohh!' [sharp intake of breath] and I think if they could just….obviously I've not got the knowledge of a psychiatrist but…just the way that they relate to patients…people…could really transform the response they get I think. And I know they've probably got to say things that I haven't had to say to people but…I just see the kind of the way sometimes they approach people, could be a bit more gentle and a bit more…kind of explaining.

Anthony: I think some staff are really good at interacting and working with people. And I think some of the best staff that I work with aren't peers…but then some staff are a little…I don't know…the…there's some staff that are not as good at reading the individual in terms of how they react and stuff and what's best to ease them. So they can wind…continue with a course of dialogue that is not…easing the person but is just…perhaps making it a little bit worse.

Adrian: it's like…sometimes it can be a bit difficult, because you don't want to upset anybody, and sometimes the things I've heard, I don't think they've been done out of malice or anything, I don't think… it's just like old fashioned views, not fully understanding, it's like that education isn't it... because I think it's going to be really difficult for those staff members that have already been in that role for so long to then turn it on its head and do it in a different way.

Anthony: You could get situations where the nurse says something really derogatory about someone, it's just how you challenge that and how you do it in a positive way so you're not…I think there's a soft way of…sometimes I've had to be a little less soft, but you, nine times out of ten, there's a soft way of actually challenging some behaviours

Sally: and try and see it from their point of view, from the member of staff. If…the nurse in charge has had seven consecutive shifts and he's said something….which conflicts with your peer values about how you would talk to a person and stuff, it's then how you would challenge in a positive way. But

I don't think I could have done those challenges right at the beginning of my journey, I think I had to get right in the role and build my expertise

Adrian: I'm not the bravest and there's been times, and I hang my head in shame, when I've just sloped off because… I'm so frightened of just getting, not a mouthful back but getting some really….clever, academic answer back that I can't deconstruct because I haven't got that background. Because I sit in that meeting with all the doctors, psychiatrists and nurses, and…I'm probably the lowest band in there and I just feel like…it's really difficult to get…your point across, above a nurse or a psychiatrist and I don't really like to do it. I remember at this meeting once, there was a lady I was seeing, she was abusive and just swearing and stuff. And so the team said I don't think…we should visit. I felt…when I said I feel like if we just don't go and see then we're kind of abandoning her… I did feel like I was really saying the wrong thing. And I should have probably been agreeing with everyone and going yeh, probably we shouldn't see her. But something in me was like I can't really say that, I don't think it's fair on her.

Anthony: and sometimes it's not about directly challenging, I think it's about allowing people to…take those steps themselves. Rather than forcing it up on them, that watching peers in the way that they interact and then watching other staff as they begin to progress themselves in that way of thinking. **I'm not saying people aren't recovery focussed but…**just modelling this behaviour let's say, or maybe sharing how you might have felt. And if...the thing is when you're wanting to change the culture, I think it's easier to change the culture when you've got somebody there with lived experience saying this is how I felt in a similar situation, you know?

Adrian: what I wish for is that peer workers will sort of…show the way, to other staff and they'll go 'oh yeh, that's a good way of working isn't it?' But there's a long way to go. And like I said earlier, it's a lot to ask from what's basically a handful of peer workers. If you think there's six thousand people in the Trust, how many peer workers there are it's still a drop in the ocean. And to expect them to change the culture which is part of the role? It's a lot to ask.

Sally: It is…there is a lot of pressure when it comes to changing people's opinions and the culture and what have you and people's attitudes and the way that they deliver…themselves, to service users. So I think the peer support workers…should, I don't want to say should, but part of their job is to change the culture and I think that's a nice part of the job, in a way.

Anthony: but when you have a culture of understaffing and firefighting you can't do it. And that's…I just don't know what would make any of that, as a peer support worker, what I could do or what anyone could do to change that. What could anyone do? It's something that's higher up that needs to change, that needs to be different. It's firefighting, we're still firefighting.

Adrian: I don't really have a feel for how it is as an overall whole at the moment. But I feel quite positive about it. [laughs] just sort of generally, I have quite a lot of faith in the peers I know. That they are doing their best and they are trying to live up to the peer ideals especially working in the Trust, in an organisation that doesn't necessarily always encourage those ideals. And I think while we're changing cultures…sometimes just by being there we're changing them…but we're being changed too. So there is an element of peer support becoming medicalised but also the medical aspect also becoming a bit more peer support-ised. So that gives me hope about the way that things are developing.

8.4.11 *Constructed conversation*: Part of me wants them to know me as me and not see me through different glasses

Lucy: Umm, I am quite open with staff, like I've got a few on like Facebook and…that I'm quite close with. And…you know I'll post on Facebook and my blog and things. So I'm quite open and sometime staff talk to me about it but I think they're quite wary about asking me because it's not a culture to ask in, even in mental health settings it's not the culture, you just sort of stay quiet about it. But I am quite open, especially with my manager, because I just think if I can't be open with my manager then I'm going to really struggle if things get…bad for me. Sometimes things come up and the team might ask me what my experience of like, using the crisis team would be or something like that. And I'll just be honest about that and they really value that. A number of staff have come up to me and thanked me for sharing certain things.

Hannah: In my team, one person asked me directly…and then other people have tried to like drop a few…hints into conversation of…what's happened? What's gone on? But I'd rather somebody just asked me, if they wanted to.

Adrian: a few of the team asked me about my lived experience when I started and I think that helped. I think there were a few of them that sort of…eavesdropped to those things and I think they didn't necessarily ask but they'd wanted to. But I think it helped because I was really, really brutally honest, if they asked, I was like well how much do you want to know, because everything you want to know, I'll tell you, because I don't mind, I've lived through this, telling it's not…not going to make it, not going to change anything that happened but it might give you an insight and to me, it's not a problem. I was quite open pretty much straight away, it stopped that wonderment but I know for other peers that they haven't been, rightly so if they don't want to be.

Hannah: I think people dropped hints because that was their way of seeing if I'm alright to…to talk about it or they might just feel uncomfortable to ask directly and not put me on the spot. But people are interested because it's a completely new role as well and it's obviously got a big label on it. So I think…there's obviously some like...they wanted to kind of know, like 'oh I wonder what it is.'

Adrian: I think there's a curiosity around someone being open like that. And that's what it was for me. Because there's a lot about, you know, boundaries, and you don't tell each other things, and you don't tell the people you work with things, and suddenly there's someone coming in and going 'ask me anything, it's fine' and I think there was a bit…'oh…ok!'

Sally: I probably am not that open about my…I almost feel like I haven't particularly with staff because I feel like there's a lot of misunderstanding and stigma. And part of me wants to share it and go 'you'll never guess what…' and they'd be like 'no…., you? No!' but…**part of me wants them to know me as me and not see me through different glasses.**

Lucy: I think when you share that kind of thing with staff, and you don't really know them massively well, then I suppose you do worry about them having a judgement on you. Whereas if you share something with…a peer, I don't feel like they judge you in the same way. So they probably judge you but it's not a negative judgement, it's a mutual judgement. Whereas I think if you share something with staff, it's not is it really?

Hannah: I'm probably more comfortable sharing with people I support than I am with staff I work with to be honest. I'm quite happy to…for people to know that I've got lived experience and that I use services, but I wouldn't necessarily share what the experiences are, but I'm quite open about the fact that I am a peer. But I wouldn't be comfortable in sharing a lot of information with, you know, certain, some members of the team. It is easier with people that I'm supporting, I think, yeh.

Adrian: I probably share with staff sometimes *more* than I do with service users, to get my point across. So like, for example, if I hear some language and I don't feel comfortable with the way that something's said or the way they've addressed a service user, I will then explain my point of view, like saying, if I was in that situation, having been a service user, and still using services sometimes, this is how I would feel. And then I might explain about well actually like if they talk about certain diagnosis I'll say 'well actually I've had that diagnosis', sharing that. And then put my point of view across.

Sally: And then I think maybe I should have started and been more open from the start because that's my whole role is being a peer and sharing lived experience. Maybe my diagnosis I have consciously more kept that back.

Adrian: I've noticed since I've been in this team, that the conversation is always opening up and people bring their own experiences in and talk about it more. So when they've seen me do that I think, it's not given them permission, but let them see that it's not that scary and that you can. And it's not a weakness or anything like that.

Lucy: I've had quite a few members of staff here that have come to me and said, you know what Lucy, I've got lived experience myself, and you know…it's like sometimes it's just they feel it's a bit more uncomfortable for them to share it because of their role. And it would just be so nice if we had a culture of it's actually ok to share these things.

Hannah: I sometimes imagine what it must be like…to be…a nurse, to be a CPN and to have those things and not be able to use your lived experience and when I was…being treated I had a nurse who did share some bits of stuff with me, and…that made such a difference.

Lucy: Absolutely, I mean the number of times that I've heard people saying, 'oh we'd love to be able to do what you're doing, just being with people without having to do paperwork or risk assessments.' You know all the things that go with working in an organisation, I guess I don't know

8.4.12 *Diary entry* 21.04.17

I spoke to one of the new peer workers today. She is hating it. She says that she doesn't want to come into work. She said it all to me, with apologies breaking up the awfulness, as if it was her fault that things were going badly. I think it was hard for her to say how difficult things were because all her peer support training tells her to be strengths focussed. I think she felt like she was getting it wrong by saying things were awful. But then it's a trap really, because things are awful and speaking about it might be the only way to make them less awful. But speaking about it might mean that you're not strengths focused, so you're a rubbish peer, so it's all your fault and it's just one more thing you're getting wrong.

8.4.13 *Constructed conversation*: It's very much dependant on how much the team you're in understands peer support

Kate: When I first started working here, the majority of staff had never even come across a peer support worker. They didn't know what it was, they didn't know what it meant, you know. And for me, I came into this job, because I did the training then came here, and it was like…not amongst everyone but I think in terms of…maybe, general lack of understanding

Adrian: When we started in this team, it was 'well, we've never had peers before.' And there was a lot of 'what do you do? What are you for? I don't really get peer support, why would we want somebody who could get…in that…unwell state again? 'Why would we want somebody who might not be stable? What if we know them?' I think there was a lot of…anxiety around that, and there was anxiety around pay bands as well, 'why are they coming in at a higher pay band than I am? What do they do? Why do they deserve that?' There was a lot of that that went on.

Hannah: I'd like to see more understanding of what peers are and what peers do, so that when peers come…I often get that 'oh, you're a peer.' And there's a bit of sympathy and 'oh I wonder what you've got and is it infectious? Aww you're a peer.' But, sometimes I see, 'oh great you're a peer, we need more of you!'

Kate: I remember when I first started, I remember the manager saying, staff are going to find it really odd to have you in the meetings because…they're going to worry…like exactly those things you've probably said, she was just like, the team do feel a little bit like that's going to be strange. But I think that was really nice of her to say that because it's better to put it out there than having to feel that and not know that the team…might have thought that as well

Hannah: I think it's just the message seems to get across for some members of staff, like in the previous team I worked in before we were re-organised, I think they had a lot more understanding, but I think…it's still kind of patchy.

Adrian: I think for me, because the team didn't understand the role it made me not understand it. And…some people took advantage of that. They just wanted to see how far they could push, to see what I would do. Not all staff, some staff were so good, but others would just think 'dogsbody.'

Hannah: I think **it's very much dependant on how much the team you're in understands peer support**, and I do think that there is an element of preparation that needs to happen for teams. Because for peers going into teams that…don't really understand about it and haven't explored their hopes and fears around it, I think it's a nightmare.

Kate: Yeh, I think, and even though when I first got there none of them really knew what it was, they wanted to learn, there was that willingness. I really got took under the wing by two people and they integrated me and made sure I was involved in everything and let me shadow things, and asked me loads about peer support and went on like training days to learn about peer support. They really got involved, and maybe that's not happening in the other teams. I don't know

Adrian: No… again a thing that I had when I started, it's this, 'you think you're special because you've got…but really it's not that great. Why are you so different to us? Because actually you're not brilliant.' It's that kind of dichotomy

Kate: I don't think a lot of people value peer support. A manager that used to be here was saying to me, after three or four years in, 'oh you've got market value now.' Basically she was saying to me, quite openly, 'I didn't rate peer support workers, because they put pressure on teams because they might become unwell, or we've always got to care for peer support workers because of the fact that they may…their wellness, that they may become unwell.' And I think that can be the view of a lot of teams and that is my experience of other peers that I've spoken to but luckily for me not, or not in my team. So…I don't think the NHS completely values peers or necessarily understands the work that peers can do

Hannah: I think it's mixed, I think there are those people that really value it and understand it, and those that are…scared maybe or…just don't value it at all.

But I think as a peer, or HCA, or a nurse, or any member of staff when they come into a role, I'm not sure their opinion and value is 100% merited within a team. I think you have to build relationships and your expertise and show that you've actually got value. And then you get invited into meetings and reviews, patients seek you out…and I think that integration into the multi-disciplinary team, for any employee, takes time and it's sometimes difficult.

Adrian: I have…through hard work and persistence and taking…critics who…also out of jealousy, on the chin, really. I went home a couple of times over the years and thought do I want to come back the next day, just because of comments. Over the two last, three years, nurses have come to me and said, that was a really good session you had, we saw evidence of that. But this form of jealously… I think peer support is resented by some of the other staff, because we're open and honest and because we get such a great….sort of therapeutic reaction or whatever.

Kate: I think it's really interesting that peer support is seen as this special thing but also has got this reputation of being a bit rubbish.

Hannah: But for me it did get better. Sometimes I've had positive feedback in like engaging people which…I think it kind of made them think a little bit more about…where it could go. And I do really like the people in the team, I think they're all awesome at what they do, and like really lovely people. I think the problem at the start is that they didn't really know about…I got told that…somebody just saw the advert and they didn't get told that this role was going to be implemented into the team. I think if you were a nurse you'd be really happy within a team like that, because they are really supportive. I've learnt a lot from them.

Kate: I think over time people see how we complement the rest of the team. And my team are all so encouraging, they're saying honestly, you are really, like we really value you and we think like your role is amazing and we'd hate for you to not be here. And if I have a bad day, they don't judge me or pussyfoot around me. I just feel so part of their team and so…loved in a way

Adrian: And I think there is a bit more acceptance since I started. I had a period where I kind of…struggled, and I think some of them realised that perhaps it was a bit much what they'd been doing, and perhaps I wasn't some threat to…that perhaps I was just there to do a job, and that I was just a person and not…I didn't think I was better than them. I still find it frustrating when new staff don't know what peer support is but I feel like I'm really settled in my role. And I think it's good for them to see people who have recovered, or who have moved past their distress. One of the really experienced nurses said to me the other day 'it brightens my day when I walk on for a handover and I see a couple of peers because I'd rather have a couple of peers than three six foot four…bulky…' whatever the words, she was happy we were there.

8.4.14 *Constructed conversation*: I pull my hair out when I hear some peer support workers

Kate: We had somebody in the team who's now left. They…they and they were very open and honest about it, they'd only become a peer worker to get a foot in the door in the trust. They thought the whole lot was rubbish. They completely dismissed…any value of being a peer worker. They completely dismissed any recovery ideas, it was all a load of mumbo jumbo rubbish. Bizarrely she was actually quite a good worker. Because we were very worried about her and…basically we spoke to a lot of her clients to find out how she was getting on, and the feedback we got was great, so she was doing a good job but she was openly dismissive of the whole thing. She was extreme. But there've been a few who…do buy into it…but…um…I'm not sure if they get it all.

Adrian: Talking to individual peer workers, I can see maybe signs of some people, taking on the medical model but using the language of peer support. But I do also think that there are lots of peer workers who do really keep to that authentic, recovery focussed…that peer core.

Lewis: it's not that they're bad workers, they're not, they're great workers, but they're becoming, again they're becoming less of a peer worker, they're becoming, they know exactly what they're doing and it's becoming very polished what they're doing. And it's becoming more routine, and I think that definitely detracts…

Kate: I think you can have peers which are not very good at communicating with people and not very good at interacting with people.

Adrian: And you can have peers who don't have boundaries, and just sort of tell it as you think it is, and I think that can be very dangerous. I know another peer for example, who if you start to talk about a particular experience, they get upset and start crying. Well, you haven't dealt with the emotional content of your experiences and are you going to impart that on a patient, if they say well I've had this experience for example, and you burst into tears? Some of the peer support workers are a bit naïve…they want all flowery…almost hippy

ideas. **I pull my hair out when I hear some peer support workers** with these woolly ideas about progression

Kate: I know some peer support workers who have stopped counselling all together. [long pause] It is a…I would not have been able to persist in this job without counselling.

8.4.15 *Poem*: Are you sure you're a peer?

I thought that peers
Had more piercings
Not just in their ears

And look at your wrists
Where are the lines?
Where are the signs
That you have felt pain?
That you've found relief
By scratching at veins?

Can you give me some suggestion
Of why you required intervention?
Did you go high or did you get low?
And what did the doctors tell you to do?
What did the doctors tell you you are?
What labels describe your emotional scars?

If you can't tell us helpfully
The nature and intensity
Of what happened to you mentally
How can we trust you
To show our patients empathy?

Have you even had an admission?
Because if not
I think the addition
Of another peer would help our team
Provide the service our patients need

Whatever your story
We've got to know
So we can tell

What triggers you

So we can protect you from the stress
Of working in this health service
Of seeing patients who won't engage
And giving them
The clear message
That they are ill and risky too
But that they will be discharged soon

So they should access our support
While it's on offer so we can sort
Their meds and then
Refer them to where
They can get more long term care

Do you think you're too much a peer?
Do you need to go home dear?

8.4.16 Summary of theme 2

Peer workers described the challenges of operating within a peer support role in the context of the institutional culture. This culture was often described as one where their non-peer colleagues did not feel comfortable sharing their lived experience, causing some peer workers to feel separate from their team members. This was not always the case however; some peer workers described the positive impact that they perceived their sharing to have on the teams they worked within, creating opportunities for their colleagues to share their experiences too. Some peer workers described a sense of 'coming home' to peer support in that they had found a role and an identity that fitted with their own values.

Peer workers also perceived that professional expertise was more highly valued within their workplaces than lived experience. This led to some peer workers feeling stigmatised within the peer identity. Some peer workers described feeling stigmatised within the role, as a consequence of being defined primarily as a person with lived experience. In some cases, peer workers felt that this identity eclipsed their other attributes. It led to them feeling overly protected by other staff members who might be wary of over exerting somebody with lived experience. Many peer workers described feeling a pressure to succeed in their role in order to prove the value of peer support, and to disprove the perceptions of peer support as 'flaky.'

Some peer workers described the methods they use to challenge the cultures they work within, including acting as a role model and talking to individual staff members about their practise. They perceived this as being part of their role, but some also recognised the unreasonable level of responsibility this placed on the peer workforce, given their low status within the organisation.

Some peer workers described the peer identity as aspirational, sharing concerns that they were not true 'peers.' Despite some peer workers feeling the stigma of the peer identity, they also described negative perceptions of other staff groups, and a sense that peer support is superior in its values and approaches.

An additional difficulty related to the lack of definition and understanding of the peer worker role. Some peer workers felt that the lack of clarity made it difficult for them and those around them to understand what value peer workers add to services. The fact that peer workers are expected to belong to both staff and service user groups created confusion in some cases, but was also a source of power, where peer workers could use this position to build relationships, influence clinical decisions, and shape the culture they worked in by acting as a role model.

8.5 Theme 3 – The emotional labour of offering peer support, and working in an institution: Apportioning emotion

8.5.1 *Constructed conversation*: You just see people come alive and it's the best feeling in the world

Adrian: I think that if I spent all day concentrating on the emotional difficulties and barriers and what have you, I'd probably wear myself out completely. I mean obviously these things need to be mentioned and discussed but, it's certainly not something I feel that's necessary to continue to concentrate on when you're trying to support other people

Lewis: I think there's about 10% of the job that I struggle with. I think just being with people, for me, I am a people person, and…90% of the time being with people energises me. I feel really pleased that I'm doing this job and I feel like it's a really rewarding job. It's not at all made me, how everyone thinks, you know, it's terrible…it doesn't take me back. It takes me back a little bit to that place but not in a bad way. Like when I go back onto the ward it feels a bit like…everything reminds me of when I was admitted, so all the smells. But I think I'm mentally strong enough to deal with that so…if I wasn't it might be completely different

Sally: And you get to explore people's strengths and learn about people. I get to learn about gambling and football and music and things like that. I like watching people's faces light up when they talk about things they enjoy

Anthony: it's the people I support that make the job, they keep me coming back

Adrian: my joy is when I have one to ones and I get to have such meaningful conversations, it's a privilege to have that one to one time. Being able to connect with someone who possibly didn't want to engage to begin with and then you have this big break through, even if it's just a few words one day and it builds on from there, that's amazing. I laugh with people when we're talking about lived experience sometimes, and finding humour in some of it.

Lewis: **you just see people come alive and it's the best feeling in the world**. I have sometimes felt I've been floating on air, when you've seen

somebody…I've worked with a couple of people who've actually gone back to flipping work and it's been...then you think you are making a difference and you are doing something around stigma. And that's very good for my…emotional wellbeing. But I also think, some of the people that I've worked with are just…I'm awe struck by them. They're just wonderful.

Sally: I feel that when I really do connect with somebody and I'm indirectly getting support from what they're saying, that feels like it's really extreme, it does really lift my mood and makes me feel connected to someone else.

Lewis: I've come across situations where people have been, that they've described, that are horrendous, worse in my eyes than what I've gone through. And it's put my life in perspective. They're sitting at the table and they're talking to me and I'm thinking, wow total respect, you know what I mean? It gives me the inspiration to be a bit more resilient and stronger.

Adrian: or sometimes for me it's been the other way around. It empowers me to look with a strengths focus at my own experience. Like what that person is going through…crikey I really escaped that, I really worked away from that. It also makes me feel alive and that my experiences have been worth it in spite of the stress and the distress that it caused.

Anthony: My own GP's remarked, it's the most well she's ever known me for such a long time, despite all sorts of stuff that life's chucked at me so…I link it to my role and that I'm doing something that…because kind of ethics and principles are so important to me.

Adrian: Since I've done the peer training, yes, I've had ups and downs, and I've had times when I've not been well, but I've not looked back in the sense of…I've never been employed for so long as I have been since I've been in this role. Never sustained it for so long.

Sally: I've had some blips myself while I've been doing this, but I don't know whether that would have happened anyway and because I was lucky to have this role where that was understood that that would happen to me, and then I was supported and looked after and I've been able to have time out. Because

if I was doing something else I probably would have ended up not working again.

Lewis: It’s impacted massively on my own life. And having that routine and feeling you’re earning your own money, coming off some of my benefits and like just it just changes your outlook on things, you feel less a victim and you feel more like you’re actually valued and you’ve got some worth in society, you’re part of something.

8.5.2 *Fictitious email*: I've handed my notice in

From: Gemma Thorpe - Peer Support Worker

To: Watson Emma - Peer Support Development Lead

Subject: Hey

Hey Emma,

I just thought I'd let you know **I've handed my notice** in and Leslie is sorting out when my date will be to leave. Nothing big happened, it's just been difficult from the start and it's too slow for me. You know I thought it would be a lot faster paced and I'd have more chance to work with people.

I think probably because of what you're considered able to do but maybe I didn't push it as much as I should have done.

I think starting with something that's got no structure, I was like a deer in the headlights and I kind of just lost motivation to push it then. And I didn't really know what I was pushing for.

I do think it is a good role and I do think like it would grow and be progressive. And I do think the team I worked in have been really good…like middle to the end, I think they have been really good. I'm happy with the experiences, I just think it just needs some more structure. I think the concept of the role is great but unfortunately not working out for me. I hope the role does work well in the future and sure it will progress well in areas

Hope you had an awesome wedding and New Year

Gemma

8.5.3 *Single Narrative*: It's important to be able to just be with people

Simone

I've become quite good at understanding where there's space and where people are ready to kind of engage in that conversation with you. Because some people want to be left alone, some people want you to listen and some people want you to talk. Initially I'll just say hello to people, even if I get rebuffed. Even when I walk into work, I try and acknowledge everybody out the front of the ward. Just recently I've worked with somebody that thanked me for just opening their bedroom door in the morning and just saying 'it's me again' you know, 'how are you?' Even if I didn't hear anything back I did that every morning. Just to say to her 'I'm not going away, I'm here,' so that maybe she could begin to trust that.

It's important to be able to just be with people, it's about just allowing that person to be in that place and sitting with them in that, so they're not alone. It's not always even about making a journey with them, it's about being with them mostly, and then if they decide they want to take a step forward, sideways, backward, whichever way, then you do that with them.

I try and validate a person's experiences particularly a black person, like saying yeh I know, but also saying in many respects, yes I was there, I understand your experience I can empathise with your experience. I think back to what I would have wanted; not someone to solve the problems for me, but someone to be there with me to listen to what I had to say and who understood. And maybe not that they understood exactly how I was feeling, like they could read my mind, but, who when I told them how I was feeling, would listen and take it in and say yeh, that's pretty shit. So to have somebody sit in that distress with you, and then afterwards be strengths based and look at possible solutions if there are any.

One of the things I keep in my mind is not to jump to…trying to reassure them. That that has to come, but not straight away. First of all, it's tap into that feeling and validate that those feelings that are there. It's horrible to be faced with

‘well it’ll be alright.’ That tapping into what is actually happening in that moment and allowing yourself to be in that distress with that person and actually feel it and then describe it to them, that for me, seems to be the most powerful thing. Even though, I suppose to other people they might see it as you’re making them feel worse because you’re wallowing in it with them. I don’t think it is, I think it’s so often that people jump to wanting to find conclusions and to make it feel better so to speak, that it can take away from what that person is feeling and make them feel like they’re making a fuss over nothing.

But I would just describe it as, a supportive enabling relationship. I’d say part of it is like guiding someone and part of it is like walking with someone because I think sometimes when you’re working with people who are very poorly, they do need a bit of guidance, but obviously, you’re trying to not be directive and prescriptive. But if you’re with someone that can’t decide whether to lie in bed or get up, they might just need a bit of encouragement.

Sometimes it’s like they look for me to set a tone, and they are looking up, they’re looking for a handle to hold onto. However it’s my job to know I’m the handle and I have my limitations. Because they are in turmoil and distress, my job is to mirror calm and structure. And…times I take to lead but then I’m also prepared to share the lead, to share…so that’s the wooliness that often recovery…it doesn’t address that, it forgets about it and puts it under the carpet. With a particular person, it was very important I was that handle for him to hold onto…until he was free to let go. My job is not to make him not…stop…not to stop that, to *encourage* that actually, yes. But very often that handle bar needs to be there. That doesn’t mean that I’m telling myself that I’m superior like psychiatry does.

But all the time I’m thinking ‘oh, should I have, have I done that right?’ And I think you never know, you just do your best and be yourself. Because you know, they’ve just been crushed or told ‘you’re no good, you can’t do this, you can’t do that.’ But I think if people really thought about…reflected on who they’re working with and ask ‘who’s that person?’ It might change the way they care for them, and the way they see some of the behaviours that we have to deal with. I feel like I dream for people, I feel like I’d be emotional if I saw

someone that I'd worked with coming to the peer training or going into work or whatever. Maybe that's not their path, I sometimes think everyone should do the peer training but that might not be their path. But just to see them moving on, or feeling just content or settled in whatever they choose to do.

8.5.4 *Diary entry* 16.06.17

Kate was at a meeting with me this week and she was describing how everything in her team is a 'piece of work' and it's hard to just be with somebody, with no expectations, if the outside pressure is to make your time into a 'piece of work' the language creates one way of working, of 'doing' and places power in that, 'being' has been relegated, it has no status, it has no power.

8.5.5 *Single narrative*: The Secret Garden

Lucy

I got her a dream catcher, because of her nightmares, so I got her a dream catcher, I got her some little…those dolls that you whisper to, and I managed to find her a dream catcher with her name on it, so got that hanging above the bed, and then she talked to me about….a film she really loved was The Secret Garden, she said 'because I'm the little girl, the plain little girl that nobody loves, whose got no friends.' And I said 'would you like to read the book?' She said 'I don't really like reading.' I said 'well how about I read you a chapter ?' And on some occasions, I would tuck her up in bed, and she would be that little girl again. And I just thought what am I doing? How dangerous this has the potential to be so dangerous. I thought no it's not because she just used to drift off to sleep while I read about Mary Lennox and her temper and her plainness and the secret garden. So I'd go and see her and we'd do all the…you know…or her CPN would come and give her a rollicking about something and then we'd go off for coffee and come back and then I'd read her the secret garden.

8.5.6 *Constructed conversation*: A little bit of putting yourself in their place

Lucy: For me, peer support is about being able to connect on a really emotional level…spiritual level, physical level with the person you're supporting. I think that's…because of your own experiences and, or your own emotions, so even though you've not, perhaps, have got the same story, there'll be something that you can connect with somewhere along the line. A similar emotion, a similar experience, a similar…I dunno, hobby or something, just something that will connect to that person, and that, that for me opens up the door.

Simone: And it's different depending on the peer worker and the person you're supporting. I feel that I work with so many different people that I very much go with them and go with what I feel might be most helpful for them, and I feel like I'm a bit of a chameleon changing depending on what I feel works best or what I feel I'm picking up from them.

Hannah: I think relationships build bit by bit. Peer support for me is just being with people, that connection, being with someone…lived experience, and that person being able to connect. But it's connecting with that person, on…a different level, no hierarchy, no thinking you should be doing it this way, do this, but just be with somebody, get to know them, build a rapport.

Simone: and letting them know they can talk to you about things. Making them feel comfortable with you and like you value them

Hannah: and then you can use that relationship…or that…knowledge you have of that person when…if you work here, and I think that's where depending on where you work and the setting you work, but in an acute setting, people will have good, bad and indifferent health, it's supporting people all through those.

Simone: And that is about **a little bit of putting yourself in their place**. I'm thinking, how would I feel? I remind myself how I would feel in their situation every time. I remind myself that I've been on this journey and it's not easy

Lucy: I think, even if it's something way from what I've experienced, I feel like…I don't know whether I do it naturally or whether that's just how I try and connect with somebody…but I would almost try and imagine what that might be like for them. Even if they've got totally different experiences, that I can't imagine going through….I feel like there might be something really tiny that I can think well actually even though I've not known what that's been like to say have been in a violent relationship…I can't imagine what that might be like, but I may have experienced feeling very frightened, or feeling very trapped. So they might have felt very frightened, very trapped, very out of control. I mean, probably on a whole other scale, but I may have had a tiny little drip of feeling trapped in my head or feeling trapped in my house, or feeling frightened of things that like, the average person would think oh that's really irrational

Hannah: That's empathy for me…genuine empathy. Just having an understanding that isn't based on 'I know how you feel' when you've got no idea how somebody feels. There is that similarity, but everybody's different, it's remembering that they are a different person, I can't walk in their shoes, I never will

Lucy: I think for me, it's all about my communication. I'm thinking all the time how I say stuff, my tone of voice, how loud, how soft. Then I might have a laugh. So it can change quickly, like but I feel like I just kind of like umm tuning in a radio. I'm often questioning myself, if I'm thinking am I talking too much? Or I'll say to them am I talking too much? I'll just check it out with them if I feel it's appropriate.

Simone: Yeh I suppose you could say it's like a little bit of intuition, or getting a feel for a person. And I don't know whether it's because your experiences make it so, that you can…what's the word? Feel…understand…there's a word that I'm trying to say that it won't quite come to me, but I think you're experience, you can almost…not mirror, but sense…

Lucy: Tune in?

Simone: Yeh, that's the word I'm trying to say. I think your experiences underpin that tuning in. And I don't always get it right, it might sound like I'm

talking like I'm some sort of Mother Teresa, I just try and gage it, but it's more messy than I'm making it sound

Lewis: Oh absolutely, and literally messy. It's quite easy to talk about it in this idealised world of you know, reflective listening, you know, it's sort of…'oh my fucking God' when you're in the middle of it.

Hannah: and some people you can't connect with, no matter what and that's, that's just normality, the way things are

Lewis: I think with some people I've had sort of shaky connections but there's always something likeable about everybody and I've had connections with them. But there's some that are just…you connect more because your experiences are that much closer I think.

Lucy: I'd still feel I could connect with them as a human being. I'd think well I'm a human, you're a human…I might not think 'oh I've got no idea what you're going through so I won't work with ya.' [laughs] I'd be *more* interested and intrigued and…Not to sound pushy but in a way that I wouldn't give up on trying to work with somebody from a very different back ground. Like if someone said to me 'oooh they won't speak to you', and I think oh, why not? But obviously I'm very careful, I wouldn't push anything at all, like if someone was saying go away I'd move away. And people do tend to have their own…their own like staff that they prefer, and they connect with, but…I just try and seem approachable, and a little bit daft.

8.5.7 *Constructed conversation*: It's about sharing in a way that's not oppressive

Simone: Well when I first started in the role I thought I'd share a lot more personal experience than I do, but actually it's not that often that I share very much information because it's not helpful to the other person. And usually when I share something, if it's going to be personal I always say is it OK if I share something with you?

Adrian: I never…sort of…I never ask permission like that but I am really mindful of what I share.

Sally: Yeh, it has to be done in a safe way. I mean… oversharing could…make them feel I don't know, see me maybe as a bit more vulnerable…I don't want sort of them worrying

Adrian: exactly, I'm not looking for counselling from the patients or my team, I've had that, I've dealt with that. Because it would be horrendous for anyone to hear a load of vicarious stuff. For me, **it's about sharing in a way that's not oppressive**. So only sharing something if I've processed it, and being a bit self-critical about that

Simone: and I always ask myself, who am I sharing this for? Who's going to benefit? Because if the other person's not going to benefit, why bother? The focus should always be on them and it's not always helpful to share so sometimes, a lot of the time actually, I don't.

Sally: and it's got to be safe for you too. There's something's that might benefit a person to hear but that you don't feel comfortable disclosing. Because I don't want to make myself feel too vulnerable disclosing too much that I then go 'oh wow, ok this person could actually tell anybody.' I mean I wouldn't be bothered really if my lived experience was shared with others, but you've got to think about being sensible with what you disclose.

Adrian: I'm able to share that without putting the nitty gritty of it in. So to me, it's like 'I've been here, I've been on the wards.' Not necessarily, 'I was pinned down and I was given an intramuscular injection and it was really awful.' you

can be a peer without telling everyone all your deep and dark secrets. I think on the peer support training I was more open because I just thought that's what we had to do.

Sally: I think the training that I did regarding disclosure when I did the peer support was quite good. Because it gave you those things about when to disclose, what to disclose, is it going to be for the benefit of the person you're working with.

Simone: it's intuition isn't it? Knowing…who perhaps wants that and who perhaps doesn't and whether it is the right time.

Simone: And there's a lot of ways that if you shared your lived experience it could do a lot of harm. Like for, me it sounds weird but I had really bad depression and what got me out of depression was my eating disorder, so how do I tell people that? [laughs] that's not something that you would share with anybody.

Adrian: and their experiences will be completely different to yours. It's just you're not using that as like a hammer to bludgeon them into submission and make them do the right things and get better…

Adrian: like you'd never say to anyone "I've done it so what's your problem?!"

Simone: [laughs] can you imagine?! But what I find is that a lot of the time it's enough for a person to know that you have lived experience and then they can identify with you.

Simone: When I had a peer worker she started off with little steps and she didn't walk straight in and say to me all her lived experience. She…just….talked about the things that I was experiencing, not at any time mentioning her stuff. And then she shared little bits with me when it came up in conversation. And when I had specific questions, she could answer them based on her experiences

Simone: a lot of what I share isn't about…what I would call lived experience at all. Like I might say to someone, like she might say I struggle on a weekend because it's a family time and people might have stuff on with family and I

might say ‘Oh I can really relate to that, like struggling on a weekend and like it helps me to have a routine.’ So I guess I’ve almost, without, I’m maybe just realising now, but I’ve maybe shared but not kind of…really outlined it as my lived experience as oh this is my condition but I’ve just made my struggles just part of me and made it…less….kind of medical.

Sally: it’s not the focus of things. I think lived experience is important umm, because I think that builds a really nice basis on…and there’s already a connection. And I just find a lot of people just want to, they don’t always want to talk about your experience, they just want to be with you and not have to talk about those things.

Adrian: sometimes the fact that you’ve got lived experience just goes over people’s heads a bit. So if you’re relying on just that, you won’t be able to support some people. Because I’ve worked with some people with autism and stuff and it had no relevance to them, my experience, because it’s not really what they’re struggling with.

8.5.8 *Diary entry* 14.07.17

That Q lab workshop. Urgh. Two days of pretending that I wanted to connect with people when I didn't. Other white middle class people who had never been on the wrong side of a mental health service in their lives mostly. Two days of sitting with the anger of feeling like every conversation is missing the point and that peer support is being made into an intervention and that the medical model is dominating. Even as we discuss how to stop it dominating, the GPs and clinicians have their view. And their view dominates. And history just fucking repeats.

By the end of today, I looked around the room and saw that most people were quite old, and I thought to myself, at least I'll outlive all these people and their ideas will die before mine do. Its true defeat when you find yourself wishing people were dead rather than arguing or discussing with them. I'm so tired. Maybe I won't outlive them, maybe the stress and the sadness will just eat me up.

8.5.9 *Constructed conversation*: Just put that mask on for a little bit just to try and get through

Simone: I do have to be mindful that I'm keeping my own stuff completely separate and away from what's happening, and if I find it's kind of…there's a…somebody that I'm supporting at the moment who…went through a particular experience a couple of weeks ago and I'm having to adjust the way I'm working with this person for my own…health as well, because I know if, if…the person that I'm working with is amazing and I want to be the best I can be for her. I'm not going to let anyone down and I want to do the best I can in that role.

Anthony: It's about protecting yourself, so you can carry on working and be of benefit to people but also be of benefit to yourself. I give 200% every day. Because people need your support so it's your responsibility you can't let them down

Lewis: If you were somebody that was very sensitive to somebody that was almost being quite personal towards you, I think that would be something that you'd have to work on as a peer. Because people can get very personal , not often but it can happen, and umm…I think you always have to keep reminding yourself and…keeping your calm

Anthony: there are a lot of things like when I've been sworn at or called this, that and the other, I just let it bounce off, because it's not at you, it's not you specifically, it's the situation, you're just in the line of fire at that moment. But it's when, there's more specific things that are definitely more targeted at you rather than general and it definitely…that gets to me. Because at that point, you can't open yourself, you've got to shut something down at that point

Lucy: I've had things that people have done and it doesn't hit me straight away, but then you think about like an hour or so down the line and it's like, yeh, that's not a good thing to have happen, that's not OK, you know? Or…sometimes it's telling other people, who aren't in that situation and they go 'Why do you think that that's an OK situation to have been in?!' I think because, for me, I have to carry on doing this job and I have to keep going and

I can't let affect the way that I do my job and the way that I work with other people.

Anthony: I've gotten very good at just taking everything in my stride, and very good…I have service users go 'that doesn't faze you does it? You just get on and do it, you're really calm.' And I'll be shaking inside, even shaking outside and I'll say that's just because of the medication I take sometimes I shake, which is true. When I was on the ward, emotionally I was cool because if I let everything get to me, if I let it all hit me straight away, then I probably wouldn't be here doing this job.

Lewis: I am aware that if I'm not feeling good, then I will put on a mask and go out and…get through the day, sometimes

Lucy: from a personal point of view….when I'm not feeling too well mentally, and I know I've got to support someone…I think right then, that's what's happening in my head…but I've got to support this person, so you might…**just put that mask on for a little bit just to try and get through**

Simone: If I've had a really bad day…sometimes I'll be like 'it's a bad day today', but then I wouldn't like share further than that. But then sometimes I will just put on a face, even though for me that's not really what peer support is, but I think we all do it. I think.

Lewis: I do try and be honest about how I'm feeling…there are occasions when I've gone into…support people and I know that I've been more emotional so I let them know that I'm more emotional than usual but it's nothing that they've said or done and it's not that I can't cope … I say I've got some things going on in my own life that I'm struggling with so if I don't seem quite on form today, it's because of that. So there's a bit of honesty around that.

Simone: You can't be too thick skinned as a peer because then you wouldn't be a peer. There's one lady I'm working with and as she was talking, I found myself getting really emotional, and I was aware that I'd got just one or two tears trickling down my face and I thought I need to say something here because it wasn't upsetting with me, it was just really resonating with me. So I

said to her, ‘you’ll notice I’ve got a few tears, you’re not upsetting me.’ I said, ‘I’m just really connecting with what you’re saying.’

Lucy: For me personally, I think that’s unfair to give them my, any emotional content I’ve been through counselling for two years and I’ve taken the emotion out of my experiences. So I’ve got not underlying emotional content that’s hanging onto my experiences that I might give to a patient.

Lewis: I do share what I’m feeling with people…I often think if I’m anxious, what are those people feeling like on the ward where there’s lots of noise and lots of chaos and lots of unpredictable things happening? They’re probably very frightened and anxious and I might be too so actually I can meet with them and share in that. And it does unsettle me when the alarms go off and I have shared that with people.

8.5.10 *Diary entry* 04.08.17

I haven't been paid properly again. For the fourth month in a row and I really get the sense that nobody cares much about it.

8.5.11 *Constructed conversation*: Of course there are emotional costs. I think, would you even be a peer if there weren't?

Lucy: I like to think of peer support as, you don't put out instructions or…directions you just offer your emotions, so you just…when you tell someone you care about their wellbeing, you're just offering your caring. So I think there is a big emotional component to the role because you're offering yourself

Anthony: I think one of the big factors of me…continuing to do well in this job is the support that's available to me. But it definitely has an emotional cost to it. I think that for anybody to think that there isn't an emotional cost to doing this job, having lived experience and helping to support people who have also got lived experience, then I think they're…I don't know, a bit blinded to the job. I just think, well you would expect that wouldn't you? I mean me, that's what I would expect.

Lucy: Yes, I think it's more unavoidable when you're a peer because you're using your lived experience you're putting yourself out there, you don't really have the choice of just putting up a front and pretending it's all OK.

Simone: How can it not cost? Even if you're feeling it…second hand or…feeling it…it is the empathy, the imagination, the actually being in the moment, because I think that's the thing that peers do. You are in the moment with somebody, you're not taking notes, you are not pathologising somebody's distress, you're feeling it. So, yes, **of course there are emotional costs. I think, would you even be a peer if there weren't?**

Gemma: It can be very demanding and very draining but I think…you know what you sign up for basically…I think that you shouldn't…apply for it if that's…if you think that you're not going to be able to listen to things. You know that you're going to be working with people that are struggling with things so if you think that's going to have an impact on you then…why would you want to?

Lucy: You have to be really OK with your own experience to be able to do peer support I think because it makes you process stuff again and that can be a bit draining. Especially when you're saying to people it's OK, I'm OK and you're

OK to talk about your experiences, I'm a peer, I've been there. And then a whole barrage of things can come out, and you're left with that.

Simone: I think it's funny because I would have thought that this kind of work would like really drain me and I'd feel just mentally exhausted and….like I've bared my soul every day and I know that is, there is this burn out thought of peer support, but…I don't experience that all the time. I think what I find….because I'm very emotional, very feeling person, I'm very focussed on that other person and some of my emotion…. it's not like I don't allow myself to feel, but I feel like the distraction of working with somebody else…I'm not thinking, oh how do I feel about that constantly. I don't know whether I've ever come away thinking 'oh I'm so drained.' Like it's heavy stuff, people are talking to you about heavy stuff. I don't feel things trigger me

Gemma: Same for me. I'm quite resilient. But I guess there would be [triggers] to others, even a nurse or something. It depends how far along people are in their recovery or whatever

Lucy: I have been triggered by some things… and felt really angry on people's behalf because of how the system is…When I thought about triggers, I thought about a situation that happened recently, and it affected me, quite emotionally because of my own lived experience. I heard that something had happened on the unit and I wasn't very happy with it and I thought about how I would have felt in that situation. Because the person that was…that this had happened to…I identified with his illness quite a lot because of my own history. And I've got to admit, it did make me very upset and made me want to cry, and also, a bit of anger as well about that situation.

Anthony: I've had connections with people when I've done this work that have made me weep when I've gone away or have made me really question all my beliefs. So…and things that key in very much and resonate very much with your own life…You wonder is this the best choice of work? But in some ways for me, it's the safest thing because I've always worked with such fantastic people within my team.

Lucy: and I think, yes it can be draining…because you're sitting with somebody's distress and not trying to fix it…actually it's sitting together and feeling that. But I think for me, as long as I stick to that progression, and once we've shared that moment, move onto things around strengths and the positivity that we can take out of a negative situation.

8.5.12 *Diary entry* 21.09.2017

I met with some team leaders on Tuesday because their peer worker is really on the edge of leaving. She has been in post 6 months I think and hasn't had any work. It was incredible the different version of events I got from the team leaders. One said that it annoyed him that she just sat in the office and did nothing. I compared this to the story Vicky told me about going out of her mind because she had nothing to do. She sneaks to the toilet just so she doesn't have the staff watching her twiddle her thumbs. She asked to help with laminating the other day so that she could be busy. She said that she would happily hoover the office just to give her something to do. The team leader said that she needs to be more proactive, Vicki says that the staff have no idea what they can refer to her, and she has no idea either.

8.5.13 *Constructed conversation*: They want to throw other people in the deep end but they're wary of what you can do

Gemma: I don't feel like they think this now but I think at the start they felt a need to protect me because obviously there was a question of if you've vulnerable still. Which I get that. But I think if you come into the team as a nurse, everything's expected of you. Because I think…it was said before in a meeting, 'we'd feel protective over anybody who came into the team.' I don't think that's true, because I haven't seen that with anybody else. **They want to throw other people in the deep end but they're wary of what you can do.**

Kate: My supervisor always checks on me, she's like 'you're not doing too much?' and I just feel like, it's kind of a wariness, of like, we know how you felt, we don't want you to be like that. So maybe there's a bit of a protective, I don't know. I don't think she'd check in with everyone like that, but I think because of my…you know that I've had real issues, and I mean I'm still on medication and I don't always like people to know that because they probably think, oh, I hope she's taking them…that's the kind of thing, it's a bit patronising. I suppose the nice thing about it is, I suppose they're just checking that you're OK and you're OK in your role and…but I would definitely, if things weren't right, people would know [laughs] I'd have to say.

Gemma: Yeh, and I think that's…like when I first started when they were very nervous around me, of what I could and can't do and that kind of thing, I felt like…very stifled by it. Because I was like…it makes no sense, I've been doing work for years, why have I gone back, why has it gone back to this rather than being less nervous? Whereas they just throw you in at the deep end, they don't know in other jobs that you've got any mental health, they just kind of…expect you to do your job. But here they were wary of like what I could do in terms of risks or…my…how I could cope with things, like what would I be able to cope with and that kind of thing, they were a bit more nervous around that I feel. It might be partly because it's a new role, but I do think part of it is the peer aspect of it. Being a bit uncertain about where you are personally in your own recovery I suppose as well.

Kate: I think they honestly worry about all that kind of stuff. I just think they've got to put a bit of trust in you really. I think as well, there's a worry that sometimes you might share stuff that's not positive when you're supporting people. Which, you might actually, you do share stuff, it's just the way you share that's important, not necessarily always what it is. I think they were very worried about overwhelming me with…too much complex things or young people or whatever. They were a bit more cautious

Gemma: I find that hard because I don't…I never felt like I needed protecting from that. And I think it kind of…made me feel a bit, like well what's the point, like if you feel like you need to protect me, I shouldn't really be here. And my role kind of just became more like 'you can meet these people who are nearly leaving' at the end of treatment, because it felt more comfortable I think for them to think, these are…you know, being discharged, obviously not in a really bad place. But I feel like they feel like they need to protect themselves as well. Or the NHS. If that makes sense. If something went wrong, maybe because I'm not qualified.

Kate: And I think they might be a bit protective of their roles too. I feel like I'm stepping on the nurses toes a little bit, if that makes any sense. Because they said things like 'you're going to tread on our toes' and 'we don't even know what you do.' I mean, I've had that, I mean that was there for a while when I started

8.5.14 *Diary entry* 08.12.17

I have been meeting with my new manager. I am torn between telling him how shit I feel and managing his perception of me. I tell him, in words that paper over the depths of this crushing agony, that I am slowly getting my head round things, but that I don't have the capacity to continue with the team as small as it is. And he says something political like 'capacity is something which will always be on this organisation's radar.' And it leaves me thinking, does that mean I just have to get on with it, or that it's something you can help with? He says that he would be 'very open to discussing' a plan for the team moving forward. He also said he would sort my pay, and it's been another two months and still nothing has happened.

That is another painful layer of this new role. I am so much more sharply aware of the void between what people are saying and what they mean. I don't feel like there are many people I can trust, because the ones that are authentic don't have any power, and the ones that lie, well … who knows what their end game is? Self-preservation I imagine.

8.5.15 *Single narrative*: It's very difficult when your whole lived experience has been around how much you should hate yourself

Lucy

I'm finding I have a big lack of confidence and a lack of I'm not sure what I have to offer. I think that's a bit of my nature, very self-critical. If something's going wrong it's probably my fault. I think that's just me. And I'm constantly questioning whether I'm doing it right. Nobody's said I'm doing the right thing so all the time I'm thinking about what I'm doing I'm thinking have I done that right? I often get stuck in this, am I doing right as a peer?

And when things don't go to plan I know I'm not supposed to take it personally but it's not that easy. Because when what you're offering is yourself and yourself isn't good enough…I was trying not to say I failed to help them but really that's what it feels like, I failed to help them, that I gave them all of myself and that wasn't good enough, and there's just that limit to what I can do. You leave feeling, what did I do wrong, what should I have done better? You go back to that, I wasn't useful, I was a failure. It does go back to those feelings of…it's …the same as you might have a good day or a bad day at another job, it's sort of magnified, you feel more connected to it, everything feels more personal…and the important thing I guess, is not to detach from that personal feeling, not to break the connection, but just to get some perspective on what that means for me. And that's a scary kind of feeling. And I try to focus on what's worked but **it's very difficult when your whole lived experience has been around how much you should hate yourself**.

And I wonder how healthy it is to keep touching that. The point is that our lived experience is a valuable thing but for me and for a lot of people, it's a very dark thing and so it's kind of drawing on that darkness inside ourselves to bring light to other people…and there is that risk that you're going back to those dark times, those dark places, those memories, you're reliving things in the hope of helping people and I think there is a risk associated with bringing our own recovery into our jobs.

People were saying on the peer support course how they've found lots of tools to help with their wellbeing by helping others. So if we're using peer support to support our own recovery and our own wellbeing, does that make it more of a risk when we find someone we really empathise with, and we can't help them? That we were here to try and help ourselves but we couldn't do that for this person who is like our self? It's like oh gosh, if that's how it is for you, and things don't work then I could be there too. So it's a scary wake up call, and more pressure to sort of be the rescuer sometimes, for both our sakes.

8.5.16 *Diary entry* 06.10.17

I have been thinking most days about how this job is killing me. And not killing me in an abstract colloquial sense; it feels like every day it is reaching into my soul and clawing little chunks away. This system is taking something from me that has been so hard fought, something so meaningful, and it just plucks it out. Probably to fill the deficit. Probably to fill the void between the money the system has and the money it needs.

Last week was the five day block of the peer support training. And in the middle of the week of training, I opened my payslip and saw that for the 6th month in a row I hadn't been paid right. I have been assured every month for six months that I would and yet I am owed more every month than I get. And when I opened it, I couldn't hold it together anymore, and I cried. I cried in front of my fellow trainers. They were so empathic and peer, but I just felt so shit and undervalued.

This week I sat in the recovery strategy summit and saw my name next to 2 of the 7 work streams in the strategy. And I saw everyone else whose name was next to a stream was paid at least 2 bands higher than me, and I thought, what the actual fuck? I feel like I'm being used. Or maybe it shows how tokenistic lived experience is to this organisation, that I am elevated to these levels like some child they're humouring but actually, financially, there is no equality. I do feel like a child being humoured at the steering groups. I am supposed to be co-lead but I wonder whether people are looking at me thinking, what does she know? Why her and not me? And I am thinking the same thing about myself, because I feel so lost in this organisation's structures, I can't hold it all in my head, not even the basic stuff that I should know.

8.5.17 *Constructed conversation*: The peer support is the easy bit

Victoria: I think there's a huge emotional cost. But more so…not because of the peer relationships…and the therapeutic-ness of it, it's the role. And the integrating into teams. For me anyway. The hardest thing is feeling like I don't have a role. Emotionally the impact has been….with the role itself…like the frustration and the self-doubt and things like that. It's made me feel like shit. I mean, it is hard seeing someone struggle but I can deal with that. What I can't deal with is feeling useless, and feeling like people think I'm useless. And a waste of resource, a waste of money that could be put into something else

Sally: It's the same on the ward, **the peer support is the easy bit**. The problem doesn't lie in offering peer support. I think every day has an emotional cost here. I don't think I realise until I get home, because then suddenly, it's like I don't want people, I just want five or ten minutes to just not do anything at all. Because you get caught up in the noise of sixteen people up and about, you get caught up in how busy it is and the things that need doing… you're always thinking about somebody or you're talking to somebody, or answering phones or the door, or even if you're sitting down, you're still checking where people are…you don't realise you get into habits of things, like checking doors and checking mirrors, and it's all mentally quite taxing, things like that, that you're always checking your safety and their safety and everyone else's' safety

Victoria: It's fast paced in my team… and they're always on the go but my role is a lot slower…and when it's slow and you've got nothing to do, and you just feel like…either irrelevant or just pointless. Like you can't do anything to help them. Then when they are going off you're sort of sat there thinking, 'crap, what do I do?' I look like I'm not helping out. Whereas peer support more that I would want to do would be more just being around people, like you are on a ward, and kind of figuring them out and them figuring me out and just natural.

Sally: but then on the ward you're so in demand and you're not necessarily working with someone for an extended period of time or talking with them…you could see them one day and then come back in a couple of days and they're not there. So it's not like a gradual way of working towards ending a relationship

Victoria: Yeh a lot of things just out of your control I guess

Sally: I think the hardest thing I'm dealing with emotionally is anxiety, which…I feel I can't control. I think it helps because you're outside, it's…so it feels less intense than being sort of caged in in a busy, noisy environment. When I first started, I'd just get anxious really easily. But I feel like I'm more aware of like I know there's people around me. Even though there's not always a lot of debrief or…that's one thing that I find difficult to access is things like the supervision and just being able to chat something through

Victoria: we've just all been restructured in the community and the hardest thing has been losing the support of the other peers, one left and the other one was…around but even if you're in the same building, if you're not in the same room, it's much harder to keep in contact that way. I did get very stressed, I'll be totally honest with you…it all happened quite early in my time of being back at work, and you know it has taken a long time to get to know new people in the sort of team where people work all over the place. I had to have some time off… And I still dread some days. I never want to say that but I do. Like this morning I was just like I don't want to get up. I literally don't. It's really impacting on my mental health now and I wish it wasn't. And my partner's really noticing…that my mood's dropping and I know it's to do with that.

Sally: I did nearly leave at first too. I think often…there's been times in my short career as a peer, where I could have gone 'I can't cope with that' and left, but something's kept me there. Whether it's just been someone saying I really appreciated what you've done today, or thanks for staying late because there's been something happen and I couldn't go on time…but I think you really need to be…in a place where you can be aware of what's coming….and keep going and keep going the next day.

8.5.18 *Diary entry* 25.10.2017

Welcome to month seven of not being paid right. I told my old manager that I felt upset and angry and I didn't know whether, or how, I could tell my new manager that. She said she didn't know how he would respond. She said as a human he would respond compassionately, but she didn't know how it would affect my relationship moving forward. I know what she meant. I said that I felt like I am becoming a peer stereotype, a volatile, angry, difficult to manage person. I never cry, I hate crying at work and yet in the past few months I have cried in front of people more than I have in the past 7 years. The system is mad making. It is disempowering and if I try and speak up about it, I get cast into the hysterical service user role. I am gagged. I am gagging.

8.5.19 *Constructed conversation*: You could easily lose peers in that kind of environment if someone's not looking out for them

Lewis: I think that there is the possibility for the emotional cost and that is something to be paid attention to…**you could easily lose peers in that kind of environment if someone's not looking out for them**, or if they're not in a place where they're actually strong enough to seek the support they need.

Sally: it's having the strength to manage but also speak up and say actually I really need that supervision that you offered me, I need that, and if that's not available, where can I go to get that support for me to stay in this role and do the best I can?

Lewis: You have to be strong enough to seek that out I think. And for me, that's like going back to counselling, going back to having a reflective practice mandatory supervision

Sally: I mean we get mandatory supervision with our line manager but it's largely about functional things…

Izzy: I think that….that is the disadvantage of splitting peers very, very thinly across the Trust so that…I think if you're left without the necessary support…from somebody who actually understands your role, I think that's what you need really.

Simone: I'm able to manage it because I've got a supportive team, there's two other ladies who come in early in the morning and we'll spend at least the first half hour, talking about our experiences with particular people.

Sally: That's why I think mandatory peer supervision, would be really good because it would be a place where you could talk about your emotions, and have someone who would understand it from a peer focussed point of view. That would be really good, because I think you are largely left…especially if you're dealing with patients who have had some challenging experiences, you need to be able to offload that or put it into some perspective

Lewis: I do feel as peers we very much look after each other. I think if we didn't we would have had more burn out, and I think we have had burn out with

people and we do get burn out. And I think the wards are particularly difficult. When I started, there was a peer support worker who sat with me when we were having coffee breaks outside and we'd chat and stuff, and I had a very, very good team

Sally: This is going to sound awful but it even makes me feel better to know that other peers are struggling in teams as well. It makes me feel like it isn't just me being a failure and not clicking with the team.

Simone: I think it's also about finding people within the team that…that I could work with, that I felt that, they were working to a similar sort of ethos and I could see where my role fitted in. I found it easier to draw into where I thought recovery focus was greater…and link in with the work that was going on there

Lewis: I've always worked with such fantastic people within my team. I've got a mentor that I'm really close to and get on with really well. But the thing is I feel like they're all my mentors, I could go to any of them, they're all just so welcoming and kind.

Izzy: I made sure I had a lot of contact with my manager but I do try and set myself free from the team…to do as much of peer support work as I can do, I have to distance myself from the team.

Lewis: But at the same time there are professionals who do really pour their heart and soul into helping people. And it doesn't matter if they're nurses, psychologists, psychiatrists, they do really care about helping people and I think they can have the same emotional cost in their own ways, and I don't want to speak for them, but I don't want to say that…the struggles a peer has are any more or less than professionals

Izzy: I think most people coming into the Trust as a worker…they're coming in because they are sympathetic. I think that gets knocked out of people….

Lewis: but breaking down that idea that we have to be intrinsically different to professionals and that we have to evaluate ourselves differently, helps to…if we want to have more peer psychiatrists, more peer nurses, it involves treating them as we would other peers if that makes sense

8.5.20 *Diary entry* 17.04.18

These past three months I couldn't write. I couldn't write in here or in my personal diary. Instead I piled psychological breeze blocks and sandbags between me and my emotions and carried on. I feel shattered. I feel emptied out and used.

I was asked to speak at a 'trauma summit' last month. They wanted somebody with lived experience to share their thoughts on trauma informed care. It is something I am passionate about and I said I would. And they asked me to talk in a way that wasn't triggering, and to share my ideas about what a trauma informed service would look like without bashing the services I received. So I had to define trauma without talking about trauma, talk about my experiences without being triggering, and talk about trauma informed care without drawing any attention to how completely impossible it is when we still lock people up and medicate them against their will.

This trauma presentation was scary, I felt frightened, I felt like if I had the choice to walk out and not do it I would. But they needed someone with lived experience, someone articulate who would toe the party line, and here I am. Ready and willing.

This year I have had several emails from people asking first what is happening with Recovery, and second, if I am the recovery lead now. And my response is I have not much idea what is happening with recovery…I am not even sure what that question means….and I am not the recovery lead (in fact I am several bands too low to be anything of the sort) but I will help if I can.

It's such an odd thing the way recovery is being talked about. That people think that recovery is some luxury that will be cut out of services if needs be, to save costs. It's like recovery is this product or cog that can be lifted out. But how can you lift out a values system? And if you did, how would that save any money? I am enraged by it, but at the same time there is a little voice saying 'maybe they understand something you don't Emma, maybe if you speak up they will see you for the idiot you are, so best keep quiet.'

8.5.21 *Diary entry* 26.05.17

Last week one of the peer workers told me about a member of his community team who couldn't find a parking space at Duncan Mac and she just burst into tears and drove home.

8.5.22 *Fictitious Email*: We need to improve in every domain

From: Chief Executive

To: All Nottshc

Subject: CQC Report

Dear Colleagues

The CQC has published their report following the inspection of our services which they recently undertook. Unfortunately, they have rated our Trust as Requires Improvement, which is a disappointment but may come as no surprise to many of us. We accept that **we need to improve in every domain** and that we all need to do more, given that we only maintained our 'good' rating in the caring and effective domains.

We need to move forward from this by learning from the feedback provided and concentrate on what we must do to improve our patient experience but also the working conditions of our staff. We say we want Nottinghamshire Healthcare to be a great place to work, but that is not the experience of many of our staff and we need to change that.

We should also continue to focus on the positives, as there remain some areas of outstanding practise in our services. I am optimistic about the future; our workforce is made up of committed and passionate individuals that we need to harness for the benefit of our patients and carers.

The full report can be found at the CQC website.

8.5.23 Summary of Theme 3

By far the majority of difficulties peer workers described in their role related to working in the mental health system in service areas which had experienced funding cuts, redesigns and cost improvement plans. Some peer workers described the stress that this had placed on them, their colleagues, and the people they supported.

Whilst they are vital within peer to peer relationships, in the clinical environment, peer workers perceived emotions to be less welcomed. Some found that often they had to actively seek support and supervision in cultures where this was not readily available. In the interviews, some peer workers described the rewarding experience of offering peer support, especially when they were able to support people to make changes in their lives. They described the use of emotion as a key part of this role, using it to empathise with others, and sharing their experiences as a means of engendering closeness and trust.

When peer support workers experienced difficult days relating to their own mental health, they described different ways of coping with this, including seeking support and ‘putting on a mask,’ concealing the extent of their difficulties from those they were supporting.

While many peer workers described the emotional impact of offering peer support as an expected part of the role, others felt that the emotional cost was minimal and that if the impact on the peer worker was too great, they should not be recruited to the role to begin with.

Chapter 9 - Discussion

9.1 Introduction

When I began this study, I thought that my findings would be a denunciation of peer support in mental health services. I thought that all I would find is evidence of it being co-opted, misused and misunderstood within mental health services. I thought that peer workers would be just more victims of psychiatry and that peer support would be found to be the sugar that is sprinkled on top of the medical model to make it more palatable. I often thought that perhaps the last piece of my findings chapter would be my own resignation from my post as Peer Support Development Lead. And yet, here I am. Still working in my role, still sometimes conflicted by working within the mental health system, but feeling a little embarrassed that the picture I once held of peer support being lost to the NHS was not more nuanced to begin with. I had assumed, because of reading so many criticisms of peer support, and feeling my own dissonance in my leadership role, that it had been entirely co-opted by the medical culture of the NHS. However, as I interviewed the peer workers, I found people whose experiences chimed with my own, but more often, I found contrast, I found them looking at things in ways that had not occurred to me, I found them breaking out of this one-dimensional perception of mine, and adding details, colour and new dimensions. It has been like catching peer support without its makeup on, or walking around the back of it and seeing it from other angles.

If only the interviews had confirmed my preconceptions, this discussion could have been a simple argument that peer support in NHS services only serves to replicate the coercive, power-over practices that psychiatry deals in. Instead, this thesis argues that peer support in mental health services is messy; it both ‘works’ and it does not, it helps and it hinders, it transforms and it is transformed by the clinical context. And it is not just the clinical context that affects peer support; the peer workers described their perceptions of the culture of austerity, highlighting the wider socio-political context beyond the medical model which impact on their everyday experience of working in mental health services. This is the original contribution of this thesis; where other

research into peer support has focussed on the peer workers and their perceptions, this study highlights the need to situate these perceptions within the wider political and economic context, including austerity and neo-liberal policies that shapes and contributes to our understanding of the mental health workforce.

I also began this study in search of mechanisms, before realising that mechanisms are nothing without context. In my methodology and method, I focused more on the experiences of peer support workers within the context of a healthcare system, and I tailored my research questions to explore these. However, it seems that I have found my way back to mechanisms in my findings. In the realist sense, the three themes presented in the previous chapter: power, identity and the use of emotions can all be considered to be mechanisms, in that they are 'real' and causal in the abductive sense to particular outcomes. Austerity is also a mechanism in the same way. I am not wedded to the idea of uncovering the mechanisms of peer support, and certainly I do not believe that the three themes that are central to my thesis are the only mechanisms that determine the success or failure of peer support in mental health services. However, what this thesis argues is that to understand peer support, it is necessary to understand how discourses of power, identity and emotions are constructed and deployed, and how context enables and constrains these. In doing so, it is possible to understand what elements of the environment contribute to the difficulty and success of providing peer support. In shifting the focus toward an understanding of the systems and wider political context that peer workers are employed within, we can begin to think about and understand what environments are more or less supportive for peer workers, but also what might benefit other staff groups who work within, and are constrained by, the same systems. If it is possible to understand better what factors within mental health systems contribute to 'successful' peer working it may be easier to clearly articulate how to bring about change, thereby moving the discourse beyond one of broad 'culture change.' It is anticipated that this broader understanding of the social and political context will also support peer workers to locate themselves within this,

and avoid unnecessary feelings of personal responsibility when the work they contribute comes up against structural barriers.

In this discussion I will explore how the institutional setting shapes the peer worker's sense of identity and their ability to offer peer support as well as how peer workers are positioned as empowered or powerless within it. I have drawn on the thinking of Michel Foucault to argue that peer workers are constructed and troubled by the regimes of power under which they exist. I had not anticipated that Foucault's thinking would be so pertinent to my thesis as I developed my methodology. However, as peer workers continued to talk about power, identity and institutional practices, Foucault's ideas became centrally relevant to my discussion as he has written widely on these subjects. His epistemological stance has been identified as being congruent with critical realism (Al-Amoudi, 2007; Joseph, 2004) and feminist standpoint theory (Ali, 2002) which I have used to underpin my method. All of these epistemologies pay attention to the context in which social practices and discourses operate, the importance of power and emancipation, and the possibility of multiple, competing versions of 'reality,' some of which offer better approximations than others.

Foucault wrote widely on the subject of institutions, arguing that institutions are the means by which discourses get shaped, rather than being the sources of power. They are the places where 'power becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention' (Foucault, 1980, p. 96). According to Foucault, institutions, like all social arrangements, rest on a regime of truth, and they must be understood in terms of the ideas or devices that give them their specific character, and how these are produced, maintained and adjusted through the practices inherent in the institution. Foucault employed the concept of 'power/knowledge' to describe how power is established through certain, accepted, forms of knowledge and 'truth.' He argued that regimes of truth are constructed, redefined and reinforced through institutions, the media, and the flow of various political and economic ideologies. Therefore 'truth' is constructed, and certain truths are authorised while others are discredited within a given historical and cultural period. Foucault described the 'battle for

truth' as being a battle about 'the rules according to which the true and false are separated,' a battle about 'the status of truth and the economic and political role it plays' (Foucault, cited in Rabinow, 1991).

Foucault (1982) also introduced the concept of 'subjection' to describe the process of categorisation and identity formation in the context of regimes of power. He argued that subjection is a form of power that 'applies itself to immediate everyday life which categorizes the individual, marks him [sic] by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects' (Foucault, 1982, p. 212). This form of cultural power positions identity as a form of social classification, created through discourse. He uses the example of the leper identity, which was constructed by linking a diseased body to a specific identity. It was constructed by institutions which further defined how people labelled as lepers were subjected to specific embodied experiences including incarceration and isolation. So, lepers were both defined by and contained within a disease discourse, causing them to become the object of pastoral power (Foucault, 1965). In the same way, the peer identity has been produced and reproduced through discourses about madness and illness, but also by the context of the institution as an organisational form. This is important because ultimately, these devices are used to construct and interpellate (give identity to) individuals, including peer workers, who are subject to the regime of truth on which an institution rests.

Because peer workers cannot live, act or form beliefs without being rooted in a particular context, I will examine the ways that their institutional context influences, limits and shapes the meanings that they take on, and how these are embedded within various discourses. Discourses construct and reconstruct our social world through a series of related practices and meaning (Foucault, 1972). They are 'a constellation of authoritative speech acts that relate to one another in some coherent way, such that it is possible to define regularities between statements' (Lewis, Benschop & Simpson 2017). Discourses operationalise power to frame social norms so that they are taken

for granted, and in doing so, they reproduce and reinforce relationships of power. For this reason, peer workers' discursive practices must be situated within the wider institutional and political context in order to be fully understood.

I will explore the current conceptualisation of peer support and situate experience within the meso and macro levels, examining power, identity and emotion within the broader clinical context, which is shaped in turn by the wider economic and political context. Throughout this discussion I will also advance the application of existing concepts of peer working at a micro level: liminality, authenticity and emotional labour. I will examine the creative and empowering ways in which peer workers cope and contribute while working within the mental health system. These insights can inform future practice for peer workers and support calls for change to the culture within NHS mental health services. I will predominantly discuss the findings from the interviews with peer workers, bringing in my own experiences only where I explicitly state that I am doing so. I have done this for purposes of transparency, and I recognise that my analysis is inevitably shaped by my own positionality.

9.2 Introducing peer support to institutional settings

There are three popular discourses which exist in the peer support literature about how peer workers have been introduced into mental health systems. The first institutional discourse is that peer support workers can support professionals in their work by complimenting an already functioning service design. Research in this area acknowledges that peer workers have something unique to offer, but frame this in terms of improving services. In this context, peer support is framed as an 'intervention' or 'a resource-oriented approach for patients with severe mental illness' (Mahlke et al., 2017, p.1). Some peer support workers that I interviewed held intentions of facilitating relationships between people in services and professionals and this was consistent with the 'complementing' discourse.

The second discourse idealises peer workers by positioning them as agents of culture change. There is evidence to suggest that, at least at a team level, peer workers are able to influence the culture of mental health services so that

they become less clinically focussed and more person centred (e.g. Repper & Carter, 2011). Peer workers in the interviews talked about how their team had come to accept and value them, how their colleagues had felt more able to talk about their own lived experience, had begun spending more time with people, and making different language choices. The narrative is one of 'early days'; that it is too soon to see any real change but that, incrementally, the idea of peer support is being accepted, and being understood and valued and that the culture is slowly changing in the same way a steam ship turns around in the ocean.

The third discourse, 'co-option' finds that the culture has assimilated peer support workers (e.g. Russo & Sweeney, 2016). Employing peer support workers might have started as a well-intentioned way of addressing the culture of mental health services and responding to the voices of people who were using them. But their roles have included many of the duties that make mental health services oppressive, including observations, notes writing, and in extreme examples, physical restraint. In this discourse, peer support has been assimilated into business as usual, and the expectation that some of the lowest paid, least valued people in the system should be tasked with changing it is evidence of this. To extend this narrative into its most cynical iteration, the fact that peer workers have been employed in such small numbers, largely excluded from formal work force commissioning, and with no plans to expand the roles available, is further evidence that ultimately mental health services are not interested in radical service change or paradigm shifts.

There was evidence of all three discourses running alongside each other in the interviews I undertook, as well as in my own diary. Among the interviewees, some described wanting to complement the existing workforce, but they also explained why they felt that this compromised the peer support they could offer. Many of the peer workers I spoke to shared either a sense of pressure, or resentment of, being expected to challenge and change culture, given their low status and, sometimes, their lack of support. The culture of mental health services was confusing or frustrating for many peer workers, and this is no surprise, given the multiple competing discourses that operate within mental health Trusts. Discourses of 'care' run parallel to those of 'risk,'

the rhetoric of ‘staff wellbeing’ operates alongside a culture of staff shortage and burnout, and the discourse of ‘mental illness’ is placed side by side with a newer, perhaps more confusing, discourse of ‘recovery focussed care.’

What I argue throughout this discussion is that the discourses that currently surround peer support are not sufficient to understand the nuanced nature of peer support within NHS services. The peer workers described these cultures as both supportive and sometimes disempowering. Many of them related their experiences of service re-designs and the impact of austerity as being central to their working environment. These factors have not been explored in the context of peer support research, although they clearly play a significant role in the experiences of peer workers. Often discourses construct peer support as wholly one thing (for example, transformed by their new peer identity), or caught between binaries (for example oppressed or empowered) and this does not reflect the cultures that they act within, or their own embodied sense of their roles.

This study found that peer workers are sometimes constrained by these discourses, but also resist them; this is true of discourses surrounding how they offer peer support, how they use emotions, their enacting of power and the interpellation of the peer identity. The first example I will discuss relates to the discourse on identity and it was the first of many surprises I experienced as I interviewed the peer workers. My understanding of the peer identity, through what is present in the research literature and through my own experience, is that it is transformational and positive. Moving into a helper role, where lived experience is valued, has been found to be beneficial to peer workers’ sense of agency and identity. Studies have found that the peer role enables people to transform that which is most stigmatised into an asset, creating a shift in identity from one rooted in shame to one rooted in pride (Debyser et al., 2019). Furthermore, sharing experiences within a peer support role has been found to transform the most traumatic experiences into something that can be useful and worthwhile (Moran et al., 2011; see Chapter 3). However, as I will show, this is only one discourse which is not sufficient to contain the experiences of the peer workers who, in the context of their

working environments, found themselves embodying and avoiding other discourses relating to the peer identity.

9.3 The institutional construction of the peer worker identity

Just as 'it wasn't as a matter of course that mad people came to be regarded as mentally ill' (Foucault, 1991, p. 76), it is not a matter of course that madness has been reconstructed as lived experience, or that peer workers have emerged as an embodiment of this. Peer workers are employed as one way of troubling the current regime of truth, by introducing a new form of knowledge and acting as role models for a values-based, mutual approach. Within the context of the institution, their identities are co-constructed through a process of integrating their identity as others perceive it, and their own perception of who they are (Ybema et al., 2009). This is an ongoing process whereby identity is constructed and re-constructed through the interaction between an individual and their social/work context (Beech, 2011). In the context of peer support, this 'agency-structure dialectic' means that peer workers define their identity for themselves, but are also defined by their organisational setting, and the discourses that are available to them and those around them. This study found that belonging to a peer support community positions peer workers within specific discourses of identity, some of which they adopted, and others they resisted depending on the stigma they associated with these.

In their 'talk' about identity, peer workers described the contradictions and challenges that the title of peer worker conferred within the context of working in a mental health service, as well as the sense of belonging that it afforded to them. The peer workers in this study described how their peer identity can be experienced as both empowering and stigmatising; an identity where lived experience is celebrated, but where peer workers are also reduced to and defined by it. It is the context which surrounds peer workers which defines whether they feel more empowered or oppressed. In the context of peer support training for example, where a person is among fellow peers, peer workers described feeling as though they had found their 'tribe,' as they identify as belonging to a community of peers. In this context, the peer identity is associated with an empowered discourse, where peers are understood as

having access to insider knowledge and are therefore a source of safety and power for each other. This is congruent with existing research which highlights the positive impact of the role on peer workers (e.g. Gillard et al., 2015b). The potential of the role to offer a valued identity was a motivator for some peer workers to apply for their current post or undertake peer support training. In many ways, the role is a personal and collective triumph of identity transformation which is crucial to survival. As Audre Lorde (1987) puts it:

> *Those of us who have been forged in the crucibles of difference – those of us who are poor, who are lesbians, who are Black, who are older – know that survival is not an academic skill. It is learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structures in order to define and seek a world in which we can all flourish. It is learning how to take our differences and make them strengths.* (p.112)

Some of the peer workers in the study referred to their younger selves, and their desire to 'make it up to' their younger selves by making something out of their lived experience. Again, this is consistent with other studies where peer workers took great comfort in the knowledge that their own experiences of distress and using services had been valuable, and were being put to good use (Austin et al., 2014; Moran et al., 2011; Rebeiro Gruhl et al. 2016; Scott & Doughty, 2012). Just as Deegan (2004) describes her survivor mission, the peer workers in the study described their negative experiences within services, including the hope extinguishing messages they had received relating to lived experience, as motivation for becoming a peer worker. In this sense, the peer worker identity offers hope simply by offering a more desirable discourse than those that construct the identity of patient or service user. This initial 'reframe' is where much of the literature on the peer worker identity has focussed rather than on the processes that follow; how perceptions change as peer workers remain within this new identity, and how it is situated in the wider context of the mental health system.

Although peer support workers described often entering into their roles with hope that their new identity would be empowering, many of the peer workers I interviewed had, at some point within the course of their work, experienced the stigma associated with being labelled as a person with lived experience. In many situations peer workers described feeling uncomfortable or ashamed to be viewed as a person with a stigmatised identity. In his seminal work, '*Stigma: Notes on the management of a spoiled identity'* Goffman notes:

> *'The standards he [the stigmatised person] has incorporated from the wider society equip him to be intimately alive to what others see as his failing, inevitably causing him, if only for moments, to agree that he does indeed fall short of what he really ought to be. Shame becomes a central possibility arising from the individual's perception of one of his own attributes as being a defiling thing to possess, and one he can readily see himself as not possessing.'* (1963, p.7)

Among some peer workers, there was a sense of not knowing what other team members were 'really' thinking about them, and of not feeling accepted on equal grounds. Peer workers described their struggle to resist being associated with a particular institutional constitution of the peer worker identity which comprised of professional's fears and concerns about peer support. This is a peer worker who is 'unstable', lacking in clinical knowledge, angry at services, ignorant of professional boundaries, and who over shares with colleagues as well as people they support. Peer workers described being well aware of this discourse, regardless of whether it is held in the minds of staff teams, and they behave in ways which limit the associations between them and it, for example by hiding their feelings on a bad day. This institutional discourse is rooted in a particular conceptualisation of 'mental illness' which continues to underpin much of the mental health service provision. Although peer workers described hoping to be perceived as a fellow colleague, some described feeling constrained by the stigma of the peer identity. In one of my own diary entries, I describe debating concepts of mental illness and trauma with a team leader. I describe my perception of their belief in an illness model

being a scientific fact, and my frustration that this continues to underpin the services that peer workers are employed within. Where illness models pervade, peer workers risk being seen as 'ill' people, stricken by a chemical imbalance and in need of support.

Although peer workers are employed in quasi-professional roles, there remains an association between peer workers and the 'sick role.' Parsons (1975), who coined the term, described the sick role as one of 'sanctioned deviance' whereby one can be legitimately seen as a victim in need of support and therefore exempt from the obligations associated with being well (for example, going to work). While in the sick role, a person occupies the lowest status within the hierarchy of the healthcare system and is expected to take the advice of experts. This study found that the concept of peer support working can fuse a 'sick' discourse with the identity of a worker, so peer workers can be seen as simultaneously 'ill' and well – deviant and normal. In some examples provided by peer workers, they described how these negative associations of the sick role constricted their sense of who they were, and what they were considered able to do.

Goffman (1963) described how people with disabilities make efforts to control how others perceive them. Stigma, he asserts, is a relationship between attributes of the body, mind or of social groups and the perceptions of these as discrediting. People who live with stigmatised identities adapt their behaviour in order to manage other people's perceptions of who they are. Goffman describes two strategies a person might use to manage their identity; defensive cowering, where a person withdraws or minimises contact between themselves and others; and the use of bravado or hostility. Both of these strategies might be used by the same person in different situations. Peer workers described using both of these strategies to different degrees. Some peer workers felt uncomfortable communicating in team meetings, and preferred spending time in peer to peer interactions than with other staff members. Others felt some hostility toward their colleagues who they felt did not understand the peer role. Building on these ideas, this study also found that peer workers used other strategies to resist the association with an

institutional discourse, including concealing or avoiding talking about their mental health, maintaining a clean record of sickness absences and encouraging other staff to talk about their mental health. The use of bravado was rarer than these other strategies, perhaps because of the concern from peer workers that any hostility or defensiveness on their part would be seen as confirmation that they cannot manage their emotions, thereby risking the justification of any stigmatising attitudes.

It is also important to note that some peer workers did not describe such strategies because they reported feeling protected by their own understanding of their identity, or being surrounded by supportive colleagues. In fact, in some situations, the stigma became inverted; peer workers saw themselves as the normal ones and other staff as the 'not quite human' ones. This is exemplified in the way that peer workers discuss other staff as sometimes not having the same understanding as them, or acting in ways that peer workers perceived to be unhelpful. There was a sense that some peer workers felt they had the advantage over their professional colleagues because they had access to a form of understanding that others did not, and because they did not experience the same pressure to be experts in clinical approaches. This is an interesting and novel finding; despite existing in a spoiled identity, peer workers retained a sense of pride, and sometimes communicated feelings of superiority in relation to other mental health professionals. My own diary is further evidence of this, as I often documented interactions with mental health professionals where I believed my knowledge to be superior to theirs.

Within this more empowered 'survivor' discourse, peer workers described their main sources of emotional difficulty related to their confusion about their role, the lack of funding or investment in the system, and their lack of opportunities to progress, rather than their own mental health issues. While staff members' most common concerns for peer workers is that they will find the work triggering, they will need extra support, or will break down at work (e.g. Repper 2013), in this study, peer workers described being triggered very rarely. They sometimes described deeply caring, or deeply relating to a person they were supporting because of similarities in their stories, but this was different from

being unable to continue to offer support. Peer workers were clear that if they felt that they were unable to offer support due to their own mental health, they would not have applied for the role. In fact, it is important to note that many peer workers said that the emotions they experienced were largely of connection, and hope.

The ‘ideal peer’ discourse was one that peer workers wanted to be associated with, but often ones that they described not feeling able to embody. This ideal peer discourse constitutes peer workers as activists, warriors, deeply spiritual, authentic and vocal, while retaining respectful relationships with professionals they work alongside. It emerged when peer workers described their ideal approach, or what they believed peer working ideally entailed, and it often led them to describe their own shortfalls in relation to it (‘not peer enough’); it is a collection of characteristics that peer workers report believing they need to have more of. So, while peer workers describe acting in ways that resist the first discourse and its associations with unreason and emotion, they are also striving to embody an identity discourse of self-actualised calm and spiritual peace or control. While they expressed their fears of not being able to embody the archetypal peer worker that they hoped to be, they also discussed times when they noticed other peer workers were not living within this ideal discourse, for example by not accessing counselling, by oversharing with people they supported, or by being too emotional at work. This indicates the sense of identity that peer workers collectively held, and how the cultural norms of peer support were produced and reproduced by the peer workers themselves.

This study advances the understanding of the peer identity by situating it within the context of an institution and the resulting constructions of madness that are produced and reproduced in this setting, as well as within the culture of peer support. Rather than being purely transformative, peer workers were empowered by certain discourses and disempowered or alienated by others. These discourses are paralleled in other arenas; Audre Lorde, and more recently Michelle Obama have described needing to be perceived as ‘black enough’ and also being perceived as ‘too black’ (Lorde, 1984; Obama, 2018). My own experiences, captured in the diary entries throughout the findings

section, provide further examples of this liminal position. I describe wondering if my own lived experience is enough to qualify me as a peer, while in another entry describe the burning anxiety at being confronted by a person who once supported me, knowing that she knew the details of my struggle.

Even as I dress for work in the morning, I consider whether my choice of clothing paints me as sufficiently 'peer' while also being competent and smart (because possibly in my mind those two things are different). I wonder if I wear a blazer will it de-legitimise what I have to say, because I look too corporate to be speaking from a place of lived experience. This is consistent with the large body of research on women's clothing choices, which are scrutinised and interpreted as significant in ways that (arguably) male clothing choices are not (e.g. Fussell, 2002). In her research on peer support, Voronka (2019) describes the difference between 'dressing for success' and 'dressing to represent;' the challenge of mediating the peer worker identity to fit both professional and peer expectations. She explains that:

> 'While peer workers must indeed follow the social and regulatory codes of professionalism, we are also required to bring forward our difficulty and make visible our disability difference. We must both breach and sustain hegemonic codes of professional conduct, and learn when to reify difference and when to subsume it.' (p.6)

There is then, a significant demand placed on peer workers to perform, monitor and adapt their identity within the context of the organisation, and to always exist in a liminal position, not just in relation to those around them, but in relation to the discourses of madness that dominate our culture. Subjection, the process of categorisation and identity formation in the context of regimes of power, ultimately leads to self-governance. The ideals of others/society become internalised and we strive to uphold these in our efforts to manage our identities in line with what is considered to be the norm. In this study, peer workers described how they understood the interplay between their own internal understandings of themselves and the broader social and political

context which they are situated within, and the ways that they acted in order to manage this.

9.3.1 Performing the peer identity within the mental health system

The existing literature has highlighted how peer workers are affected by the negative or stigmatising attitudes of professional colleagues when they are employed within mental health services. (Macini & Lawson, 2009; Rebeiro Gruhl et al, 2016). This study built on these findings by illuminating how peer workers manage these perceptions. 'Identity work' is used to describe the labour that a person undertakes to present a desirable identity and influence how others perceive them (Sveningsson & Alvesson, 2003). Peer workers described accepting some elements associated with the peer identity, while resisting others that they felt were being imposed on them. While some peer workers were employed within teams who valued their lived experience, others found themselves resisting being associated with institutional discourses. This led to a self-conscious management of the perceived impression they made which included behaviours such as concealing their 'bad days' from colleagues, foregrounding other components of their identity to balance their sense of other people's perceptions of them and most importantly, by not taking time off sick. This is a form of presenteeism, which has been found in a broad range of workplaces; it is the phenomena where employees come to work despite being unable to perform the tasks of their role, because they fear the consequences of not doing so (Hemp, 2004). In the case of peer workers, this is intensified because they are in a role where they are associated with an institutional discourse, identified as having a condition which they believe colleagues perceive as making them less able to do their job. In some instances, peer workers described being told by staff members that they 'did not rate' peer support, or that, having been in their roles for a number of years without incident, certain peer workers now had 'market value'.

Peer workers described being aware of how their peer identity could work against them in the context of the institution. They must decide how much of their 'service user' identity to foreground in order to be credible, how much to conceal in order to be treated as a colleague, how much to challenge those

around them by sharing an alternative perspective, and how much to agree with the status quo in order to be accepted. This is a discursive practice, but also an act of resistance as they avoid the stigma associated with some constructions of their role. Spivak (1988) argues that when a person is required to speak from a position of lower status (or subaltern position), they must learn to adapt their language and tone in order to be received by those in power. In doing so, however, the 'subaltern' transforms themselves, becoming an informant, and moving away from their original identity. More recently, Brune and Wilson (2013) have described the concept of 'disability passing' where people conceal aspects of their disability in order to be perceived in a particular way. In other contexts, they may also amplify some elements of their disability where this is advantageous to them. They argue that 'passing is an act that blurs the lines between disability and normality' (p.13) and it is precisely these lines that peer workers describe walking along.

Peer workers questioned how long it is permissible or healthy to continue to exist in a peer identity, especially when this involved amplifying aspects of their lived experience which they felt were no longer relevant to who they perceived themselves to be. Again, this has not been explored within previous research but was an important issue for peer workers, many of whom had been working in their roles for a number of years. While being defined by survivor discourses may have been acceptable to many peer workers when they first took up their roles, as they continued, some began to feel restricted, having outgrown the peer identity they were expected to embody. This highlights the need for more routes for peer workers to progress from their peer roles, but also the need for a wider skill set than lived experience to be foregrounded within peer worker roles. This would avoid the peer worker identity becoming essentialised, and enable peer workers' other skills and attributes to be validated.

When the discourse of peer worker is essentialised and defined by lived experience alone, it unifies a diverse population of workers based on one shared characteristic; other elements of their identities, including other skill sets, cultural, gender and class differences become side lined, simplifying the identity of peer worker beyond what is realistic. As described in Chapter four,

this ‘strategic essentialism’ is often effective in meeting collective goals in the context of activism, and this was certainly understood by the peer workers in this study, many of whom shared a strong belief in the power of peer support to challenge ‘us’ and ‘them’ cultural norms, by demonstrating how lived experience can be an asset and a form of knowledge/power. Paradoxically, it also homogenises the diversity of voices and identities within a particular group. By essentialising the peer worker discourse within the confines of a stigmatised identity, this study found that peer workers perceived the ‘us’ and ‘them’ mentality sometimes being reinforced rather than challenged. The inclusion of peer workers troubles the institutional discourse of ‘professionals providing treatment’ but, within the same context, their inclusion may also be dismissed because they may not be seen to bring the relevant expertise.

Other authors have related the concept of essentialism to peer support, (e.g. Voronka, 2016) and this study advances these ideas, because it was not simply being essentialised that was the source of struggle for peer workers. The combination of being reduced to a particular peer identity *and at the same time* being introduced to a poorly defined role created an overlapping process of disadvantage for some peer workers. Peer workers described their concerns that being associated with illness identities, and being unsure what they could offer within their role, would reinforce the institutional discourse of peer workers as ‘flaky’ or unreliable, rather than challenge it.

9.3.2 Caught between discourses – expanding the concept of liminality

Fortier (2000) describes identity as a process of constant transition, a movement between being and becoming, belonging and yearning to belong. This definition is particularly relevant to the identities of ‘peer’ and ‘peer worker’ which have been described as liminal for a variety of reasons. I argue that concept of liminality, which has previously been applied to peer worker identities, has not yet been advanced enough to fully describe the different spectrums of liminality that peer workers embody. Previous research has applied the concept to describe how peer workers occupy a space which is between two distinct identities; that of service user and that of healthcare

provider, but also between those who are socially accepted and those who are marginalised (Chapter 3). The experiences of the peer workers in this study enable us to develop our understanding to constitute the peer worker identity as liminal in several other respects.

As evidenced in their talk about their peer worker identities, the polarisation of the existing identity discourses (one can be too peer, or not peer enough) creates an in-between space which peer workers embody. In the context of mental health services, I contend that peer workers exist between two identity discourses, the institutional discourse which constructs peer workers as flaky or ill, and the ideal peer discourse which constructs them as deeply connected and attuned to the needs of others. While peer workers resist associations with the former, they strive to be associated with the latter, yet often feel that they fall short of this. As a means of achieving the balance between these two discourses, I also argue that peer workers are required to occupy a liminal space in relation to their own recoveries/lived experience. Peer workers described on one hand needing to be close enough to their lived experience so that it is still relevant, while on the other not being too close that it presented an ongoing issue, or affected their ability to be in work. This is important in the context of the institution because it illustrates a discursive practice to display the characteristics of an ideal peer worker, one who is able to access their lived experience but not inhabit it, so that they can continue to manage themselves and not reinforce illness discourses.

This highlights an overarching liminal position which I argue is inherent in peer support within institutional settings; peer workers are liminal in relation to the cultural norms of peer support, and the cultural norms of the institution. These two sets of norms value different forms of relationships (professional/peer), and different forms of knowledge (clinical/lived). The peer workers' training in one set of (peer) cultural norms, and the understanding of a particular way of offering peer support that arose from this, sometimes could not be sustained when they were introduced to mental health services. While some peer workers viewed this as a failure of peer support (and I often counted myself among these) others saw it merely as a by-product of working in a new way

within an old institution. The different liminal positions that peer workers occupy were the source of unease for some peer workers, because of the lack of certainty they felt in their role and their place in the team, however, it also afforded peer workers greater freedoms to work in ways that they believed to be most effective. It often meant that they had to adapt their approach in order to accommodate the socio-cultural practices of peer support and the institution. In particular, the concepts of power/mutuality, authenticity and love labour, which are considered to be cornerstones of peer support were evolved and adapted by the peer workers in this study in order for them to work within their clinical settings while still maintaining their sense of credibility as a peer worker.

9.4 Knowledge and Power within an Institutional setting – beyond authenticity and mutuality

Examining the concept of power in relation to peer workers in NHS services provides another example of how the existing discourses do not encapsulate the 'messiness' or nuance of what peer workers embody. In understanding power in relation to peer support, it is possible to illustrate how peer workers are able to find points of compromise between the ideals of peer support and the institutional context they work within. Foucault argued that power and knowledge are fundamentally intertwined. He contended that 'it is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power' (1980, p. 52). Knowledge is subjective; what we class as knowledge is linked to what we hold as powerful and the claims we make to power, and power is not static; it is not 'owned' by some people and not by others. Power is dependent on context and perception, and is better understood as held between individuals, and perhaps within systems, rather than as a possession.

Existing literature consistently defines peer support as a mutual profession (e.g. Gillard et al., 2017; ImROC, 2013; Mead & Filson, 2016), highlighting the importance of equality and shared power within peer support relationships. It is often levelled as proof of the co-option of peer support within clinical settings that when peer workers are employed, this mutuality is lost and with it, the

essence of peer support (see Chapter 4). While some literature fails to recognise the conflict that peer workers face, most research offers a polarised view of peer support, by describing the mutuality inherent in the approach (e.g. Filson & Mead, 2016), and criticising services which prevent this mutuality from occurring (e.g. Brown & Stastny, 2016). Some have gone further in their criticism of introducing peer workers to mental health institutions, arguing that these workers become part of a 'neoliberal dream' (Voronka, 2015) whereby they enforce the rules of normative citizenship, by both controlling themselves (by managing their own wellbeing and identity) and others (by promoting self-governance).

The existing literature exploring power in peer support is problematic because it either assumes peer workers are able to offer mutual support within mental health services, or criticises them for failing to do so. This precludes any honest discussion about how exactly peer workers navigate power dynamics within mental health services and how they are, and are not, able to offer a mutual approach within the constraints of a hierarchical system. Rather than establish a binary whereby peer workers are powerful or powerless, this research found that peer workers simultaneously enact power, feel empowered, feel powerless and reject power.

Experiential knowledge as a form of power is discussed in Chapters four and six. In the interviews, some peer workers described how their experiential knowledge can be a claim to power (within peer relationships), as well as being a source of powerlessness (within a clinical setting). Identifying people as 'peers' who have 'lived experience' attaches particular forms of (experiential) knowledge to them, and positions them as able to access knowledge that others cannot. Because mental health systems have come to identify lived experience as a form of knowledge that could improve services, peer workers have access to a form of power. Peer workers in this study experienced their lived knowledge as a form of power in the context of the relationships they built with the people they supported. Here, peer workers described their comfort and confidence, and they frequently derived a sense of safety from the knowledge and experiences they shared with those they supported. Within these relationships, when a peer worker communicated that they have lived

experience, they also communicated that they can be trusted, because they do not occupy powerful position of a healthcare professional. Their shared understanding creates closeness. Peer workers sometimes explicitly told the people that they supported that they had no power; they used this as a means of building trust, of holding their hands up and saying ‘I am just like you in this situation, neither of us has power.’ This is a sort of therapeutic use of powerlessness which, ironically, affords peer workers some power. In saying ‘I have no power’, they are granted access to information that peers would not share with other mental health professionals. Further, they may understand this information differently, because of their own experience, increasing their knowledge, and therefore their power.

Although peer workers might say that have no power, and might subjectively feel powerless in the system, they have far more power than the people they support. As I interviewed the peer workers, I was well aware of the criticisms I described above, and I was concerned as they talked to me that the relationships they described were not equal. How would I present this in my thesis? I thought. As a failure of peer support? As confirmation that peer support in the NHS has been co-opted, and that we as peer workers are re-enacting the power hierarchies that create distress in the first place? I put these concerns to peer workers in the interviews; tentatively I shared that perhaps peer support was not equal, perhaps we were more powerful. And to my surprise I was met with responses along the lines of ‘of course it’s not equal.’ Long before I reached this understanding, many of the peer workers I interviewed had accepted that they were not in equal relationships, but they had also come to understand that power was not bad, and that it did not have to equate to superiority. In fact, peer workers described using some forms of power to create safety. They described being aware of the power they held as peer workers, and at times being able to choose how to use this. These findings advance the understanding of how a discourse of power (or empowerment) is used by peer workers beyond what is established in research literature. Rather than assuming either mutuality or unhelpful hierarchy, peer workers described their awareness of the power imbalances within clinical services, and their own attempts to negotiate these.

In several examples, peer workers described how the people they support have the expectation of being powerless in mental health services, which meant that the prospect of a mutual relationship was sometimes unfamiliar or unwanted. While shared power was the aim of some peer workers, they described how this was difficult within a system where people using services had been let down or expected a 'power over' approach, based on what they had already experienced from the mental health system. While literature about supporting recovery talks about sharing control and power (Mead & Filson, 2016), it often does not confront the consequences of long-term institutionalisation for people within services, and the difficulties of empowerment in systems which continue to disempower. At times, this led peer workers to offer them a 'handle to hold,' where they felt that the people they supported were looking for some reassurance or guidance. This, I argue, is a form of psychological containment (Bion, 1985) as peer workers sensed what a person needed in order to feel safe, even if this meant that they offered direction for a time. Some peer workers shared their frustrations that the power dynamics in peer support are often not discussed within the recovery literature, because in their experience, knowing how to enact strategies of power, and how to evade them, (rather than assuming mutuality) are crucial. Once we clear away the understanding that power is bad and mutuality is good, we can see that peer workers associated with a more nuanced discourse in relation to power, which is necessary in the context of a hierarchical mental health system.

VeneKlasen et al. (2002) conceptualise how power can be used as a positive rather than a dominating force, and this can be applied to the approaches taken by peer workers. They outline three expressions of power which can be used to support co-operative efforts of social change. 'Power to' refers to the potential for mutual support to help develop a persons' belief in their ability to effect change. It can begin with a growing awareness of one's own potential, and evolve into taking action and understanding our part in bringing about change. 'Power with' refers to collective agency and both the political and psychological power that this affords individuals. It involves building collective strength, mutual support and collaborations which can resolve conflicts and

create equality within relationships. ‘Power within’ relates to a person’s sense of self-worth and personal empowerment that is developed through realising one’s own abilities to effect change. In relation to their peer support relationships, peer workers described their use of ‘power to’, ‘power with’ and ‘power within.’ Peer workers gave examples of ways that they attempted to share power within peer support relationships, including asking permission before entering a person’s room, or before laying a reassuring hand on their arm; asking for feedback when they have shared their lived experience; and reminding people that they don’t have to continue to see each other if they do not want to. In sharing their own lived experience, peer workers are also offering some power to the person they are supporting by communicating that they are trusted with personal information. The process by which peer workers negotiated power dynamics within their peer support relationships took into account the contexts they worked in, as well as the ideals of peer support. Rather than being able to offer wholly mutual relationships, peer workers tempered mutuality with the demands of their role in the context of the mental health system. This advances the concept of power within peer support. In a similar sense as the discourses on mutuality, the separate but related discourse of authenticity within peer support requires further development within the existing literature.

9.4.1 Emotional labour and love labour – moving beyond authenticity

Like mutuality, authenticity is considered to be central to peer support relationships (e.g. Scott, 2011). The literature review in Chapter Four found that peer support has been described as a form of love labour; it was argued that while other professions undertook emotional labour – concealing their emotions or managing them, peer support workers use their emotions actively, conveying these as a way of building peer support relationships. This discourse constitutes peer support as idealistic and removed from the contexts which peer workers act within; it is a binary assumption that peer workers employ love labour and other workers use emotional labour. I contend that this discourse needs re-formulating for an NHS context where peer workers use both emotional labour and love labour in different ways, and that both are

important in peer support work. In the interviews, there were certainly times when peer workers described the emotional labour involved in offering peer support, and they felt that this was the kindest, and sometimes the only option available to them. Peer workers described how they manage their own emotions within peer support relationships and their wider working environment, adjusting how much they share, or putting on a 'mask', if they are feeling vulnerable. This is done with the motivation to offer the best possible relationship to the other person and not burdening them with too much of the peer worker's own struggles. There are times within peer support that peer workers felt that their emotional honesty would be detrimental to the peer support relationships, and so they chose to manage their emotions privately. This was especially the case if peer workers were having difficult days in relation to their own mental health. They described being unwilling to share the depths of these difficulties with people they supported because of their desire to offer hope. They sometimes feared that sharing this would act as proof that recovery is not possible. This is another example of the ideal peer discourse operating in a way that meant peer workers felt their own approach was not enough in relation to it. Peer workers communicated some shame in not being completely honest with people, highlighting the assumption that an 'ideal' peer worker would be able to do so. This discourse, which constructs peer workers as purely and consistently authentic needs to be challenged so that individual peer workers do not experience their emotional labour as a personal failing, but can understand this as a normal part of offering support.

Peer workers were also sometimes concerned that sharing their emotional struggles much would shift the focus too much on to the peer worker, and their belief was that the focus of peer support relationships should be on the person receiving services. The strong focus on supporting others within clinical contexts, rather than both people deriving support from relationships, shifts the balance of peer support relationships within mental health services so that it is clearer who is receiving and who is offering support. However, this does not mean that peer workers did not learn or benefit from the supportive relationships they entered into, as they provided numerous examples of being inspired by those they supported and benefitting from witnessing other

peoples' recoveries. Again, this study found a more nuanced discourse of the work that peer workers undertake, it is not wholly love labour; it cannot be entirely authentic all the time. For the self-preservation of the peer workers themselves, and out of concern for those they support, peer workers, like all mental health professionals, sometimes forewent authenticity and privately managed their own embodied experiences, instead of sharing these. By moving beyond the assumptions of mutuality and authenticity within peer support, we can begin to understand the emotional experience of the peer worker as more complex. Within the context of peer support relationships, peer workers both used and concealed their emotions. In the wider context of their institutional setting, peer workers described how their emotions were a vital source of information, but that this was sometimes at odds with the prevailing clinical cultures they worked within.

9.4.2 Discourses of emotion within institutional settings: emotions as information and inconvenience

When peer workers talked about their embodied emotional experiences within the interviews, they did so in two different ways. They described their emotions as a source of information within peer support relationships, but they also described the embodied experience of being part of an NHS mental health service, which sometimes included feelings of confusion, burn-out, and the trauma of chronic underfunding and service redesigns. In the context of peer support relationships, peer workers used their emotions first and foremost as a means to connect. Peer workers described the task of peer support as being 'offering yourself,' 'offering your emotions' and 'offering space'. The language that peer workers use, of 'offering,' indicates the tentative, gentle intentions that they bring to peer support relationships. They 'offer' with the understanding that it may not be accepted, with the understanding that this is a small way of engendering trust. Within their talk about peer relationships, there were prominent ideas of empathy and 'being with' (rather than 'doing to') and peer workers gave examples of using their own experiences implicitly as a means of understanding how a person might be feeling. Their body knowledge, in the form of lived experience, instinct and emotion was a vital tool for them in this process. This is consistent with the existing literature on

peer support, which emphasises the importance of empathy and connection within peer support.

However, peer workers sometimes found themselves at the mercy of this ideal peer discourse which sometimes positioned them as able to 'work magic' that other professionals could not in building therapeutic relationships. There were times when peer workers also described not being able to connect with everybody, although they tried, and that sometimes, empathy and shared experience was not what people using services were looking for. In the context of the institution, peer workers found trust more difficult to establish with some of the people they supported, because trust had been broken in their relationships with services before. While they were keen to be associated with the ideal peer discourse of 'being with', they continued to be concerned that they were 'coming up short of the ideal.' Again, this ideal peer discourse needs to be challenged so that peer workers can understand that not being able to connect with everybody is normal, and that their 'magic' will not always work.

The ideal peer discourse of 'being with' was also challenged within the intense clinical settings that peer workers acted in because they described needing a 'thick skin' in order to cope. There is literature which describes the difficult experiences of peer workers within clinical working environments (e.g. Irwin, 2017), as well as literature which describes the emotional attuning required to build peer support relationships (Scott, 2011). It seems that these two bodies of literature miss each other, and therefore miss a central issue; how can peer workers to undertake this emotionally close, reflexive work, in environments where they often feel under threat? In fact, this is a relevant question for the whole workforce, many of whom experience the same threats as peer workers and who strive to offer the highest level of care in this context. The institutional discourse of 'thick skin' and ideal peer discourse of 'being with' presented opposing challenges for peer workers who are required to draw on their emotions to build relationships but work in emotionally challenging environments; they work to simultaneously tune into, and out of, their embodied experiences. Their 'thick skin' was needed in relation to their fears of being negatively judged by colleagues and sometimes feeling useless in the fast paced teams that they were employed within. This was compounded by

the lack of clarity they experienced around their role. Several peer workers described having to ‘sell’ peer support in order to receive referrals from clinicians, but that this was difficult when they themselves were unsure of the role.

The importance of role clarity is well documented within the peer support literature. It has been found to significantly predict job satisfaction, and has been identified as crucial for the successful implementation of peer support (Davis, 2013; Gillard & Holley, 2014). Some peer workers in this study described a lack of clarity in the specific activities that they should and should not undertake, as well as a lack of clarity about how their role was different to other staff members. While they had a sense of the potential that peer support could offer services, it was not clear how this translated into a specific set of activities. Some peer workers also described the perception that their colleagues were equally unclear about what the peer worker role should entail, and in some instances, this led to peer workers having little to do, or being asked to undertake ‘unskilled’ work because of their lack of professional registration. What is little explored in the literature is precisely why peer workers encounter these difficulties with role clarity, despite an awareness of its importance. By exploring further, the demands placed on institutional structures, and the discourses that construct these, it is possible to elucidate this further.

9.5 Introducing a new cog into the institutional machine

While the organisational discourse around peer workers is positive, the peer workers described how they felt that this did not always filter down into teams or offer them an understanding of what peer workers should be doing beyond ‘offering hope’ or ‘sharing lived experience.’ Peer workers described the strong institutional discourse which constructed their working environments. This discourse was shaped by clinical language, as well as practices including risk assessments, patient reviews and brief clinical interventions. The information provided to people accessing community mental health services highlights that ‘service users are supported to engage in recovery focused interventions’ (Nottshc, 2020); The institutional discourse of ‘interventions’ is at odds with the

ideal peer worker discourse of ‘being with.’ However, it is not merely the presence of a clinical paradigm that peer workers described as difficult, although they were aware of the ways that their values conflicted with this. The difficulty was amplified by the intersection of institutional and austerity discourses.

The austerity agenda impacted on every peer workers’ working context; they perceived that funding cuts had led to reduced staff numbers, greater pressure on remaining staff, increased pressure to discharge people, fewer resources and less time to offer people support. It is important to acknowledge the impact that this had on individual peer workers, who described feeling under more pressure to be effective, while also being less able to access support or supervision. It is equally important to comprehend how the austerity discourse has embedded particular socio-cultural practices which, when combined with an institutional discourse, interpellated peer workers as less relevant to the demands of mental health services. In the wider context of a burnt-out mental health workforce, the rhetoric of peer workers inspiring change comes up against the austerity discourse of short-staffing, and needing ‘boots on the ground.’

Peer workers described how the teams they worked in sometimes had too few staff to physically complete the duties that were required of them. This led to the rationing of resources so that teams focussed on what was essential in order to manage risk, including routine checks, updating patient records and medication dispensing. The austerity discourse served to crystallise and strengthen the institutional interpellation of mental illness and medical treatment because it narrowed the focus of what services were able to offer. In this context, the introduction of peer workers is made more difficult because their role does not include any of the clinical duties that are deemed essential in order to manage risk.

Peer support could be interpellated as not removing any of the burden from teams, because they are not able to perform risk assessments, patient observations, or deliver medication. Within this heightened clinical culture, peer workers may also be constructed as further draining resources from the

team, who have little capacity to contribute to the development of a new role or support the wellbeing of a service user colleague. It is not possible to know from the interviews with peer workers whether staff members did construct peer support in this way, but this was the subjective sense of some peer workers when they were newly introduced to teams. They felt that their confusion about their role was compounded by cultural norms of clinical intervention, and professional support, but also by the phenomenal demand that their colleagues were placed under, which sometimes reduced the peer workers' access to support and their sense of purpose within their teams.

In one example, a peer worker shared how the staff in her team discussed whether or not she should be allowed to answer the telephone in the office. This was reported to be a shaming experience for the peer worker, who knew that she was capable of answering the phone, but was unable to advocate for herself as she was not clear about her key responsibilities (and was new, and felt her own low status in relation to the nurses in her team). Sinclair (2018) has described actions such as this as micro aggressions; 'everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory or negative messages to target persons based solely upon their marginalized group membership' (Sue, 2010, p. 3). In previous research, microaggressions toward peer workers have been related to a 'sanist' culture, where peer workers are positioned as deviant in relation to the norm (LeBlanc & Kinsella, 2016). I argue that, in the context of NHS services, microaggressions are more to do with the overstretched workforce being unable to accommodate more innovation in the form of a new role in their teams. Further, I contend that the whole workforce is subject to what I conceptualise as 'institutional microaggressions,' in the form of systemic practices and unmanageable workloads, as a result of austerity

In the example described above, the peer worker described how the staff were trying to ensure that she was not over stretching herself and she speculated that their intention was to protect her and the people using their service. The peer worker also felt that the nurses they worked alongside were protective of their own roles and unsure how much peer workers would 'tread on their toes.' This highlights the demands that all staff experience within mental health

systems. The impact of austerity has meant a reduction of resources across mental health services, which has led to professional roles changing both in terms of numbers and skill mix. For mental health nurses, this has meant a fragmentation of their role and diminished autonomy (McKeown, 1995). In this context, peer workers perceived that some of the conflicts faced by other professionals led their colleagues to protect the tasks that they believed were the preserve of professionals. Within the mental health system, peer workers are not the only workers who are fighting for a sense of their own identity, or for recognition of the unique value they have to offer. This is a novel finding which situates peer support within a wider systemic context of competition for resources.

The institutional interpellation of peer workers as in need of protection from the high demands placed on other staff members had physical consequences for some peer workers' roles. It was experienced as stifling for some peer workers and they felt it led to their roles being constrained, either because they were prevented from lone working, or from working with anybody deemed too 'high risk.' As other professionals simultaneously moved to protect their own role, and struggled to understand the peer worker role, it led to peer workers feeling de-skilled and 'useless', especially those that had come from other roles in 'high risk' environments, who had significant experience of managing these. Add to this the psychiatric interpellation of peer workers as ill or 'flaky,' situated within a context of austerity, where peer workers are sometimes seen as a way of saving mental health services money. These are all couched within an organisational discourse of commitment to peer workers and the culture change they are seen as being part of. Framed in this way, it is easy to see why peer workers struggled to define their role in the face of competing expectations about what they have been employed to do, and diverging assessments of the added value they bring to the workforce.

9.6 The Master's House

This study situates the role confusion that peer workers experienced in the context of the institutional and austerity discourses that operate within mental health services. It is important to note that peer workers are not the only staff

members who sometimes feel powerless in the mental health system. While I did not interview other staff, I work alongside them daily and I hear their stories, not dissimilar to the stories of peer workers, about how undervalued, underpaid, and over-stretched they are. The peer workers also communicated their concerns for their colleagues to me in interviews, using examples to illustrate how nobody feels in control or empowered in mental health services, not peer workers themselves, not nurses, and certainly not patients. This was largely due to the impact of austerity and understaffing over a prolonged period of time. In this context, the experiences of peer workers are not dissimilar to the experiences of other mental health workers, who also report feeling alienated, undervalued and compromised within contemporary mental health systems (McKeown & White, 2015).

The added complexity for peer workers comes from their liminal identity as both staff member and person using services, as well as their position among those at the bottom of the workforce hierarchy. In this study, peer workers frequently and consistently described their sense of disempowerment in the system they worked in. They described feeling disempowered for four important reasons; first, because their role was not clearly defined, and was often re-formulated in the context of service change; second, because they were not able to find opportunities to progress, even after working in the same role for several years; third, because they are among the lowest paid members of the teams they work in; and finally, because of the institutional discourse which constructs peer support in terms of un-reason and flakiness. Lack of career progression and low pay are examples of structural powerlessness; while peer workers may have a sense of their own power within peer support relationships, and may be valued within their teams, within the system some peer workers described feeling disempowered and used; ‘we’re valued because we’re cheap.’

Several peer workers described how professional knowledge is valued over experiential knowledge, so that, while in the context of their peer to peer relationships they felt confident, in the context of team meetings or conversations with colleagues, they felt powerless to communicate what they knew. My own experiences, documented in the diary entries detail similar

feelings of futility, frustration and powerlessness to what some peer workers communicated in the interviews. Underpinning these frustrations was (and is) a sense of tokenism, a fear that peer workers are only employed to tick a box, and that the wider cultures of oppressive power remain intact. In contrast to existing findings that show that peer workers can change cultures (e.g. Repper & Carter, 2011), some of the peer workers in this study questioned whether they have any ability to create meaningful change in cultures given their low status within the system. Further to this, they and I questioned whether the system wants peer workers to bring with them culture change, or if it is satisfied with their employment within the business as usual of the prevailing psychiatric and business cultures. In the most extreme examples, peer workers described their experiences of 'moral injury.' Litz et al. (2009) define moral injury as 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.' Working within mental health systems, which were sometimes significantly at odds with the values that peer workers held was most difficult where peer workers felt they could do little to change these systems.

There has long been an awareness that the culture of mental health services is in need of change and peer workers are employed, at least overtly, as one way of changing the culture of mental health services (ImROC, 2013). They are told to challenge non-recovery focussed practice where they can, to role model different, mutual ways of working, and to use their lived experience to break the divide between staff and people using services (See Appendix F for a peer worker job description). The question of whether peer workers feel empowered to change and challenge existing cultures returns us to the three discourses relating to the introduction of peer workers into mental health services outlined at the beginning of this discussion, and the debates around whether peer support has been co-opted by its introduction into mental health services.

The examples of disempowerment that peer workers discussed during the interviews could be taken as evidence of the tokenistic way that peer workers have been employed within mental health services. Some of the peer workers described living with a sense of unease in being employed within mental health

services which continue to do harm to people who are supported by them. The peer workers also described some experiences of feeling used or exploited, as well as conforming to practices that encourage compliance with the models of mental illness that the survivor movement campaigned against. bell hooks (1992) writes about the 'commodification of otherness' in relation to race and cultural appropriation. She writes that:

> *'marginalized groups, deemed Other, who have been ignored, rendered invisible, can be seduced by the emphasis on Otherness, by its commodification, because it offers the promise of recognition and reconciliation.'* (p.367)

hooks argues that the power for social change is diminished when groups become commodified; communities of resistance are replaced by communities of consumption. There were also some instances where peer workers constructed their roles within the 'complimenting' discourse, where the already functioning service design could be enhanced by the addition of peer support. Peer workers framed this as a personal success, where they had been able to find their role in relation to their professional colleagues and operate as part of a wider team. It could also be framed as 'assimilation', a term used by Boyle (2013) to describe how medical paradigms have diffused competing ideas by absorbing them into current models. Drawing on Kuhn's (1970) model of paradigm shifting, she argues that assimilation happens when ignoring or attacking new ideas has been unsuccessful. Where new ideas pose a threat to current models, they are assimilated in ways which neutralises them, by removing their radical elements so that they complement the current worldview. Assimilation also has the added benefit of making it appear as though the ruling paradigm (in this case, psychiatry or neo-liberalism) is open to new ideas, while ensuring that these are of no consequence to current processes. As Audre Lorde (1987) frames it:

> *The master's tools will never dismantle the master's house.* They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change. And this fact is only threatening to those women who still

> define the master's house as their only source of support. (p.112; italics original)

As the 'recovery movement' has become a 'recovery model', which can be further broken down into 'recovery interventions', many of the radical intentions of peer support have been smoothed or lost. As peer workers are employed in such a way that leaves individuals feeling disempowered, it could be argued that the demand for peer support within mental health services is paradoxical. It communicates an honest aspiration to change medical and hierarchical cultures, while also reinforcing the institutional discourses that these cultures are embedded within. It simultaneously offers some peer workers a role in changing culture, while recruiting them to govern themselves and others in accordance with what is expected of people with 'mental illnesses.'

To frame peer support in this way would be to ignore the ways that peer workers resist these disempowered discourses. I argue that it is less important to debate which discourse is 'truer', than it is to acknowledge that contradicting discourses run parallel to each other. Peer workers *are* changed by the contexts they work within, and do often feel disempowered within these, but they also resist and subvert these cultures. They find ways to work within competing discourses, and live with compromise, but they also re-construct themselves as empowered. This is the biggest thing that peer workers taught me; while I was lamenting the death of peer support and the weight of responsibility of culture change, peer workers were finding ways to resist and break out of those discourses, develop their own ways of being, of coping and of offering peer support.

9.7 Subversion, resistance and advancing the disempowered discourse

Given the criticisms of their inclusion in the literature on peer support, and the weight of the cultures that they work within, it is easy to construct the experience of peer workers within mental health systems as disempowered. This would have the consequence of positioning peer workers as passive,

within a deterministic understanding of peer support in mental health services. Foucault (1982) used the concept of subjection to describe the process by which human beings are made into subjects through different modes of objectification. This process is always linked to external mechanisms of power, but this does not mean that these mechanisms deterministically dictate how we constitute ourselves. In fact, Foucault (1990, p.95) also argued that 'where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power.'

What this means is that, because power exists in a multiplicity of relations rather than one central point, power relations are obliged to change through a similar multiplicity of points of resistance; power and resistance always lie in relation to one another. This research found that most peer workers were aware of the conflict between the cultural norms of peer support and the cultural norms of the services that they worked in. They found abundant ways of navigating and resisting the institutional contexts they worked within so that they could still stand for the values of peer support within these settings. One example of this is how peer workers who worked within inpatient settings navigated the issue of physical restraint. Physical restraint is an actual and symbolic expression of power over someone and it is used within some of the services where peer workers are employed. There was not a unified opinion among peer workers about the extent to which they should be involved in physical restraint, which highlights the heterogeneity of the group, but also the divisiveness of the topic. This is consistent with the views about physical restraint expressed by survivors and people with lived experience. While there is not a consensus within the survivor literature on the use of force, views are clearly more in favour of the use of little or no force (O'Hagan, 2003).

What is interesting about the peer workers is that they were not in a position to merely acknowledge the difficulty or debate the concepts surrounding the use of force, they had to make choices about how to act and resist in these situations. They were aware of the damaging effects of crude forms of institutional power, and while they could not prevent it's use, they could control and resist their involvement in it. Some peer workers took a pragmatic view of restraint; they saw times when people were restrained as opportunities to

make a terrible experience less terrible and so chose either to be a part of the restraint, or part of the debrief process following it. Being involved in the debriefing process following a restraint allowed peer workers to support their colleagues and the people on the ward, while also resisting being a part of the oppressive practices that peer support is culturally opposed to. Other peer workers were more extreme in their resistance, sometimes not undertaking the required training in order to absent themselves from the practice of restraint. In the absence of an overarching position for peer workers, in a profession where the critical debate about restraint is ongoing, individual peer workers resisted and involved themselves in a way that highlights the contextual nature of peer support.

There were also examples of peer workers resisting the demands of 'through-put' within the discourse of austerity where services were under-pressure to discharge people or spend less time with them in order to see more people in less time. The peer workers stressed the importance of taking time to build trust and allow relationships to grow and peer workers found that their desire to 'be with' people conflicted with the pressures faced by services. Often alongside feelings of guilt, but also alongside feelings of pride and defiance, peer workers described how they knew that the one hour visits that are the customary practice within mental health services were often not sufficient time frames to build relationships in, and so they spent much longer than an hour with people in spite of the cultural norms. Though I feel it on their behalf, the peer workers themselves rarely expressed a sense of outrage at what was being asked of them in relation to offering and managing the competing discourses around the use/control of emotions. Many found opportunities to offer their emotions, and were aware of when they also needed to protect themselves. Within peer support relationships, peer workers described sourcing energy from, learning from, and being inspired by, the people they supported and that this was often what sustained them in their role.

Peer workers were also aware of the institutional discourses that were used to construct peer support within the Trust, which included the perception of them being flaky, or being viewed as ill patients. The peer workers that described picking up on these perceptions responded in various different ways to resist

being associated with them. They resisted the institutional discourse of illness partly by building an alternative, more empowered discourse around their own identity and skill set. This empowered discourse involved developing a relationship with, and trusting in, their own intuition. Intuition is a form of body knowledge whereby a person is able to directly perceive important information without any formal or conscious reasoning process (Bastick, 1982). Within nursing professions, the concept of intuition is little discussed, and authors have argued that because it is difficult to quantify or investigate using traditional scientific methods, it has been perceived as something mystical and unworthy of the profession (McCutcheon & Pincombe, 2001). Similarly, there is little discussion relating to the role of instinct within the existing peer support literature, but this study found that peer workers used this 'body knowledge' in their approach as a means to 'tune into' people and develop a sense of what would be most helpful. Their use of intuition was sometimes so effective that peer workers described the expectation from their colleagues that it would enable them build relationships where others were not able. This is an example of how peer workers not only resist the institutional discourse that interpellates them as ill, but subvert, reconstruct themselves and advance the discourse surrounding their identities as one of unique skills. There is currently no formalised guidance for peer workers within their training as to how to use their instinct as a form of knowledge within peer support (Machin, 2019). This is even more important in a population of workers who may have consistently received the message that their internal experience cannot be trusted as illness narratives may have been imposed on them. Adding this to existing peer support training would provide peer workers with skills and assurance to help them to trust and employ their instinct, but also to understand when instinct may also be prejudiced and involve other discourses (for example, gender or ethnicity).

As described above, peer workers described resisting the institutional discourse which interpellated them as 'flaky' predominantly by not taking time off sick, or not showing others if they were having a bad day, but they also used other acts of resistance. These included ignoring the views of others and focussing on their peer support relationships, seeking support from fellow peer

workers or other staff, directly challenging and withdrawing. Seeking support, especially from fellow peer workers, is an act of empowerment as it enabled peers to collectively reframe their experiences and to share times when they felt confined by the institutional discourses that surrounded them. This support was often described as helping the peer workers to remain in their roles. For some peer workers, the support of fellow peers was available to them, and they benefitted most from this in the first few months of beginning their role. For others, there were no peer workers for them to gain support from, but they found like-minded staff members who were able to offer supervision or guidance. Some peer workers expressed how helpful their manager had been in helping them to protect and define their role. This was often important as their manager could champion peer support to the wider team, where there was less understanding or more scepticism.

Often, peer workers described needing to feel strong enough to ask for help, because regular supervision was not readily available. Sometimes, when supervision was not easy to access, or did not suit the peer worker's needs (for example because it was largely functional and not reflective) peer workers established their own support networks, making regular times to meet with other peers or with like-minded colleagues. Several peer workers also described the importance of ongoing counselling, which helped them to reflect on their practice but also to explore a wider range of topics than would normally be covered in supervision, and without the same fear of consequences that they would have in discussing these topics with their manager.

In addition to finding the support that worked, peer workers also described moving away from the environments that did not work for them. This included distancing themselves from staff members, working more independently of their team, but also, in some cases moving role or leaving the Trust. In moving to a different role (for example, Occupational Therapy Assistant) peer workers could reject the institutional discourses which foregrounded their lived experience and framed this as stigma. Although they continued to possess the same amount of lived experience, they found themselves more able to work and live within the mental health system when they were not defined by this subaltern identity. Leaving the Trust may be the ultimate act of resistance,

although some peer workers framed this as failure. Leaving enacts a choice to remove oneself from the institutional discourse of mental illness and from the socio-cultural practices of the institution which are embedded in these. Rather than positioning oneself in terms of culture change, some peer workers resisted the role altogether, as well as the organisational frame which it exists in.

Peer workers also resisted the expectation that they should challenge and change cultures to some extent. Some peer workers found the notion that they should change culture within their new role and new position within the workforce quite comical, and others were able to focus on small scale changes at a team level. Deegan (2011) argues that peer workers exist at the intersection of love and outrage, and that the creative tension between these two emotions is what allows peer workers to be 'disruptive innovators' which is what is needed in order to change cultures. Peer workers focussed less on changing cultures than they did on resisting particular discourses. They, and I, believed that the notion of peer workers holding the responsibility for culture change was unrealistic, while simultaneously working to challenge the prevailing psychiatric culture.

9.8 Peer support and culture change

The examples described above highlight how resistance among peer workers is not lacking, but does this resistance amount to culture change? The peer workers described their perception of the culture of the Trust, and the services they were employed within, which was often, but not always, defined by underfunding and pressure to move people through and out of services. Peer workers who had been in their role for a number of years were able to reflect on their perceptions of how the culture around them had changed because of the impact of austerity and cost saving measures. The peer workers largely did not locate these issues as faults that lie within institutions or within individual teams or staff members. They perceived that the systems that they worked within were at the mercy of a wider socio-economic context.

Foucault argued that institutions are the vehicles that power uses, rather than being the sources or origins of power (Caputo & Yount, 1993). Rather than searching for the origin of power, it is more helpful to examine the power relations that bathe the governance of mental 'illness' in this century, and to position the experiences of peer workers within this. As described in Chapter 4, neoliberalism emphasises personal autonomy and resilience, and this obscures the damaging effects of inequality, wide-scale oppression and neo-liberal policies themselves. As some peer workers themselves identified, austerity has served to strengthen the tendency for services to treat 'mental illness' as a problem that lies within individuals, minimising the social realm and the impact of inequality (which is associated with increased emotional and behavioural issues at every level of society; Barr et al., 2015; Psychologists Against Austerity, 2015). At the same time that peer workers are being introduced as a way of positively influencing culture change, the culture of mental health services is changing for the worse because of chronic underfunding within neo-liberal economic models. This places peer workers in a precarious position as the discourse of personal recovery which has been championed by the survivor movement is at risk of being co-opted to reinforce the neoliberal focus on individual dysfunction. On one hand, peer workers act in ways which counter institutional discourses about mental illness or flakiness, but on the other, they are confirming a neoliberal discourse about 'getting mentally ill people back into the labour market' as they themselves are the embodiment of this.

Alongside peer workers' acts of resistance, and their labour to construct more empowered discourse, wider political, social and economic forces are transforming the environment that peer workers act within. This wider context means that the inclusion of peer workers can both trouble *and* maintain the ideological systems that underpin mental health services as they both challenge and serve the neo-liberal discourses that construct the management of mental illness. They trouble these discourses by challenging ideas about mental illness, challenging the practices of psychiatry by subverting them or presenting alternative approaches, and by illustrating that lived experience can be a form of power, thereby decentring the importance of clinical/professional

expertise. They maintain these discourses by embodying the neoliberal goal of self-management and return to the labour market, by supplying the mental health system with cheap and effective labour and by sometimes supporting practices which reinforce the power of the medical model, for example advising someone to comply with their treatment plan.

The peer workers in this study were unanimous in their belief that the culture of mental health services needed to change, and they enacted all the power that was at their disposal in order to both be a part of the positive changes they believed were necessary, and to protect themselves from the damaging impact of austerity and a neo-liberal policy context. They acknowledged that what they could offer was sometimes imperfect, because the system they worked within was heaving under the strain of competing discourses about recovery, involvement, cost-improvement and efficiency.

9.9 Imperfect peer support in an imperfect system

I began this discussion by stating that peer support both 'works' and does not; that it is messier and more nuanced than current research illustrates. By exploring the findings of this study, I have shown how this is the case, and argued that we must move beyond the binary of co-option versus culture change, in order to see the ways in which peer workers resist these discourses and construct themselves in more 'realistic' or empowered terms. There are some who argue that peer support within mental health services can never be successful (e.g. Brown & Stastny, 2016) but it is not within any of our individual powers to prevent its implementation. In fact, the numbers of peer support workers are set to swell within the NHS in the coming five years. In any case, I contend that there remains an important place for peer workers within the NHS, and this is partly because of what the peer workers taught me as I interviewed them. They described all the ways that they had found to cope within the system so that they could still come to work, and importantly, so that they could still stand for something. They were all aware of the economic and existential compromises they made to do this, but they also knew that peer support can offer *something* within these difficult contexts, and that it is needed. To write off peer support would be to dismiss the efforts of the peer

workers who have found ways to resist, to influence, to protect themselves, to seek support and to shape an identity that they can sustain the weight of.

There is a way of offering peer support within NHS contexts; that way is messier than one might ascertain from the existing literature, which talks of mutuality and shared control, without recognising the difficulty of this for individual peer workers working with people who have been institutionalised. Peer support in NHS systems cannot always be mutual or authentic, it cannot always be an act of love labour, it cannot always challenge psychiatry. Sometimes there must be power imbalances, there must be emotional labour, inauthenticity and agreement with psychiatric regimes. This is the nature of peer support in the NHS, and the strength of individual peer workers is that they have found ways to offer this and ways to seek the support they need in a system which is not always welcoming, because everybody is competing for resources. This is peer support that I am able to champion, that I can feel proud of, because these peer support workers are doing the best they can with what they have, and although the circumstances are not ideal (for any member of staff) we can still stand for something.

Foucault (1990) believed that revolution is difficult to define but never impossible. It involves ‘dealing with mobile and transitory points of resistance’ (p.6), and the ways that these begin to connect and grow. In the same way as neoliberalism has connected a web of institutional tools through times of austerity, points of resistance can combine to form ruptures and revolution. While the resistance of individual peer workers was clear, what is less clear is a strategic resistance, and this is what is needed to continue to move in a direction of culture change. I argue that, to enhance the possibility of peer workers contributing to culture change, there are some pre-conditions that support this.

9.10 Changes before the culture changes

There are several recommendations that could be made in light of the experiences of the peer workers I interviewed. These relate not only to the implementation of peer support, but also to the wider culture of NHS mental

health services; both of these need to be reviewed and actively improved in order for peer workers to become (or re-join) part of a collective change movement. For services in general it is clear that the collision of the medical and business model work to reinforce each other and serve neoliberal agendas. For these to be challenged takes ongoing and renewed efforts from those who work within services, those who use services and those who commission and plan service provision. The activist roots of peer support are important and have been obscured by their inclusion into the mental health workforce. Peer workers need networks which help them to reconnect or strengthen connections with the political nature of their role. It has been highlighted that 'discursive strategies used by neoliberalism undermine social and collective ideas about recovery' (Morrow, 2013, p. 328). This can undermine discourses of social change and collective movement in favour of self-care and responsibility. Peer workers need to be familiar with these criticisms, as well with as the impact of inequality and poverty on mental distress. This would support them to position their own recovery, and the recovery of those they support within a wider social context, and understand that it is this that requires change, rather than the individuals themselves.

Peer workers often shared a sense of 'coming up short of the ideal' as they described their effort to offer peer support or to challenge cultures. As previously discussed, the expectations and previous experiences of people receiving services about supportive relationships shaped how peer support relationships could be built within mental health services. It was also clear that peer workers were not able to build relationships with every person that they intended to support, and that this was little discussed among peer workers. An appreciation of the wider social and economic factors that influence our own abilities to effect change would be helpful in preventing peer workers internalising a sense of personal failure if they are not able to build connections with everybody that they meet. It would be sensible for this to be a core part of peer worker training given that peer workers are often faced with the challenge of supporting people who are unfamiliar with the concept of shared power, after years within mental health services. The growth of peer-led

alternatives should also be invested in alongside the employment of peer support workers within NHS mental health services.

For peer workers to be meaningfully employed within NHS mental health services, we can learn from the experiences of peer workers who have felt supported and valued in their roles. Where this has happened, the peer workers' training and values base has been echoed by team members, reducing the level of compromise that they feel, and reducing the expectation or need for them to challenge the working practices of colleagues. Peer workers also described the valuable support that they received from each other, both informally and through supervision. This was especially important when they were new to their roles and in times of service change. Despite this support, there were some issues which were enduring for all peer workers I interviewed. The low pay associated with peer worker roles was a source of frustration. Although some peer workers were content with their wage, they viewed this as something which needed addressing in the longer term, alongside opportunities for them to progress without having to access professional training (e.g. nurse or Occupational Therapy).

Ultimately, the culture of mental health services needs to become one that genuinely values lived experience, as well as the importance of connection and empathy. This will come as no surprise; survivor movements, as well as organisations such as ImROC, the King's Fund and the British Psychological Society have long campaigned for this. The introduction of Trauma informed practice, Open Dialogue, and the publication of the Power Threat Meaning Framework (Johnstone et al., 2018), as well as calls for compassionate leadership (e.g. Kanov et al.2004), represent efforts to shift the paradigm in a way that would be supportive to peer workers. It might be that if the culture changed significantly toward a compassionate, trauma informed environment, there would be no need for workers to carry the title of 'peer'. Many peer workers suggested to me that the peer title is not helpful within the context of mental health services because of the stigma and stereotypes they become associated with. This highlights the work that must be done around the perceptions of mental health within the mental health workforce.

Because of the relative novelty of peer support as an addition to the mental health workforce, there is a need to embed a leadership structure within mental health Trusts to support and champion peer working at every level. My role as Peer Support Development Lead was part of this emerging leadership structure, however, as my diary evidenced, I often felt that what was required of me was unreasonable, and I had very little support to develop or hold a vision for peer working. My own pay issues, and my relatively low band in comparison to those who I was working alongside in leadership positions felt disempowering to me. I did not feel that my situation was created through any malign intentions toward the concept of peer support, only through a lack of understanding or clear vision for what is needed in terms of leading peer support and how the organisation must mobilise this. Nottshc has positioned peer support alongside its wider vision for recovery orientated change across its services (Nottshc, 2016a). However, especially in the context of ongoing austerity, this discourse has not occupied a central position in terms of the prevailing socio-cultural practices of the organisation. It is a difficult task to make recovery and peer support centrally relevant in times of austerity without their original intentions being subverted by the neo-liberal discourses, and so it is only in the process of constant resistance, revisiting and reframing of the discourses that construct peer support and recovery that we can preserve their radical intentions.

We should all be prepared to challenge existing practice where we see that it could be improved, but the impact that austerity, understaffing and service change has on working practices and staff wellbeing should also be acknowledged. Many peer workers spoke out of concern for their colleagues who they described as also undervalued and struggling to cope in their roles. True culture change requires us to collectively, repeatedly highlight the unacceptable demand placed on mental health services. The simple (and difficult) act of reducing the demand placed on individual staff members within mental health services might free up space for them to contemplate the value of lived experience, and engage the workforce in defining the role alongside peer workers. However, although increasing funding is a positive step, a ‘more

of the same' approach has no transformative potential, and is not sufficient. Although attitudes toward the introduction of peer workers may be shifting, their inclusion is still viewed largely in terms of traditional service models. A paradigm shift away from medical interventions toward social understandings of human experience requires the development of a broader range of policies that focus on confronting social inequality and social injustice (Cummins, 2018)

The continued innovation that is necessary to effect change within mental health services can only be possible in the context of particular political circumstances. Drawing on the political methodology of Peter Sedgwick, Moth and McKeown (2016) describe how transformative change requires the integration of diverse populations of survivors, professionals, trade unions and wider communities. These cross-sectional alliances may have the power to collectively create the necessary pre-conditions for social change based on alliance building. This alliance-based change may have been a feature of the recovery movement in the past decade, with its emphasis on co-production and uniting different stakeholders in social change. However, as the arguments regarding the co-option of this movement grow, there is a need for renewed focus on the original values and how they have become warped within the context of neo-liberal economic aims. Moth and McKeown argue for:

> *'A politics that rejects prioritisation of market demands in favour of the tangible and diverse needs of communities. The construction of need here is not oriented to minimal biological requirements but is concerned instead with creating the conditions for human flourishing and wider distributive justice.'* (2016, p.10)

Peer workers describe the great skill that they use to build peer support relationships with those that they support, and how they use power to empower others where they can. There needs to be opportunities for peer workers to feel collectively empowered within a wider movement of change in mental health and welfare services. Renewed activism through strategic alliances would drive a shift away from narrow expert-based bio-social

understandings of mental health toward valuing the embodied experience of madness and addressing structural issues. This would contribute to the role of lived experience being valued within the context of the wider mental health system. This is a necessary step in the name of culture change within mental health services, but it should not be the responsibility of individual peer workers to make this happen.

9.11 Limitations of the research

While I am not convinced that the concept of limitations is particularly 'recovery focussed', it is difficult to find an alternative word which does not suggest that I am ignorant to the shortcomings of my research. And I am certainly not ignorant to how my research might be criticised, but I do not believe that all of these criticisms constitute limitations. For example, that this research bears the maker's mark and has been shaped by my own selection and analytic process, is not something that I consider to be a limitation. The literature relating to reflexivity in qualitative research suggests that knowledge is co-constructed (Bhaskar, 1978). I understand it to be a fact of undertaking any inquiry that my method is unique to me, and different to anybody else, even if we followed the same analytic framework. I hope that I have been transparent throughout this research about my thought process and my position in the study including the power that I have as Peer Support Lead within the Trust. This is a cornerstone of rigorous qualitative research (Tracey, 2010), and one that I have strived toward using a reflexive approach. The research has taught me things I thought I knew, and challenged my old understandings of peer support, but by definition, I cannot be aware of my blind spots, and for this reason supervision and feedback have, I hope, woken me up to a great many of them.

During the research, I often felt aware that peer workers talked about their relationships with staff members, and how they felt they were perceived by the teams they worked in. While peer workers described being accepted or discriminated against by those around them, I cannot know what the understanding of staff members was without asking them. If the research had

included the perspective of staff members, this might have offered a more 'rounded' understanding of peer support in the organisation. However, it might also have diluted or invalidated the experiences of the peer workers. Even if it is 'only' their perception that peer support is not fully accepted or valued within the organisation, it is still important, and tells us about the outsider-ness that peer workers can feel. This research made other staff the outsiders, by not including their voices. While I intended to privilege the experiences of peer workers, it was not my intention to invert the usual power dynamic between lived and professional experience, but perhaps this is what I have done. I also did not include the experiences of people who have received peer support, unless they had gone on to become peer workers. I chose not to do this in order to maintain the focus on the experience of peer support in an NHS organisation. Expanding the focus would have risked collecting far too much data to be respectfully analysed. A case study design could be employed within future research to gain this 'bigger picture'

I endeavoured to protect the identity of the peer workers I interviewed by first anonymising their interviews, and then by presenting my findings in ways that combined or fragmented individual voices. This approach did not allow for the individual settings of peer workers to be explored, for example in what ways the experiences of peer workers based in Child and Adolescent services differed from those in Adult Mental Health settings. In future research, with larger samples, it would be interesting to explore the unique differences in the experiences of peer workers in different service areas.

The experiences of peer workers' lack of career progression or low pay in Nottshc might not apply to other organisations where the career structure for peer workers may be more advanced. However, the broad mechanisms of paradoxical power, identity and emotions are theoretically transferable (Lewis et al., 2014). Future research could determine how these mechanisms are expressed within different contexts, and what other mechanisms also play a role, as it is unlikely that these three mechanisms can explain all of peer support.

This thesis does not end with an argument either for or against peer support in formal mental health services. What I argue is that, for it to continue in a meaningful sense, the debates surrounding peer support need to evolve, or at least to remember their roots. Instead of talking about recovery, we must talk about oppression, instead of inclusion, we must talk about power and stigma. Instead of lived experience or 'peer' labels, we must explore broader, more diverse identities. Before peer support becomes included, assimilated and de-clawed, it must be re-politicised so that peer workers, survivors and service providers can collectively design ways to respond and act within, rather than being 'worked over by' mental health systems.

9.12 Implications of this research

This research is important both in terms of what it tells and how it is told. In exploring survivor research and standpoint theory as epistemological underpinnings, I developed a method of undertaking an inquiry which embodies the values of peer support, something which I believe is vitally important. In doing so, I have avoided replicating the power dynamics that are often found within mental health services of expert knower and passive recipient. Instead, I have positioned the peer workers' experiential knowledge as central to understanding peer support, alongside my own reflexively offered experiences. In reporting my findings, I troubled the notion of 'authentic voice' by constructing conversations between peer workers and using other creative methods to evoke for the reader a sense of the peer workers' experiences. Drawing on the work of feminist researchers and ethnographers, I developed an approach to presenting findings which enabled the reader to make their own sense of what was found, positioning them as a partner in the meaning making process. This may be used as a template or an example to support future research into peer support which need not be at odds with its values.

This is also one of the fist studies to explore the concept of peer support and how it is offered within UK mental health services. Much of the research surrounding peer support has come from the US and Canada, as well as Europe. While this is helpful, mental health services are organised and peer

workers are included very differently across these cultures. This research highlights the impact of austerity on the experiences of peer support workers, which has not previously been explored, and would not be captured in research from outside of the UK.

Theoretically, the research contributes to the narratives surrounding recovery, social inclusion, stigma and power within mental health and disability studies. I have shown that with the inclusion of peer workers comes the creation of a new 'peer' identity, one that can be constructed through both stigmatising and empowering discourses. I have shown that in some ways, the inclusion of peer workers does little to challenge the hierarchical nature of psychiatric systems, but that it does do something. In teams where peer workers are supported, they contribute to, and sometimes lead, a gradual culture change away from 'us and them' systems toward valuing shared humanity. However, with inclusion often also came a sense of exclusion for peer workers, one of the many paradoxes experienced by peer workers when they work in systems that are at odds with their values.

The research also has practical and clinical implications for peer workers. The importance of training, ongoing support and supervision was regularly stated by peer workers and often contributed to them staying in their roles. It is not a new finding that supervision is important, however, in current mental health services, it is often one of the first structures to suffer in the face of high demand and limited time. This research tells us that supervision that is aligned to the values of peer support must be consistently provided, and that this should be a pre-requisite for employing peer workers. In fact, the research tells us that there are several pre-requisites for employing peer workers. These include a supportive manager, high quality training, and perhaps most importantly, a team which understands and shares the values of peer support. It seems that when a peer worker is employed within mental health services, either the services or the peer worker must change, because the values that underpin each approach are so different. Some peer workers found teams which shared their values and welcomed them as an additional resource. This tells us that peer support can be successful in mental health services where

services are truly able to enact the values of peer support, or where peer workers are resilient enough to persevere in the face of clashing cultures.

The findings of this study are relevant not just for peer workers, but for anybody who came into a profession to care, and found themselves at the mercy of cost-saving agendas, austerity and endless risk assessments. This study communicates the need to shift our focus onto the institutions that employ peer workers, and further, to the structural or political pre-conditions that shape these institutions. It highlights the need for renewed political efforts from survivors, peer workers, professional staff and the wider community to build alliances which can mobilise against the neoliberal agenda which commodifies lived experience.

9.13 Relevance to practice

While peer support workers have been the subject of much research in recent decades, this study has highlighted the need to shift the focus away from peer workers and onto the contexts that they are employed to work within. Peer workers thrive in the context of a supported and supportive team and organisational environment, where their approach is valued and understood. The experience of some peer workers was of being undervalued and even those peer workers who felt valued by colleagues were unsure of how the Trust was investing in lived experience at other levels of the organisation.

Cultures that truly valued lived experience demonstrate this by investing in leadership structures and peer-led services, as well as by supporting staff members in any role to be open about their lived experience. This would communicate an understanding that the peer identity does not simply equal lived experience, but that peer workers bring other skills, as well as other identities to their roles. Expanding the understanding of ‘peer’ to encompass cultural, gender, age and class differences is also important to avoid essentialising peer workers, or tokenistically including lived experience in service provision without understanding the intersectional nature of this.

Peer support training does not consistently include an understanding of the social and political determinants of mental health, or the impact of long-term

institutionalisation on people using mental health services. These are both issues that would support peer workers to develop their understanding of how to work within NHS services. In addition, the message that it is not always possible to connect with everyone, despite our skills and good intentions, would be a way of helping peer workers position themselves in the context of a wider picture where other forces, beyond themselves, also determine the success or failure of peer support relationships.

Peer workers used skills including empathy, 'being' with and sharing lived experience within their peer relationships. They described how they perceived these skills led to peer relationships which were defined by trust, closeness and mutual learning. These skills are relevant to the whole mental health workforce. As lived experience becomes more valued as a form of knowledge that many people can bring *alongside* other forms of knowledge, these skills may begin to hold an equal footing alongside scientific and clinical expertise.

9.14 Personal reflections on the study

Like a pendulum, I have swung between different extremes throughout the process of this study. As my diary documented, I have felt extreme anger toward the systems that employ peer workers, but this anger has only served to mask my own anxiety that I have been contributing to a damaging, co-opted, approach which I would be better to walk away from. Alongside this anxiety, I have been (and continue to be) awestruck by the peer workers I work alongside. Their wisdom and their humour commonly surpass my own and it is those individuals who have kept me coming to work, and kept me believing in peer support.

It has been a strange and rewarding experience for me to become a researcher, and for my friends and colleagues to become 'participants.' At first, I was concerned about how I might be criticised for my biased viewpoint and proximity to my field of study. Again, I have swung with the pendulum toward feeling the power of my own standpoint, but I have not remained at this point. I can see that my standpoint has been an advantage and a disadvantage. I have been much too close to some elements of peer work to notice that they are salient, and I have to thank my supervisors for highlighting when this has

happened. Because I feel a great debt to the peer workers that I interviewed, not only for their participation, but for their ongoing relationships with me, I have been wary of the message that I communicate in this thesis. I have felt a desire to protect the peer workers from the conclusions that I have drawn, and to protect myself from the feeling that I might have hurt them by criticising peer support. This wariness has been helpful to me. It has led me to return to the interview transcripts to check that what I have written is balanced and fair, and it has called for me to sharpen my reflexive skills to prevent myself from censoring what I found out of misplaced concern. It is ironic that I have been so concerned with protecting the peer workers; it parallels the experiences that some of them communicated to me in interviews of feeling over protected within the clinical teams. I am reminded of the frustration that they spoke of as they told me that they did not need protecting, and this helps me to loosen my grip, and accept that I cannot control the impact of my thesis, good or bad.

I am profoundly grateful for the awareness that I have gained about the broader political context surrounding peer support. But, as Foucault (1984) wrote, ‘knowledge is not made for understanding: it is made for cutting’ (p.88). Knowledge is unsettling; in some ways I feel that the process has been like opening Pandora’s box and that it was easier to work in the field of peer support without having heard of concepts of co-option, assimilation, or even neoliberalism. Now that I do know these things, everything feels messier and more difficult to define. Certainly, less difficult to put into boxes labelled ‘good’ and ‘bad. But I am told, that is the task of being an adult, to hold happiness and sorrow in the same hand, and call it being alive.

Chapter 10 - Conclusion

It is October 2019 and in my full time role as Peer Support Development Lead, I find myself standing on a stage at the end of a staff training day filling a slot about recovery focussed practice. I have slides I have used before, detailing the CHIME framework (Leamy et al., 2011) and with information about the Trust's recovery strategy. I find myself a little embarrassed to be talking about this topic. Isn't recovery dead yet? For some staff members, was it even alive?

As well as this, I know that the way to make this topic interesting is to share my own lived experience of recovery. I am weary of doing this. Since I started working as a peer support worker myself in 2010, I have inched my way up Maslow's hierarchy, away from the raw pain which I associate with my lived experience, and it is with a sigh that I find myself reaching back down to those memories, and clawing out a few handfuls of them to offer to the audience. I feel like it makes the point for me, but I also feel a little defective.

In the process of this study, I have been able to situate these experiences, of feeling simultaneously important and exploited, among the experiences of other peer workers, and within the wider discourse which constitute peer support within the context of mental health services. I have shown the dissonance that exists between the rhetoric of culture/service change and the experiences of peer workers within these services. I have explored how the discourses of peer identity are constructed within the context of mental health services. These identity discourses can be empowering for individual peer workers, but also a place of confusion and stigma, as they bear the weight of inclusion within a hierarchical, medical system. While lived experience continues to be pathologized, peer workers will feel simultaneously included and excluded within mental health services, but individual peer workers have found ways to resist and challenge the stigma that is sometimes associated with their role. I have argued that true inclusion lies in significant culture change across the health and welfare provision which can only be achieved though cohesive activism and re-politicising the concept of recovery.

Chapter 11 – Postscript

It has felt strange to work on the final stages of this thesis during a period of global upheaval because of the impact of Covid-19. As I write about peer support for this thesis, I am also aware that the picture I describe of mental health services has changed, at least temporarily. Peer workers who have fiercely protected their roles have been redeployed to deliver medication. Others who are used to being busy have been directed to work from home, as have most of us, and they are bored. The peer workers on the wards, who so beautifully described the importance of connection, are now working in masks and gowns. Locally, some peer workers are shielding for twelve weeks, others have contracted Covid-19, but thankfully they have recovered and returned to work.

It will be interesting to see how the landscape of the NHS changes as a result of this crisis, and how the discourses that construct peer workers also change. 'Protect the NHS, save lives' is a powerful slogan, and one that is accompanied with the valorisation of NHS workers, as well as of science and professional expertise. I do not doubt that this is needed, but it remains to be seen how the role of lived experience will fare as these messages pervade. This crisis has at least exposed the importance of caring for the NHS workforce (as well as other 'key' workers), and new staff wellbeing initiatives are emerging daily. There is extra counselling and physical health support, as well as the added benefits of discounts and priority access to services. I am aware that this is all in the context of a shortage of essential protective equipment and staff testing, and so it is difficult to fully trust that workforce wellbeing is a true priority.

I do not want to end with the message that the landscape has changed so much as to invalidate the findings of my thesis, I do not believe that to be the case at all. It simply felt important to me to at least acknowledge the extraordinary times we are living in. While it has been frightfully difficult, especially for those of us on the front line, I know that my lasting memories of this time will be of solidarity and hope. Peer support is needed now, more than ever.

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Appendices

Appendix A – Information, method and key findings for each study in the literature review (Chapter 3)

Table 2. Information, method and key findings for each study selected for review..

Author (date) (country of origin)	Aims of research	Definition of peer support	Methodology (sample size)	Data analysis approach	Key findings	Quality rating
1. Repper & Watson (2012) (UK)	To examine the nature and dynamics of peer support based on experiences of PSWs	Title: Peer support workers Employed in an NHS organisation for a period of six months, received accredited training	Service evaluation using including document analysis, interviews and focus groups (six PSWs)	Not-specified	PSWs were found to offer emotional, practical, social support as well as support specific to their recovery. Self-disclosure was critical in developing trusting relationships	18
2. Scott (2011) (New Zealand)	Investigates peer supporters experiences of boundaries, authenticity, and the sustainability of paid emotion work	Title: Peer supporters Mix of paid and volunteer roles. Based on IPS model, and Kaupapa Māori peer support. Based on either consumer-led organisations or mental health trusts	Observation and Semi-structured interviews with peer support managers and PSWs in 14 peer support services (37 peer staff)	Thematic analysis	To create authenticity, peer supporters engage in 'authenticity work', a form of emotion work that draws on mutuality and reciprocity. While providing peer support as a paid service within the health system, it is impossible to be completely true to this vision	28
3. Moran et al. (2011). (USA)	To examine the benefits of peer support to the PSWs themselves (In the process of this, the study uncovered the mechanisms for PSWs recovery)	Title: Peer provider Employed in either conventional mental health agencies or peer-run agencies	Semi-structured interviews (31 PSWs)	Grounded theory	Identified two types of mechanisms: role-related (refer to core aspects in the work) and work environment mechanisms (refer to specific characteristics of the employing agencies)	31
4. Scott & Doughty (2012) (New Zealand)	To describe how PSWs use documentation and explore tensions this generates	Title: Peer supporters Mix of paid and volunteer roles. Based on IPS model, and Kaupapa Māori peer support. Based in consumer-led organisations and mental health trusts	Observation and semi-structured interviews with peer support managers and PSWs in 14 peer support services (37 peer staff)	Thematic analysis	Peer supporters challenged disciplinary uses of documentation by either keeping minimal information about their interactions with peers, or keeping notes in a collaborative, manner. This generated tensions with regard to the wider mental health system	29
5. Austin et al. (2014) (USA)	To explore the means and mechanisms of peer work, the formation of peer expertise, and its potential contribution to recovery	Title: Peer advocates Employed full or part time in a peer run agency	Ethnographic fieldwork and semi-structured interviews (9 PSWs)	Grounded theory analysis	Identified three themes that describe how peer support influences recovery: transforming experience into expertise, understanding the mechanics of peer support, and	28

(continued)

Author (date) (country of origin)	Aims of research	Definition of peer support	Methodology (sample size)	Data analysis approach	Key findings	Quality rating
					launching peers towards their own recovery	
6. Mancini & Lawson (2009) (USA)	To understand how PSWs experience emotional labour, and organisational conditions necessary to enhance positive emotional labour	Title: Peer providers Employed in community agencies, consumer-run services or in program development services. Only six participants provided direct peer support	Semi-structured interviews (15 peer staff)	Retrospective thematic analysis	Five categories emerged through analysis (1) Engagement/connection (2) Re-traumatization (3) Stigmatization and discrimination (4) Role confusion (5) Social support	21
7. Scott et al. (2011) (New Zealand)	To explore the ways that risk, violence, suicide and self-harm are managed within peer support services	Title: Peer supporters Mix of paid and volunteer roles. Based on IPS model, and Kaupapa Māori peer support. Based in consumer-led organisations and mental health trusts	Observation and semi-structured interviews with peer support managers and PSWs in 14 peer support services (37 peer staff)		Peer support services deal with risk in different ways, leading to a continuum of approaches. Some peer supporters are beginning to develop a specifically ''peer support'' way of addressing risk	22
8. Gidugu et al. (2015) (USA)	To develop an understanding of peer support's mechanisms of action	Title: Peer support specialists Employed in traditional mental health services, undergo training	Semi-structured interviews Part of a larger study (23 peers)	Thematic analysis using grounded theory	Peer support provided various practical, emotional, and social supports which were perceived as beneficial, particularly in their non-clinical nature Individuals' expectations of peer support did not always comport with available services	23
9. Proudfoot et al. (2012) (Australia)	Test whether four theoretical mechanisms underpin peer support in people with a diagnosis of bipolar disorder	Title: Informed supporters Trained and Paid for the purposes of the study. Trained by the first and fifth authors	Email exchange, face-to-face interviews with three PSWs (48 PSWs and peers)	Thematic analysis of interview transcripts and email extracts	The four mechanisms (experiential knowledge, social support, social comparison and helper therapy) were all found within the data analysis	28
10. Coatsworth-Puspoky et al. (2006) (Canada)	To explore the factors that influence peer support relationships	Title: Consumer survivors Offering peer support in a within peer-run organisations	Semi-structured interviews (14 peers)	Ethno-nursing method	Findings revealed that the peer support relationships may develop or deteriorate through three, overlapping phases	29
11. Mourra et al. (2014) (USA)	To communicate the experiences of peer support workers in developing peer to peer relationships	Title: Peer staff Employed within traditional mental health services, received 40 hours of training	Semi-structured interviews (seven PSWs)	IPA	PSWs described an approach involving pushing, patience and the need for gentle persistence The mutual nature of peer	24

(continued)

Author (date) (country of origin)	Aims of research	Definition of peer support	Methodology (sample size)	Data analysis approach	Key findings	Quality rating
					support was both an advantage and a source of challenge	
12. Gillard et al. (2015) (UK)	To model change mechanisms that underpin peer support interventions	Title: Peer workers Work in a mixture of volunteer and NHS settings in a range of peer roles	Structured and semi-structured interviews (22 Peer workers, 18 peers, 31 managers and non-peer staff)	Grounded theory	Identified three key change mechanisms: building trusting relationships, role modelling recovery, and engaging people with the community they live in	28
13. Rebeiro Gruhl et al. (2016) (Canada)	To examine the role of the PSW including challenges and benefits	Title: Peer support workers Working and volunteering in consumer survivor initiatives in North Eastern Ontario, Canada	Web based survey and face to face focus groups (52 PSWs in the survey, 25 PSWs and eight peers in the focus groups)	Thematic analysis	Authentic peer support is highly important to recovery. Authenticity was defined as being able to draw on persona experience and engage in mutually beneficial discussions	25

Appendix B – participant information sheet

The University of Nottingham
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NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Participant Information Sheet
(Final version 1.0: 26th May 2017)

IRAS Project ID: 219031

Title of Study: Peer Support in an NHS Mental Health Service

Name of Researcher(s): Emma Watson

I would like to invite you to take part in our research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask if there is anything that is not clear.

What is the purpose of the study?

The aim of the research is to explore the nature of peer support within NHS mental health service including the mechanisms that underpin it

Why have I been invited?

You have been asked to take part in the study because you are working or volunteering in Nottinghamshire Healthcare NHS Trust and you have been identified by the Workforce Recovery Lead as having a relation to peer support in Nottinghamshire Healthcare NHS Foundation Trust.

This study will involve individual interviews with up to 18 people.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

I would like to interview you in private about your experiences and opinions of peer support. The interview will last between 30 and 90 minutes, and its length will depend on how much you want to say. The interview will be audio-recorded and later transcribed. Your anonymity, and anyone else mentioned, will be preserved in any written publication produced as a result of the study.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Being involved in an interview creates the possibility that sensitive issues may arise for discussion. However, you will never by under any pressure to talk about issues or reveal information about yourself that you prefer to keep private. The researcher (Emma Watson) will be available to talk through issues which you may have found distressing and signpost you to other sources of support should you need this.

What are the possible benefits of taking part?

The study will not have any bearing on your normal activities, current relationships, or any professional relationship with mental health services. Although it will not benefit you directly, the results of the study may help to further develop our understanding of peer support within the NHS and contribute to refining the role.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Samantha Eagling, Nottinghamshire Healthcare NHS Trust's Service Liaison Manager: Moorgreen House, Highbury Hospital, NG6 9DR, or email: complaints@nottshc.nhs.uk

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are supporting the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personally identifiable data (address, telephone number) will be kept for 3 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far can also be erased up until it has been analysed.

What will happen to the results of the research study?

The results of the study will be made available through journal publications, conference presentations and at public events. Individual participants will not be identified in any publication resulting from the study. If you would like a summary of the results at the end of the study, please tell the researcher and provide your contact details so that they can send this to you.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham School of Nursing, Midwifery and Physiotherapy Ethics Committee.

Further information and contact details

Researcher:

Emma Watson
Peer support development team

Duncan Macmillan House

Porchester Road

Nottingham

NG3 6AA

Tel: 07824 528050
Email: emma.watson@nottshc.nhs.uk

Supervisor:

Dr Theodore Stickley
School of Health Sciences
Faculty of Medicine & Health Sciences
University of Nottingham
Institute of Mental Health Building
Triumph Road
Innovation Park
Nottingham
NG7 2TU
Tel: 0115 7484305
Email: theo.stickley@nottingham.ac.uk

Thank you for your interest.

Appendix C – participant consent form

The University of Nottingham
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NHS
Nottinghamshire Healthcare
NHS Foundation Trust

CONSENT FORM
(Final version 1.0: 26th May 2017)

Title of Study: PEER SUPPORT IN UK MENTAL HEALTH SERVICES

IRAS Project ID: 219031

Name of Researcher: Emma Watson

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1.0 dated March 2017 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that, in the event of my withdrawal, the researcher will seek to utilise the data collected. I understand that I can request that my data is erased unless it has already been analysed. ☐
6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Appendix D – interview topic guide

The University of Nottingham
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NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Interview topic guide
(Final version 1.0: 26th May 2017)

IRAS Project ID: 219031

Title of Study: Peer Support in an NHS Mental Health Service

Name of Researcher(s): Emma Watson

Introduction

- Thank you for agreeing to take part in the interview
- The aim of the research is to provide insights into how peer support is undertaken in an NHS mental health service and offer an understanding of the role that context plays in influencing this
- I would like to ask you about your experiences of peer support and your perspective of peer support in Nottingham NHS Trust. I have some questions as a rough guide but will be responsive to themes that come up in conversation
- The interview will last up to 90 minutes.
- Participation is optional and they can stop the interview or decline to answer specific individual questions at any time should they wish.

Confidentiality and consent

- Read through the participant information sheet, talk through each section
- Check if they have any further questions before beginning the interview
- Ask them to read through the consent form and, if they agree to take part, to tick the boxes and sign their name

Peer Support – general information

- What is your connection with peer support in Nottinghamshire NHS Trust – what context do you work in, what different roles have you offered peer support in – how long have you been in your role?

Perspective on peer support

- How would you define peer support work?
- What do you think are the important components of peer support?
- What do you think makes the peer support role different to other roles?
- Do you think that the NHS context changes the way that peer support is offered/you offer peer support?
- In an ideal world, what would peer support look like in Nottingham NHS Trust?

Experience of peer support

- How easy do you think it is to offer peer support
- Have you experiences any barriers to implementing/offering peer support
- What do you think the emotional cost of peer support is?
- What support do you think people need/have you needed to offer peer support?

Final comments

- Is there anything further you would like to add
- Are there any questions that you would like to revisit to amend or elaborate?

Debrief

- Thank you for taking part
- How did you find talking about your experiences and perspectives of peer support?
- Draw attention to the contact details on the information sheet and make it clear that the researcher can be contacted if needed
- signpost to sources of support if appropriate

Appendix E – Written ethical approval from the University of Nottingham

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

30 June 2017

Emma Watson
PhD Student
c/o Dr Theodore Stickley
Associate Professor of Mental Health
Room D15, Institute of Mental Health
University of Nottingham
Jubilee Campus
Nottingham
NG7 2TU

Dear Ms Watson

Ethics Reference No: 128-1706 **– please always quote** **IRAS Project ID:** 219031 **Study Sponsor Ref:** RGS 17033	
Study Title: Peer Support in an NHS Mental Health service	
Short Title: Peer Support in an NHS Mental Health service	
Chief Investigator/Supervisor: Dr. Theodore Stickley, Associate Professor, Institute of Mental Health	
Lead Investigators/student: Emma Watson PhD Student, School of Health Sciences	
Type of Study: PhD project, qualitative/quantitative	
Proposed Start Date: 01/06/2017	**Proposed End Date:** 31/05/2017 24mths
No of Subjects: 15+	**Age:** 18+years
School: Health Sciences	

Thank you for submitting the above application which has been considered by the Committee on 23 June 2017and the following documents were received:

Peer Support in an NHS Mental Health service:

- IRAS Form version 1.0 date 04.04.17
- Sponsorship Statement dated 31.05.1
- Evidence of Insurance dated 07/2016
- Protocol Final version 1.0 date 26/05/17
- E-mail Invite Final version 1.0 date 26/05/17
- Participant Information Sheet Final version 1.0 date 26/05/17
- Consent form Final version 1.0 date 26/05/17
- Interview Topic Guide Final Version 1.0 date 26/05/17
- CV Dr Theodore Stickley dated 26/05/17
- CV Emma Watson dated 26/05/17

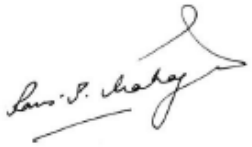
These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that the conditions set out below are followed:

University of Nottingham
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1. You should follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (please request a form).

Yours sincerely



Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix F – the peer support worker Job description used at Nottshc

JOB DESCRIPTION

Job Title: Peer Support Worker (PSW)	
Reports to (post title): Ward Manager / Team Leader	
Role Purpose: The role of peer support worker has been developed specifically for people who have lived experience of mental distress. Through sharing wisdom from their own experiences, Peer Support Workers will inspire hope and belief that recovery is possible in others. As an integral and highly valued member of the multi-disciplinary team, the PSW will provide formalised peer support and practical assistance to service users in order for them to regain control over their lives and their own unique recovery process. Within a relationship of mutuality and information sharing, they will promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities. The PSW will act as a recovery champion within the team and an ambassador of recovery for the Trust with external agencies and partner organisations. There is also an expectation that PSWs will be involved in the ongoing development of peer roles in the Trust including the Peer Support Training Programme and evaluation.	
Role Context: The postholder will be required to work as part of a multidisciplinary team.	
KEY ACCOUNTABILITIES	**PERFORMANCE MEASURES**
Working Practice To establish supportive and respectful relationships with people using mental health services. To help people identify their own Recovery goals	

To support service users to identify and overcome fears within a relationship of empathy and Trust To share ideas about ways of achieving Recovery goals, drawing on personal experiences and a range of coping, self help and self management techniques To assist others to create their own Recovery plans and develop advance directives To model personal responsibility, self awareness, self belief, self advocacy and hopefulness To sign-post to various resources, opportunities and activities within the Trust and in communities to promote choice and informed decision making To accompany service users to appointments/meetings/activities of their choice and performing a range of practical tasks, aligned to recovery goals To raise awareness of recovery language among Trust staff by modelling positive, strengths based, non-discriminatory, non-jargon, non-medicalised language in all areas of work To support the team in promoting a recovery orientated environment by identifying recovery focused activities and imparting information and education as required Be actively involved in the continued development of the PSW training programme and in the ongoing evaluation of the PSW role	Appropriate professional standards are met. Recovery benchmarking will demonstrate improvements.

To abide by the PSW Code of Conduct, so that the central focus of work, inspiring recovery, is not compromised in any way To act as an ambassador for the Trust with external agencies and partner organisations To undertake any other duties which may reasonably be regarded as within the nature of the duties and responsibilities/grade of the post as defined, subject to the proviso that normally any changes of a permanent nature shall be incorporated into the job description in specific terms	
Education and Development Attend and complete agreed induction programme If not completed to attend the Trusts Peer Support Worker Training Programme To identify personal developmental needs in conjunction with Line Manager and Recovery focused supervision Work to standards which equate to NVQ Level 3 Care Standards, undertaking further training as necessary To participate in mandatory training as required Participate in regular supervision including recovery focused supervision Maintain a working knowledge of current trends in mental health, recovery and peer support by reading books, journals and accessing peer support networks	Personal development and training targets are met. Participation in Personal Development Appraisals.
Health and Safety.	

To work within Health and Safety Policies in accordance with Nottinghamshire Healthcare NHS Trust, Nottinghamshire Social Services Department, Nottingham City Social Services Department, as applicable	Health and Safety Practices are adhered to.
Policies and Procedures. The duties and responsibilities of the post will be undertaken in accordance with the Policies and Procedures of Nottinghamshire Healthcare NHS Trust and Nottinghamshire Social Services Department, Nottingham City Social Services Department as applicable.	Policies and Procedures are adhered to.
Risk To assist in risk assessments with multi-disciplinary staff, highlighting any changes in service users presentation relevant to their safety plan and feed back accordingly.	Risk Assessments and safety plans are implemented efficiently and effectively.
DIMENSIONS	
As a core member of the multi-disciplinary team, the PSW will work alongside an agreed number of service users on a 1:1 and/or group basis. The PSW will take a lead role in embedding recovery values within the service setting in which they work with other Trust recovery champions. Reporting directly to the Team Leader/Ward manager and under the professional supervision of the Peer Support Worker Lead, the PSW will be responsible for the delivery of peer support interventions as agreed within the peer relationship.	
SKILLS, KNOWLEDGE AND EXPERIENCE	

To have lived experience of mental health problems
To have experience of recovering a meaningful life
To have experience of being in a supportive and enabling role
To be computer literate in Microsoft office
Ability to share personal story of recovery in a professional manner
Ability to assist people to develop recovery plans
Ability and willingness to reflect on work practice and be open to constructive feedback
Ability to work in an enabling and creative way
Willingness to support people with a range of needs to meet their recovery goals
Ability to manage stress and to plan and prioritise workload
Ability to carry out practical tasks
Ability to maintain a healthy home/work life balance
High level of self-awareness – ability to critically appraise own performance
Critical thinker
Understanding and practical knowledge of recovery
Understanding of the issues and concerns of mental health service users
Knowledge and commitment to service users rights
Understanding of the impact of stigma and discrimination
Knowledge of Mental Health Legislation

Knowledge of local policies in respect of safeguarding children and the protection of vulnerable adults

Able to organise and plan own work activities

NVQ 3 or equivalent level of knowledge training and experience

COMMUNICATION AND RELATIONSHIP SKILLS

Excellent written, verbal and non-verbal communication skills.

To communicate effectively with a range of service users, carers, professionals and agencies

Receiving highly complex and sensitive information. Persuasive and reassurance skills required

Ability to develop and maintain sound working relationships with all members of the multi-disciplinary teams

To be aware of professional roles within the therapeutic relationship

Willingness to use the Trust IT systems

Professional in appearance and behaviour

Able to manage conflict and to help others to do so

Good team-working skills

PHYSICAL EFFORT

In frequent requirement for movement and handling of service users and objects. May need to travel within service area, as required. Use of breakaway techniques may be required.

EMOTIONAL EFFORT

The role is emotionally demanding due to the nature of distress experienced by service users and the workers own lived experience

Issues may be encountered which may be emotionally distressing for the workers involved

WORKING CONDITIONS

Frequent exposure to potentially aggressive behaviour from patients, carers and relatives, and occasional actual aggression from patients.

The postholder will occasionally become exposed to communicable diseases

The postholder will occasionally come into contact with body fluids and foul linen.

ORGANISATION

Executive Director-Adult Mental Health

General Manager

Service Manager

Modern Matron

Ward Manager

Clinical Team Leader

Staff Nurse

This Post

SIGNATURES

After reviewing the questionnaire please sign to confirm agreement

Post holder:	Date:
Line Manager:	Date:
Next level Manager :	Date: